CHAPTER 100– GENERAL INFORMATION

CHANGE LOG

Replace	Title	Change Date	Effective Date
Sections: 110, 121, 150, 151, 152, 153, 160, 161, 170, 180, 191	Various	12/02/04	01/01/05
Section 140	Manual Updates	12/02/04	01/01/05
Section 153	Other Contact Information	12/02/04	01/01/05
	Medicaid Managed Care	12/02/04	01/01/05
Section 161	General Non-Covered Services	12/02/04	01/01/05

CHAPTER 100– GENERAL INFORMATION

12/2/2004

Sections: 110, 121, 150, 151, 152, 153, 160, 161, 170, 180, 191

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 140

Introduction: The manual update process has undergone some changes. Also the contact phone numbers in this section have changed.

Directions: Replace the page containing this section.

Change: Replace old phone numbers with the new ones.

Section 153

Introduction: Some of the contact phone numbers in this section have changed because of the change in contractors.

Directions: Replace the page containing this section.

Change: Replace old phone numbers with the new ones.

Introduction: Added wording related to PCCM Program.

Directions: Replace the page containing this section.

Change: Add PCCM Program.

Section 161

Introduction: Removed Gastric By-pass from the section since this surgery is now a covered service under certain conditions.

Directions: Replace the page containing this section.

Change: Delete gastric by-pass as a non-covered service.

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CHAPTER 100–GENERAL INFORMATION

100 INTRODUCTION

This chapter provides a general overview of the Medicaid Program and organization of the provider manuals. It includes general information regarding the legal basis of Medicaid in West Virginia (WV), its relationship to other programs (for example, Children with Special Health Care Needs), provider telephone contact information, a general description of covered and non-covered services, its relationship to the Medicare Program, and basic information on reimbursement for out-of-state providers.

110 MEDICAID PROGRAM OVERVIEW

Congress established the Medicaid Program under Title XIX of the Social Security Act of 1965. Title XVIII of the Social Security Act of 1965 created Medicare. Title XIX created the Medicaid Program to provide access to health care for certain low-income individuals and families. Medicaid is funded and administered through a cooperative state-federal partnership. Nationally, the Centers for Medicare & Medicaid Services (CMS), operating within the U.S. Department of Health and Human Services (DHHS), provide federal financial assistance to the states, establishes minimal program requirements, and provides regulatory oversight. Although there are broad federal requirements for Medicaid, states have a wide degree of flexibility to design and administer their programs within federal guidelines. These guidelines are in the Code of Federal Regulations, Title 42, Sub-part C.

The WV Medicaid Program is administered pursuant to regulations promulgated under Title XIX of the Social Security Act, as amended. State administrative authority for the Medicaid Program is provided pursuant to Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) in the Department of Health and Human Resources (DHHR) is the single state agency responsible for administering the Medicaid Program in WV.

The mission of the WV Medicaid Program is to provide access to appropriate health care for Medicaid-eligible individuals. In its administration of the program, BMS strives to assure access to appropriate, medically necessary and quality health care services for all members while maintaining accountability for the use of resources.

BMS establishes eligibility standards for Medicaid providers, determines benefits, sets payment rates, and reimburses providers. BMS also coordinates with other entities in DHHR to develop and implement Medicaid-related programs and services. In particular, BMS contracts with the Office of Families and Children to determine eligibility for Medicaid. BMS monitors and tracks program information related to member eligibility, service utilization, program expenditures, fraud and abuse, and financial management.

BMS maintains the WV Medicaid State Plan and files amendments to the plan with the appropriate regulatory authorities. If BMS identifies the need for major change to the Medicaid State Plan, the Medical Services Fund Advisory Council, appointed by the Commissioner, reviews the change and makes appropriate recommendations to BMS prior to implementation.

120 PURPOSE OF THE MANUAL

WV Medicaid provider manuals contain detailed information about the WV Medicaid Program. The manuals document and communicate current policy requirements applicable to Medicaid-covered services as provided by specific provider types.

The following information is included:

- General and specific provider information
- Service delivery requirements
- Provider participation requirements
- Covered services, exclusions, and limitations
- Reimbursement and billing instructions.

All Medicaid providers, BMS employees and contractors, and other interested parties are encouraged to familiarize themselves with the content of applicable manuals by types of services.

121 ORGANIZATION OF THE MANUAL

The WV Medicaid provider manuals are organized consistently for all providers and services. The following is a listing of the organization and format of each manual:

- **Cover Page** – The cover page identifies the types of services included in the manual.
- **Table of Contents** – The table of contents follows the cover page. Chapter titles, chapter subtopics, and appendices are identified and labeled to facilitate information retrieval.
- **Chapter Titles** – There are a minimum of seven chapters in each manual. The right corner of the page header identifies whether the information contained in the chapter applies to all or specific providers.

The Chapter Titles are:

- Chapter 100 General Information
- Chapter 200 Definitions
- Chapter 300 Provider Participation Requirements
- Chapter 400 Member Eligibility
- Chapter 500s Covered Services, Limitations, and Exclusions
- Chapter 600 Reimbursement Methods
- Chapter 800 General Administration

130 OTHER RESOURCE INFORMATION

The manuals summarize the description and administration of the WV Medicaid Program. BMS makes every attempt to ensure that the information contained in the provider manuals is concise and reliable as of the date of issuance. Compliance with all applicable WV state laws, regulations, and administrative guidelines, as well as applicable federal laws and regulations, is required. Specifically, you must consider the content in this manual, along with applicable federal and state laws and regulations, when determining actions or interpreting guidelines.

140 MANUAL UPDATES

BMS will distribute new, revised, or clarified information, as applicable to all or specific manuals, using the Medicaid Provider Manual Update process. The update notification from BMS will include information related to the manual change and identification of the actual section number(s) to replace or add to the manual by chapter, appendix, or attachment. Updates may be communicated by letter or posted on BMS' website (www.wvdhhr.org/bms).

Retaining, filing, and understanding the WV Medicaid Program Instructions and manual revisions are your responsibility. If any information is not clear or not understood, please call the Medicaid Provider Services at either of these numbers:

- (304) 348-3360
- (888) 483-0793

BMS maintains mailing lists of all providers and other interested parties who receive program instructions. To ensure that you receive all mailings or emails, it is essential that you notify BMS in writing of mail/email addresses or any type of health care or business organizational change. Refer to Chapter 300 for additional information on your responsibility for reporting changes.

150 WRITTEN OR PHONE INQUIRIES

Questions regarding the Medicaid Program including service, coverage, provider participation, member eligibility, prior authorizations, claims inquiries, or billing procedures may be addressed in writing or by telephone. Additional information is available on the DHHR website (www.wvdhhr.org/bms

151 VOICE RESPONSE SYSTEM

WV Medicaid's Voice Response System is an automated Provider Inquiry System. It is a quick and easy way to verify member eligibility and obtain Medicaid accounts-payable information. For the Voice Response System, call 1-888-483-0793.

Information on the Voice Response System is available 24 hours a day, 7 days a week. Your 10-digit Medicaid Provider number is required to access the system. Call and follow the voice prompts to:

- **Obtain recent accounts payable information**

Enter the 10-digit Medicaid provider number and select **Option 1**. The Voice Response System will provide cumulative payment information. This information can assist you in managing your receivables. It provides the amount and date of the reimbursement and the amount of the accounts payable (approved but not released for payment) as of the date of the inquiry. The Voice Response System does not provide specific claim information. For claim specific information, call the Provider services Unit.

- **Verify member eligibility**

Enter the 10-digit Medicaid provider number and select **Option 2**. Enter the member's Medicaid ID number from the Medicaid ID card and follow the prompts. The Voice Response System should be used each time a member requests service.

When the member's ID number is not available, you can follow the voice prompts and use the member's social security number or a combination of the member's last name and date of birth.

Request the Medicaid ID card from the member with each office visit and verify the effective dates, provider restrictions, managed care information, and other insurance information on the member's Medicaid ID card. Obtain the Medicaid Member Number from the ID card (MAID #) and call the Voice Response System to verify eligibility. Members enrolled in the Medicaid Health Maintenance Organization (HMO) program Mountain Health Trust (MHT) have the name and telephone number of the HMO on their ID cards. Members enrolled in the Medicaid Primary Care Case Management (PCCM) Physician Assured Access System (PAAS) managed care programs have their Primary Care Physician's name on their ID cards.

Verification of a member's eligibility does not guarantee payment for the services you provide. The services you provide, in addition to verification of the member's eligibility, must be:

1. Determined to be medically necessary
2. A covered Medicaid service
3. Prior authorized or approved when applicable
4. Referred or approved by the PAAS primary care provider (PCP) or HMO when applicable
5. Billed to the HMO for medical services provided to members enrolled in MHT
6. Properly documented in your office or facility medical records including, but not limited to, items one through four above, as applicable.

Additional information on your responsibility as a participating provider for verifying member eligibility is covered in Chapter 400.

152 CONTACTING PROVIDER SERVICES

BMS ensures that provider services and support services are made available through their fiscal agent organization. To obtain general information or make a general or specific inquiry regarding denied claims, claims status, accounts payable, program coverage, member eligibility, billing procedures, managed care issues, Electronic Data Interchange (EDI) training, or Electronic Funds Transfer (EFT) issues, call:

- (304) 348-3360
- (888) 483-0793

Provider Services Representatives are available Monday - Friday excluding state holidays from 8 a.m. to 5 p.m. Charleston providers should use the local provider services number. Provider Services staff will respond to requests during the call whenever possible. Occasionally, calls may be referred to another state agency for assistance. When the inquiry cannot be answered during the call, the representative will take the request and follow up appropriately at a later time. Consider the complexity of the request when waiting for the response. The response to the inquiry may be in writing or by telephone and may identify that further research and time is necessary to respond to the initial request.

EDI technical support is available to answer your inquiries related to: software issues, transmission difficulties, EDI enrollment procedures, claim format issues, EDI testing procedures, and rejected reports. To obtain technical support on electronic claims, excluding Pharmacy Point-of-Sale (POS), call 1-888-483-0793.

To obtain technical information regarding Medicaid's Pharmacy (POS) Program, call 1-888-483-0801. For technical support on electronic remittance vouchers, call Monday - Friday 8 a.m. to 6 p.m. at 1-888-483-0793. You may also access the EDI provider website, www.edihelpdesk@unisys.com, for additional information.

153 OTHER CONTACTS

Other important telephone numbers available for use by Medicaid providers are listed below:

- **Provider Enrollment**

  For information and requirements regarding participation in the WV Medicaid Program as a provider, contact the Provider Enrollment. Any change to information supplied in your provider enrollment application must be sent to BMS in writing. This includes changes to addresses, group affiliations, specialty services, telephone numbers, tax ID, Medicare provider numbers, etc.

- **Inpatient Admission Approval And Prior Authorization**

  To obtain inpatient hospital pre-certification and prior authorization of services, call 1-800-982-6334.

  This telephone number will connect you with the utilization management services manager for the WV Medicaid Program, including hospital pre-certification and prior authorization of applicable services. (Note: For HMO enrolled members, follow the respective HMO's admission approval and prior authorization requirements.)

  Pre-service review and prior authorization is performed for the following services:

  - General and Acute Inpatient Hospital Services
  - Organ Transplant Services
  - Psychiatric Inpatient Facilities and Psychiatric Residential Treatment Facilities
  - Inpatient Medical Rehabilitation Services
  - Intensive Medical Case Management
  - Home Health Services exceeding calendar year limits
  - Certain Durable Medical Equipment (DME), Orthotics and Prosthetics Services, and Medical Supplies
  - Speech Therapy
  - Physical Therapy and Occupational Therapy exceeding calendar year limits
  - Private Duty Nursing Services
  - Nursing Visits for Home IV Services
  - Outpatient Partial Hospitalization Services
  - Chiropractic Services exceeding calendar year limits
  - Nursing Facility Services
  - Aged and Disabled Waiver Services

- Home-based Community Services
- Certain General Dental Services
- Certain Vision Care Services
- Children with Special Health Care Needs
- Mentally Retarded (MR)/Developmentally Disabled (DD) Waiver Services
- Intermediate Care Facility (ICF)/Mentally Retarded (MR) Services.

In addition, you must obtain prior authorization on members who have exhausted their service limits. All services that require prior authorization are identified in the applicable provider manual that addresses the services.

- **Behavioral Health Services**

  You may obtain prior authorization for behavioral health clinic and rehabilitation services by calling American Psychiatric Systems (APS) Healthcare at 1-800-343-9663.

  Prior authorization of behavioral health services provided by private practitioners is obtained from BMS. All services that require prior authorization are identified.

- **Audits and Settlements**

  To obtain information regarding audits and cost settlements, call:

Hospital	1-304-558-0460
Nursing Facility	1-304-558-0460

  If you need information regarding the payment of audits and cost settlements, call 1-304-558-1700.

- **Pharmacy Help Desk**

  To obtain both procedural and technical information regarding the Prescription Drug Program, call 1-800-847-3859.

- **Rational Drug Therapy Program**

  To obtain procedures, prior authorizations, and information regarding the Prescription Drug Prior Authorization Process, call or fax:

Call	1-800-847-3859
Fax	1-800-531-7787

- **Third Party Liability/Coordination of Benefits(TPL/COB)**

  To ask questions regarding commercial insurance and Medicare applicability to Medicaid member claim reimbursement, call 1-304-558-1700 or visit www.wvrecovery.com.

  Medicaid is always “the payer of last resort.” BMS, in conjunction with its subcontractors, conducts coordination of benefits, third party liability identification, cost avoidance activities, and recovery functions for the WV Medicaid Program, and maintenance of compliance with federal regulations.

- **Medicaid Managed Care**

The BMS contracts with an Enrollment Broker to inform Medicaid members about managed care. The enrollment broker enrolls applicable members in either the HMO or PCCM programs. The HMO and the PCCM (PAAS) programs are known as the Mountain Health Trust (MHT) program.

The enrollment broker assists eligible members in selecting a managed care program and a primary provider of their choice. BMS assists providers who have managed care member assignment issues. For assistance on managed care assignment questions for the MHT Program, call the enrollment broker at 1-800-449-8466.

- **Department of Health and Human Resources (DHHR) Offices**

  To refer a member for Medicaid coverage or obtain information regarding policies related to member eligibility call your local DHHR office. These telephone numbers vary by geographic area. Use your local telephone directory, State Government section, to find the telephone number of the local DHHR office.

- **Medicaid Related Programs**

  The Office of Maternal, Child and Family Health (OMCFH) of the Bureau of Public Health has a toll free telephone number for information about specific health and Medicaid-related programs. To obtain information related to the programs below, call 1-800-642-8522 or 1-800-642-9704.

  - Children Specialty Care (CSC) Program
  - WV Birth to Three Program
  - Women, Infants, and Children Nutrition Program (WIC)
  - Family Planning Program
  - Breast and Cervical Cancer Diagnosis and Treatment Fund
  - Right From the Start Program (RFTS)
  - Ryan White Fund
  - Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) (HealthCheck) Program
  - Children's Dentistry Services.

  These toll free telephone services are available weekdays between 8:30 a.m. and 5:00 p.m. except holidays. The lines are staffed by registered nurses and licensed social workers that serve as the initial service coordinator for children, families, and professionals seeking information on the services offered. They can also offer instructions on how to apply for programs.

- **Medicaid Waivers**

  WV's Medicaid website contains additional information that includes, but is not limited to, information on the BMS organization, Medicaid Program Instructions and policies, Resource Based Relative Value Scale (RBRVS) with specific reimbursement issues, general information related to the Health Insurance Portability and Accountability Act (HIPAA), and specific information related to pharmacy services. You are encouraged to routinely access and view new information posted on the BMS website (www.wvdhhr.org/bms).

The Centers for Medicaid and Medicare Services is also an excellent resource to use in conjunction with the above WV website. The Centers for Medicaid and Medicare Services website is located at www.cms.gov.

160 COVERED SERVICES

The WV Medicaid Program pays for medically-necessary, covered health services, as well as certain waiver services that are provided to eligible members by Medicaid providers. The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. The following is a general listing of services covered by the WV Medicaid Program:

- Aged and Disabled Waiver Services
- Behavioral Health Clinic and Rehabilitation Services
- Chiropractic Services
- Dental Services for Children
- Durable Medical Equipment (DME) and Medical Supplies
- Early & Periodic Screening, Diagnosis & Treatment Program (EPSDT) – also known as HealthCheck
- Family Planning Services
- Free Standing Ambulatory Surgery Services
- Home Health Services
- Hospice Care Services
- Intermediate Care Facility Services for the Mentally Retarded (ICF/MR)
- Inpatient Hospital Services, Acute care
- Inpatient Psychiatric Services for individuals under age 21
- Inpatient Rehabilitation Services for individuals under age 21
- Mentally Retarded/Developmentally Disabled Waiver Services (MR/DD)
- Nurse Practitioner Services
- Nurse Midwife Services
- Nursing Facility Services
- Occupational Therapy Services
- Optometry Services
- Orthotic/Prosthetic Services
- Outpatient Hospital Services
- Personal Care Services
- Pharmacy Services
- Physical Therapy Services
- Physician Services
- Podiatrist Services
- Private Duty Nursing Services
- Psychiatric Services
- Psychological Services
- Rural Health Clinic Services and Federally Qualified Health Center Services

- Speech and Hearing Services
- Transportation Services
- Vision Services.

Certain services are covered only for specific categories of eligible members. All covered Medicaid services, both traditional and special services, must be medically necessary, may be limited in scope, i.e., specific number of units of services, and may be subject to prior authorization.

BMS contracts with West Virginia Medical Institute (WVMI) for the review and approval of all hospital inpatient services for Medicaid members. However, physicians, acute care hospitals, rehab hospitals for members under age 21 only, and psychiatric hospitals for members under 21 only, must obtain prior authorization before admission of the patient. For documented emergencies, the patient may be admitted, but the request for prior authorization must be made to WVMI within 24 hours or the first working day after admission.

Refer to appropriate the applicable provider manual for specific provider policy and billing instructions for each of these covered services.

161 GENERAL NON-COVERED SERVICES

The WV Medicaid Program does not cover certain services and items regardless of medical necessity.

Some examples are identified below:

- Acupuncture
- Artificial insemination, in vitro fertilization, infertility services, or sterilization reversal
- Autopsy
- Christian Science services
- Cosmetic surgery services
- Dental services for members 21 years of age and over (except for treatment of fractures of mandible and maxilla and biopsy), removal of cysts and tumors, and emergency extractions
- Drugs for weight gain or loss, hair growth, fertility, cosmetic use, and those considered investigational or unproven
- Duplicate services
- Equipment or supplies which are primarily for patient comfort and/or family or caretaker convenience (Note: One mobility item is covered in a five-year period.)
- Experimental or investigational/research services or drugs
- Inpatient psychiatric services for individuals between 22 and 65 years of age, except acute care admissions
- Optometry services for individuals over age 21, except the first pair of glasses after cataract surgery
- Personal comfort and convenience items or services, whether on an inpatient or outpatient basis, such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
- Radial Keratotomy; Lasik surgery

- Services rendered outside the scope of a provider's license
- Sterilization for individuals under age 21
- Transsexual surgery
- Fees for missed appointments*
- Fees to copy medical records
- Weight loss programs or drugs for weight loss
- Services rendered by students as part of their clinical or academic training.

* Enrolled providers cannot bill Medicaid members for missed appointments.

The above list is illustrative only. It should not be construed as a complete or exhaustive list of excluded items or services.

Refer to Chapter 400 for additional information on member responsibilities for payment, and appicable provider manuals for specific covered and non-covered services.

The “WV Works” Program covers dental and optometry services for certain eligible adult Medicaid members. Please note: Not all Medicaid-eligible members are eligible for enrollment in the “WV Works” Program. Contact the local DHHR office for questions regarding specific benefits and possible coverage for patients.

170 RELATIONSHIP TO MEDICARE

Medicaid covers medically necessary health services furnished to individuals who meet specific income, resource, and eligibility standards. Medicare is a federal program that offers health insurance coverage to individuals 65 years of age or older, to those who have received social security disability benefits for 24 consecutive months, to those who have end-stage renal disease, to those on advanced life support, and to other eligible individuals, as specified by other provisions of the Social Security Act.

WV Medicaid covers the applicable co-insurance and deductible amounts, not to exceed Medicaid’s allowable payment, for services covered by Medicare Parts A and B for all eligible Medicaid members who are also entitled to Medicare benefits. The Medicaid Program may also provide payment for services not covered by Medicare.

A member with both Medicare and Medicaid coverage is identified as “dual eligible.” Medicaid reimburses secondary to Medicare. If a Medicare Supplemental policy exists in addition to Medicare and Medicaid coverage, Medicaid is the third-party payer subsequent to Medicare and Medicare Supplemental payments. Medicaid is always the payer of last resort.

Refer to Chapter 300 for more specific provider information on the Medicare program and its relationship to WV Medicaid, including Medicare provider numbers as part of your Medicaid participation responsibilities.

For information related to claim submission procedures for services rendered to a “dual eligible” member, refer to Chapter 300.

180 OUT-OF-STATE SERVICES

Non-emergency, out-of-state services provided to WV Medicaid members routinely require prior authorization from the BMS Out-of-State Unit, Bureau for Medical Services. For HMO members, follow the respective HMO prior-authorization requirements. If applicable, contact BMS at 1-304-558-1700.

The following are exceptions to this policy:

1. Services provided by WV Medicaid-enrolled border providers
2. Services provided by out-of-state providers who are enrolled as in-state providers
3. Services for WV Medicaid-eligible children who have been placed in foster homes outside WV.

A physician practicing in WV, who determines it necessary to refer a Medicaid member out-of-state for outpatient physician services should submit a request to the BMS Out-of-State Unit. Information that must be provided in the request is as follows:

1. Reason for the out-of-state referral
2. Patient's diagnosis
3. Expected treatment
4. Whether or not treatment is available within WV (services available within the state are not covered outside the state)
5. Other pertinent information.

Payment to out-of-state physicians is made at the same reimbursement rate as payment to in-state physicians. Under Federal law, the Medicaid Program prohibits balance billing by all providers, regardless of location. All out-of-state providers' claims for providing non-emergency medical services will deny unless:

1. The provider is enrolled as a "border" provider
2. The provider is enrolled as an "in-state" provider
3. The services have been prior authorized.

Emergency out-of-state Medicaid-covered services are eligible for Medicaid reimbursement. The documentation provided with the claim must clearly indicate that an emergency situation existed. The emergency room patient record must be submitted with the claim.

Refer to Chapter 300 for additional information regarding out-of-state providers.

190 FRAUD AND ABUSE

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to either the person or another. In particular, any provider that acts intentionally and with knowledge to deceive or misrepresent information used in Medicaid administrative processes, and the deception or misrepresentation results in some unauthorized benefit to him/her or another, commits fraud. It also includes any act that constitutes fraud under applicable federal or WV state law.

Abuse is defined as provider practices that are inconsistent with sound fiscal business or medical practices and result in an unnecessary cost to the Medicaid Program. It also includes reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. In particular, any provider that acts in a repetitive manner to cause unnecessary costs for the Medicaid Program is considered abusive of the Medicaid Program.

Examples of activities that constitute fraudulent practices or abuse of the Medicaid Program are identified in Chapter 800, General Administration. A person is subject to prosecution by federal and state authorities when any actions identified during the Medicaid administrative process is determined to be fraudulent or abusive.

It is recommended that 42 U.S.C. §1320a-7a, 42 U.S.C. §1320a-7B, and 42 U.S.C. §1320 a-7 be reviewed by appropriate provider office staff. These codes contain information related to fines and exclusions that can be imposed upon persons and/or entities convicted of submitting false or fraudulent claims to federal or state medical programs.

191 CONFIDENTIALITY

Information you obtain from BMS or any other DHHR bureau regarding Medicaid members' eligibility, health history, health care services, or any other personal information, is to remain strictly confidential and shall not be disclosed for any purpose other than those directly concerned with Medicaid administrative requirements.

CHAPTER 200—DEFINITIONS

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CHAPTER 200–DEFINITIONS

200 INTRODUCTION

This chapter contains separate lists of acronyms and definitions that are frequently used in the administration of the West Virginia Medicaid Program. The acronyms and definitions are in alphabetical order.

In certain circumstances, more specific definitions will be found in other chapters of this manual. It is suggested that chapters regarding the types of services being utilized also be referenced (e.g., Chapter 501, Aged and Disabled Waiver Services) in addition to the definitions below.

210 – ACRONYMS

ADA – American Dental Association
ADG – Ambulatory Diagnostic Group
ADL – Activities of Daily Living
ADW – Home and Community Based Waiver for the Aged and Disabled
AFDC – Aid to Families with Dependent Children. Now referred to as TANF.
ALC – Alternate Level of Care
ALS – Advanced Life Support
AMA – American Medical Association
ANA – American Nurses Association
ANSI – American National Standards Institute
AWP – Average Wholesale Price for a drug
BLS – Basic Life Support "or" Basic Living Skills
BMS – (West Virginia) Bureau for Medical Services
BoSS – (West Virginia) Bureau of Senior Services
CAHPS – Consumer Assessment of Health Plans Survey
CC – Complication or Comorbid Condition Code
CDC – Centers for Disease Control and Prevention
CF – Conversion Factor
CFR – Code of Federal Regulations
CLIA – Clinical Laboratory Improvement Act
CM – Case Manager
CMA – Case Management Agency
CMS – Centers for Medicare and Medicaid Services (HCFA prior to July 1, 2001)
COB – Coordination of Benefits
CPT – Physician's Current Procedural Terminology
CRNA – Certified Registered Nurse Anesthetist
CSHCN – Children with Special Health Care Needs
DD – Developmentally Disabled
DHHR – (West Virginia) Department of Health & Human Resources
DHHS – (US) Department of Health & Human Services
DMERC – Durable Medical Equipment Regional Carrier
DOB – Date of Birth
DOS – Date of Service
DRG – Diagnosis Related Group

DSM – To be determined at a later date - Place Holder
DSS – Decision Support System
DUR – Drug Utilization Review
DX – Diagnosis
EAC – Estimated Acquisition Cost
EDI – Electronic Data Interchange
EDP – Electronic Data Processing
EFT – Electronic Funds Transfer
E/M – Evaluation & Management
EMC – Electronic Media Claims
EMS – Emergency Medical Services
EOB – Explanation of Benefits
EOM – End of Month
EOMB – Explanation of Medical Benefits
EPSDT – Early and Periodic Screening, Diagnosis and Treatment
EQRO – External Quality Review Organization
F&A – Fraud and Abuse
FA – Fiscal Agent
FFP – Federal Financial Participation
FFS – Fee for Service
FFY – Federal Fiscal Year
FI – Fiscal Intermediary
FIFO – First In/First Out
FMAP – Federal Medical Assistance Percentage
FQHC – Federally Qualified Health Center
FPL – Federal Poverty Level
HCBS – Home and Community Based Services
HCFA – (U.S.) Health Care Financing Administration (renamed CMS effective July 1, 2001)
HCPCS – HCFA Common Procedure Coding System
HEDIS – Health Employer Data and Information Set
HHA – Home Health Agency
HHS – (U.S. Department of) Health & Human Services (also DHHS)
HIO – Health Insuring Organization
HIPAA – Health Insurance Portability & Accountability Act of 1996
HM – Homemaker
HMA – Homemaker Agency
HMO – Health Maintenance Organization
HM RN – Homemaker Registered Nurse
ICD – International Classification of Diseases
ICF – Intermediate Care Facility
ICF/MR – Intermediate Care Facility for Persons with Mental Retardation
ID – Identification
IG – Implementation Guide
ISO – International Standards Organization
IT – Information Technology
JCAHO– Joint Commission on Accreditation of Health Care Organization
LOC – Level of Care

LTC – Long Term Care
LTCF – Long Term Care Facility
MAC – Maximum Allowable Cost
MADC – Medical Adult Day Care
MARS – Management Administration Reporting Subsystem
MCO – Managed Care Organization
MDS – Minimum Data Set
MFCU – Medical Fraud Control Unit
MMIS – Medicaid Management Information System
MR/DD – Mentally Retarded/Developmentally Disabled
MSIS – Medicaid Statistical Information System
NABP – National Association of Boards of Pharmacy
NCPDP – National Council of Prescription Drug Programs
NCQA – National Committee for Quality Assurance
NDC – National Drug Code
NF – Nursing Facility
NH – Nursing Home
NPI – National Provider Identifier
NUBC – National Uniform Billing Committee
NUCC – National Uniform Claim Committee
OCR – (U.S.) Office of Civil Rights
OEMS – Office of Emergency Medical Services
OHFLAC – (West Virginia) Office of Health Facility Licensure and Certification
OMCH – (West Virginia) Office of Maternal & Child Health
OSURS – Office of Surveillance and Utilization Review Subsystem
OTC – Over the Counter (Drugs)
PA – Prior Authorization or Prior Approval
PAAS – The Physician Assured Access System
PAHP – Prepaid Ambulatory Health Plan
PASARR – Preadmission Screening and Annual Resident Review
PCCM – Primary Care Case Management
PCP – Primary Care Physician (or Provider or Practitioner)
PHI – Protected Health Information
PIHP – Prepaid Inpatient Health Plan
POC – Plan of Care
POS – Point of Sale
PPS – Prospective Payment System
PRO – Peer Review Organization
PSC – Public Service Commission
QI – Qualified Individual
QIO - Quality Improvement Organization
QMB – Qualified Medicare Beneficiary
QMRP - Qualified Mental Retardation Professional
RA – Remittance Advice
RBRVS – Resource Based Relative Value Scale
RBRVU – Resource Based Relative Value Unit
RHC – Rural Health Clinic

RN – Registered Nurse
RTP – Return to Provider (or Plan)
RUG – Resource Utilization Group
RVS – Relative Value Scale
RVU – Relative Value Unit
SCHIP – State Children's Health Insurance Plan
SCP – Service Coordination Plan
SFY – State Fiscal Year
SLIMB – Specified Low Income Medicare Beneficiary
SMPMT – Specialized Multi-Patient Medical Transport Provider
SMPV – Specialized Multi-Passenger Van Provider
SNF – Skilled Nursing Facility
SSA – Social Security Administration
SSI – Supplemental Security Income
SSN – Social Security Number
SUR – Surveillance and Utilization Review (SUR)
TANF – Temporary Assistance for Needy Families
TOB – Type of Bill
TPA – Third Party Administrator
TPL – Third Party Liability
UB – Uniform Bill
UB-92 – Uniform Bill Form 92
UPIN – Unique Physician Identification Number "or" Uniform Provider Identification Number
UMWA – United Mine Workers of America – Union of coal miners
UR – Utilization Review
WIC – Women, Infants and Children Program
WVDHHR – West Virginia Department of Health and Human Resources

250 - DEFINITIONS

Abuse of Program – Improper fiscal or medical practices that may result in unnecessary costs to the West Virginia Medicaid Program or the provision of medically unnecessary or inappropriate services.

Active or Curative Care – Any medically necessary care or treatment meant to ameliorate or cure illness or injury.

Activities of Daily Living (ADL) – Activities that a person ordinarily performs during the ordinary course of a day, such as mobility, personal hygiene, bathing, dressing, sleeping, eating, and skills required for community living. A person's ability to perform these activities is indicative of his or her physical ability to function independently.

Activities of Daily Living Rating Scale – A numerical score used to determine the level of care needs of a beneficiary in performing activities of daily living.

Acute Care – Services available to all Medicaid eligible beneficiaries including, but not limited to, services such as pharmacy, X-ray, laboratory, physician visits, and other services defined in the Medicaid State Plan and approved by the Centers for Medicare and Medicaid Services (CMS).

Advance Directive (Health Care) – Written ahead of time, a health care advance directive is a written document that indicates how an individual wants medical decisions made if he or she loses the ability to make decisions for himself or herself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.

Advanced Life Support (ALS) – A sophisticated level of out-of-hospital emergency medical care provided to patients being transported by an ambulance to a hospital.

ALS service is appropriate when the patient manifests symptoms that the absence of immediate medical attention could result in serious harm to the patient.

ALS services include administration of intravenous fluids and the administration of medications by intravenous, endotracheal, intramuscular, subcutaneous, sublingual, inhalation or oral routes, and insertion of endotracheal tube or other advanced airway adjunct device. (Also reference Chapter 524, Transportation Services.)

Aged/Disabled Home and Community-Based Services Waiver (ADW) - West Virginia's home and community-based services waiver program for aged and disabled individuals, administered by the Bureau for Medical Services of the Department of Health and Human Resources in collaboration with the Bureau of Senior Services pursuant to a Medicaid waiver option approved by the Center for Medicare and Medicaid Services (CMS). The Aged/Disabled Waiver Program is a long-term care alternative, which enables individuals to remain at or return home rather than receiving nursing facility (NF) care. The Aged/Disabled Waiver Program provides eligible individuals with a range of services comparable to those services provided in a nursing facility. The Aged/Disabled Waiver Program provides services in homes and local communities instead of a nursing facility. The Aged/Disabled Waiver Program includes case management, homemaker, and adult day care services.

Air Ambulance – An aircraft used for air ambulance operations.

Air Ambulance Transportation – Transport of a patient whose medical condition requires transportation by air ambulance as certified by a physician.

Allied Health Professional – An individual trained to perform services in the care of patients other than a physician or registered nurse; includes a variety of therapy technicians (e.g., pulmonary, radiology technicians, physical therapists, etc.).

Allowable Charge – The maximum amount that West Virginia Medicaid will pay for a covered service.

Ambulance – A vehicle designed, equipped, and appropriately staffed to transport patients to the nearest medical facility that can provide the needed medical care. As classified in West Virginia Health Legislative Rules §64 CSR 48 and §64 CSR 29:

- Class B – Basic Life Support
- Class C – Advanced Life Support
- Class D – Critical Care Transport
- Class E – Aeromedical (Fixed and Rotary Wing)
- Class F – Specialized Multi-Patient Medical Transport Vehicle

Ambulatory Patient – An individual who can move from place to place and exit a building without any means of assistance**.**

Ambulatory Surgical Center (ASC) – A licensed health care setting that provides outpatient surgery not requiring a stay over 24 hours.

American Dental Association (ADA) – A professional organization for dentists whose mission is commitment to the public's oral health, ethics, science, and professional advancement and leading a unified profession through initiatives in advocacy, education, research, and the development of standards. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

American Medical Association (AMA) – A professional organization for physicians whose mission is the development and promotion of standards in medical practice, research, and education; strong advocacy agenda on behalf of patients and physicians; and the commitment to providing timely information on matters important to the health of America. The AMA is the secretariat of the NUCC, which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT) medical code set.

Appropriate Medical Facility – A medical facility is any hospital, medical clinic, physician's office, or other similar facility, licensed or certified by the appropriate State agency, at which medical care and treatment is available. An appropriate medical facility is one whose personnel and equipment are approved to provide medically necessary services to Medicaid patients either on an outpatient or inpatient basis.

Assessment – Use of clinical, functional, demographic, and other information to determine a person's physical, mental, and personal care needs and the most appropriate setting in which to meet those needs and develop a plan of care.

Attending Physician – Physician providing the major portion of care or having primary responsibility for care of the beneficiary.

Authorization of Payment – The transmittal of written notification by the WV Department of Health and Human Resources indicating that an individual has met the financial and medical requirements for Medicaid reimbursement.

Authorized Representative – An individual who has been authorized under West Virginia State law to authorize the termination of medical care or to elect or revoke the election of hospice on behalf of a terminally ill individual who is mentally or physically incapacitated.

Balance Bill – Charges made to the patient for the difference charged for a service and the amount paid by a health insurance plan or other third party. A limit may be imposed on the amount that a provider may balance bill the patient.

Basic Life Support (BLS) – A basic level of out-of-hospital and interfacility emergency medical services provided when a patient requires BLS services or continual medical supervision in those instances when services are determined to be medically necessary in an emergency transport. An emergency transport is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Impairment to bodily functions

- Serious dysfunction to any bodily organ or part.

Bed Confined – Individuals who are unable to tolerate any activity out of bed. In order to be considered "bed confined," all of the following criteria must be met:

- The beneficiary is unable to get up from bed without assistance
- The beneficiary is unable to ambulate
- The beneficiary is unable to set in a chair or wheelchair.

Benefits – Services, procedures, and items covered by the West Virginia Medicaid Program or other third party health insurers.

Beneficiary (aka enrollee, client, or recipient) – An individual who is eligible to receive or is receiving benefits from Medicaid.

Board and Care Home – A type of group living arrangement designed to meet the needs of people who cannot live on their own and need help with chore services, homemaking, and other personal care needs.

Board Certified – Formal recognition to a physician that has special training in a certain area of medicine and has passed an advanced examination in that area of medicine. Both primary care doctors and specialists may be board certified.

Breast and Cervical Cancer Early Detection Program – On October 24, 2000, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) was signed into law. This Act, which has an effective date of October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer, including pre-cancerous conditions.

Bureau for Medical Services (BMS and sometimes referred to as "Bureau") – The single state agency within the West Virginia Department of Health and Human Resources (DHHR) that administers the Medicaid Program mandated under Chapter 9 of the West Virginia Code and Title XIX of the Social Security Act.

Bureau of Senior Services (BoSS) – The Bureau for Medical Services contracts with the Bureau of Senior Services for the day-to-day operation of the Aged and Disabled Home and Community Based Waiver Services program.

Capitation Payment – A payment made periodically to a contractor on behalf of each person enrolled under a contract for the provision of medical services. The payment is made regardless of whether or not the particular person receives services during the period covered by the payment.

Care Management Fee – A per-member, monthly payment to a provider that covers coordination of a member's health care, such as appropriate referral to consultants, specialists, ancillary provider and services. Care management is intended to ensure continuity of services and accessibility to overcome fragmented services and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Case Management – A method of coordinating, linking, advocating, and monitoring services for clients to reach goals developed by the beneficiary and the case management agency, other providers, family members, guardians, or legal representatives. Effective case management promotes access to care, containment of escalating costs, enhancement of quality products and services, identification or creation of viable alternative care plans, and patient awareness regarding self-determination and empowerment.

Case Management Agency (CMA) – A privately operated profit or nonprofit organization/agency licensed to do business in West Virginia, having a provider agreement with BMS and enrolled as a provider of case management services.

Case Manager (CM) – Person who arranges for beneficiaries to obtain medically necessary and appropriate services in a coordinated, cost-effective manner.

Case Mix Index – A numerical indicator of the medical needs of the patients a provider treats. The higher the index, the greater the need and cost of caring for the patients.

Categorically Needy – Low income aged, blind, or disabled individuals, low income women and their children, and certain other persons who are *[required by Federal law to be covered by a State's Medicaid Program]* eligible for Medicaid services and meet financial eligibility requirements.

Certification (Laboratory) – Approval of a laboratory facility to receive reimbursement from the Medicaid Program for specific clinical laboratory examination. Such approval is a condition of participation and is granted by the regulating agency (West Virginia Department of Health, Office of Laboratory Services) when a laboratory facility is in compliance with Medicaid regulations.

Certification (Radiology) – Approval of an independent radiology facility to receive reimbursement from the Medicaid Program for specific clinical radiological examination. Such approval is a condition of participation and is granted by the regulating agency (West Virginia Department of Health, Office of Environmental Health Services) when a radiology facility is in compliance with Medicaid regulations.

Certified Medicaid Provider – All transportation entities which have a current Medicaid Provider Number, including aeromedical and ground transport services, which receive reimbursement from the Bureau for Medical Services.

Certified Registered Nurse Anesthetist (CRNA) – A registered nurse who is trained and licensed to administer anesthesia.

CHAMPUS – The Civilian Health and Medical Program of Uniformed Services provides health insurance for active and retired military personnel and their dependents.

Children with Special Health Care Needs (CSHCN) – formerly Handicapped Children's Program - A program for remedial services to medically needy and Medicaid children age 0 to 21 years which is administered by the Department of Human Services under Title V of the Social Security Act.

Claim – An invoice for the health services provided to a patient.

Claimant – A person who requests a hearing under the West Virginia Department of Health and Human Resources Fair Hearing process.

Class I Laboratory – A clinical laboratory independent of a Medicare-approved hospital that is certified for participation in Medicare as an independent laboratory.

Class II Laboratory – A clinical laboratory maintained by one or more physicians for performing diagnostic tests for their own patients provided:

- The laboratory is not held out to other physicians as available to perform diagnostic tests
- The laboratory does not accept more than 100 specimens on referral from other physicians in any one year in any of the following five categories:
  - Microbiology ad Serology
  - Clinical Chemistry
  - Immunohematology
  - Hematology
  - Pathology
  - Radiobioassay.

Client (aka beneficiary, recipient, or enrollee) – An individual who is eligible to receive or is receiving benefits from Medicaid.

Client Grievance Procedure – The process by which clients are afforded an opportunity to express dissatisfaction with services provided by the Medicaid Program.

Clinic – A legal entity licensed to provide medical services. Group practices and similar arrangement with Medicaid payment to individual members are not considered clinics.

Clinical Laboratory – A facility for the microbiological, cytological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, of treatment of any disease of assessment of a medical condition.

Clinic Services – Federally defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients under the direction of the physician. These services must be furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. Clinic Services must be provided at the clinic, the only exception being services provided to the homeless. (Also refer to Chapter 502, Behavioral Health Clinic Services.)

CMS 64 – A statement of expenditures for the Medicaid program that the Bureau for Medical Services must submit to CMS 30 days after the end of each quarter. The report is an accounting statement of actual Medicaid expenditures for which West Virginia is entitled to receive Federal funding under for the quarter.

CMS 416 – The annual Early and Periodic Screening, Diagnosis and Treatment (EPSDT) report that the Bureau for Medical Services must provide to CMS. The information is used to assess the effectiveness of State EPSDT programs in providing child health screening services.

CMS 1500 — Claim form to bill for most outpatient services that West Virginia Medicaid covers. Formerly HCFA-1500.

Cognitive Impairment – A breakdown in a person's mental state that may affect their moods, fears, anxieties, and ability to think clearly.

Coinsurance. - The portion of the allowed amount payable for a service that is paid by the patient.

Common Carrier – Such services as public railways, buses, cabs, airlines, and other public transportation may be reimbursed at rates approved by the West Virginia Public Service Commission (PSC) or other applicable State or Federal regulatory agency. Transport via common carrier must be preauthorized by the appropriate county Department of Health & Human Resources (DHHR) staff and reimbursed through local DHHR offices.

Communication System – A provider agency for a Medicaid home and community based waiver program having an emergency call down system that is available 24 hours a day, 7 days a week for both the client and any other provider agency to contact in case of an emergency.

Comprehensive Primary Health Care Services – The ongoing responsibility of directly providing preventive and primary health care (including diagnosis and/or treatment and health education) to an enrollee and, as necessary, referring the enrollee to another provider for diagnosis and/or treatment.

Comprehensive Risk Contract – A risk contract that covers comprehensive services, to include, inpatient hospital services and any of the following services, or any three or more of the following services:

- Outpatient hospital services
- Rural health clinic services
- FQHC services
- Other laboratory and x-ray services
- Nursing facility services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Family planning services
- Physician services
- Home health services
- Prescribed drugs
- Other services.

Consultation – Referral to a provider for professional advice or services.

Consumer Directed Case Management – Aged and Disabled Waiver program service that gives a client the ability to direct his/her own case management activities personally or through a representative, without reimbursement.

Contractor – An entity that performs specific tasks for the Department under contractual arrangements.

Coordination – Bringing together relevant parties to plan, arrange, implement, and monitor service provisions to beneficiaries.

Co-Payment – A cost sharing amount which is the liability of the beneficiary for the medical services received.

Cost-Based Payment Method – A system of payment for health care whereby reimbursement is based on a percentage of cost.

Cost-Based Reimbursement – A method of payment for health care whereby reimbursement is based on the reasonable and allowable cost a provider incurs in rendering patient care.

Cost Outlier – A patient whose medical care costs extraordinarily more than the care provided to a typical patient with similar medical problems.

Covered Services – Services and supplies for which Medicaid reimbursement is available.

Covered Surgical Procedure – Those surgical and other medical procedures which may safely be performed in the ambulatory surgical center setting and which the ASC is authorized by Federal and State law and regulation to perform.

Crossover Claims – Claims for which Medicare and Medicaid may be responsible for payment for services provided to a client eligible for benefits under both programs.

Current Procedural Terminology (CPT) – A clinical coding system developed and maintained by the American Medical Association and mandated by the Centers for Medicare and Medicaid Services for use in billing Medicare and Medicaid for physician services.

Date of Service – Actual date or number of days that services were received by a client during a month.

Deductible – The amount that an individual must pay before health insurance is liable for some portion of the amount a provider bills for a service. The deductible is ordinarily a flat amount for a year.

Department – The term often used to refer to the West Virginia Department of Health and Human Resources.

Department of Health and Human Services (DHHS) – The organizational unit of the federal government responsible for administration of the provisions of the Social Security Act as amended.

Diagnosis (DX) – Identification of a condition or disease.

Diagnosis Related Group (DRG) – A classification system that groups hospital inpatients according to their diagnoses, surgical procedures, age, and other criteria.

Direct Care Provider – Individual with a special relationship to the client who under normal circumstances would be considered as an informal support.

Dispensing Ophthalmologist – An Ophthalmologist who, in addition to performing the professional services, also dispenses eye appliances.

Disproportionate Share Hospitals – Hospitals that provide care to a large number of Medicare, Medicaid, and low-income patients. Medicaid makes additional payments to these hospitals for the cost of these patients. The Bureau for Medical Services determines whether a hospital meets the criteria to be considered a “disproportionate share hospital” and calculates the additional payment, subject to Federal minimum standards.

Documentation – Process of recording all observations and events in writing and maintaining records or files and reporting information to entities having a right and need to know.

Drug Rebate – Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a

national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS' Center for Medicaid and State Operations (CMSO). This law was amended by the Veterans Health Care Act of 1992 which also requires a drug manufacturer to enter into discount pricing agreements with the Department of Veterans Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid.

Drug Utilization Review (DUR) – Drug Utilization Review in the Medicaid program consists of the monitoring of: 1) clinically appropriate prescribing of outpatient drugs, 2) clinically appropriate dispensing of outpatient drugs, 3) drug usage review, evaluation, and intervention, and 4) medical quality assurance.

Dual Eligible – Medicaid beneficiaries who are also eligible for health benefits under Medicare or other public-sponsored health programs.

Durable Medical Equipment – Items, articles, or devices that are prescribed by a physician, primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of disease, illness, or injury; capable of withstanding repeated use; are durable and nonexpendable (e.g., hospital bed, wheelchair, walker and suction equipment).

Durable Medical Equipment Regional Carrier (DMERC) – A private company that contracts with Medicare to pay claims for durable medical equipment.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program – A comprehensive and preventative child health program for Medicaid eligible individuals under the age of 21. EPSDT includes periodic screening, vision, dental, and hearing services. Periodic schedules for screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice.

Economic Status – Information about a person's income and other related financial resources used to determine Medicaid eligibility.

Electronic Media Claims (EMC) – Claims that are submitted by tape or other electronic forms of communication in lieu of paper claims.

Eligible Hospital – A hospital certified as a provider of hospital services by the Office of Health Facility Licensure and Certification (OHFLAC), the provisions of Title XVII of the Social Security Act, or certified as an out-of-state provider by the Bureau for Medical Services.

Eligible Medicaid Patient – An individual with a valid identification card receiving financial and/or medical assistance from DHHR and children in foster care under Department supervision.

Eligible Person – A person eligible for West Virginia Medicaid according to Title XIX regulations and who has been determined financially eligible by the local office of the Department of Health and Human Resources.

Emergency Medical Services (EMS) – All services which are set forth in West Virginia Code §16-4-C, "The Emergency Medical Services Act of 1996" and those services included in and made part of the emergency medical services plan of the Department of Health and Human Resources including, but not limited to, responding to the medical needs of an individual to prevent the loss of life or aggravation of illness or injury. EMS Rules §64 CSR 48.

Emergency Medical Services Agency – Any authority, person, corporation, partnership, or other entity, public or private, which is licensed by the Office of Emergency Medical Services to provide emergency medical services in West Virginia.

Emergency Medical Services (Ambulance) Certification – The Office of Emergency Medical Services (OEMS) is the certifying agency for emergency medical services (EMS) agencies and has authority over patient transportation through its licensure process. The Bureau for Medical Services of the Department of Health and Human Resources (Medicaid) has the authority to enroll licensed providers for submission of claims for reimbursement.

Emergency Medical Services (Air Ambulance) Provider – Any authority, person, corporation, partnership, or other entity, public or private, which owns or operates a licensed emergency medical services agency providing emergency medical service in this state. Certification of eligibility is issued by the Department of Health and Human Resources and the Office of Emergency Medical Services for the purpose of providing medical treatment and transportation services to Medicaid patients in the State of West Virginia. WV Code §16-4-C; EMS Rules §64 CSR 48.

Emergency Medical Services Provider – Any authority, person, corporation partnership, or other entity, public or private, which owns or operates a licensed emergency medical services agency providing emergency medical service in this state. Certification of eligibility is issued by the Department of Health and Human Resources and the Office of Emergency Medical Services for the purpose of providing medical treatment and transportation services to Medicaid patients in the State of West Virginia. WV Code §16-4-C; EMS Rules §64 CSR 48.

Emergency Medical Services Vehicle (EMS vehicle) – Emergency Medical Services (EMS) transportation vehicles including ambulances, air ambulances and non-medical transportation vehicle as described within EMS Rules §64 CSR 48.

Emergency Medical Technician – **Basic (EMT-B)** – An individual certified by the Office of Emergency Medical Services (OEMS) to render emergency medical services as defined in the scope of practice and authorized pursuant to West Virginia State Code §16-4C and West Virginia Health Legislative Rules §64 CSR 48.

Emergency Medical Technician – **Paramedic (EMT-P)** – An individual certified by the Office of Emergency Medical Services (OEMS) to render emergency medical services as defined in the scope of practice and authorized pursuant to West Virginia State Code §16-4C and West Virginia Health Legislative Rules §64 CSR 48.

Emergency Transport – Transport of a patient with a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the beneficiary's health in serious jeopardy
- Impairment to bodily functions
- Serious dysfunction to any bodily organ or part.

Enrollee (aka beneficiary, or client) – An individual who is eligible to receive or is receiving benefits from Medicaid.

Evaluation – An initial and ongoing process to determine service requirements and the effectiveness of plans of care.

Explanation of Benefits (EOB) – A statement mailed once per month to selected clients to allow them to confirm the services they received.

External Quality Review Organization (EQRO) – A private entity that systematically reviews the quality of care provided to Medicaid patients often through medical record reviews.

Federal Financial Participation (FFP) – The proportion of West Virginia Medicaid payments that is the Federal Government's financial responsibility.

Federally Qualified Health Center (FQHC) – An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services to meet Medicare program requirements under 42 CFR 405.2434, and:

- Is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the beneficiary of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the Public Health Service Act
- Based on the recommendation of the Public Health Service, is determined by Centers for Medicare and Medicaid Services to meet the requirements for receiving such a grant
- Was treated by Centers for Medicare and Medicaid Services, for purposes of part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990

OR

Is an outpatient health program or facility operated by a tribe or tribal organizations under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

Federally Qualified HMO – A Health Maintenance Organization (HMO) that the Centers for Medicare and Medicaid Services has determined is a qualified HMO under Section 1310(d) of the Public Health Service Act.

Federal Medical Assistance Percentage (FMAP) – The percentage of a State's Medicaid payments that is the financial responsibility of the Federal government.

Fee Schedules – A list of fees or rates for specific inpatient or outpatient services, identified by Diagnosis Related Groups (DRG), Resource-Based Relative Value System (RBRVS), Healthcare Common Procedural Coding System (HCPCS) code, or other coding systems.

Financial Eligibility – The determination of whether the level of a person's income, assets, and categorical standards established by the Department of Health and Human Resources qualifies the applicant for public assistance or Medicaid benefits.

Fixed Winged Aircraft – The fixed wing air ambulance (airplane) services are deemed appropriate when the beneficiary's medical condition is such that transport by ground ambulance is not appropriate. Transport by fixed wing may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. The fixed wing aircraft shall be designed, constructed, or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in West Virginia Health Legislative Rules §64 CSR 48.

Fraud – An intentional deception or misrepresentation made by a person or organization with knowledge that the deception could result in an unauthorized benefit to himself or some other individual. It includes any act that is defined as deliberate and intentional under applicable Federal or State laws.

Freedom of Choice – The guaranteed right of a beneficiary to select a provider of their choice.

Full Time Equivalent (FTE) – Forty hours of service per week delivered by one or more individual providers.

Generic Drugs – A generic drug is identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance, characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price.

Goals – Statement of outcome with specific tasks and objectives to achieve those outcomes. Goals are set to ensure that effective services are being provided to the client.

Grievance – The process by which clients are afforded an opportunity to express dissatisfaction with services received by a provider.

Group Practice – A group of persons licensed to practice medicine in the State, who as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their professions, primarily in one or more group practice facilities, and who in the connection share common overhead expenses if and to the extent such expenses are paid by members of the group, medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs.

Health Care Financing Administration (HCFA) – Formerly the Federal Agency that administered the Medicare and the Medicaid Programs. HCFA has been replaced with the Centers for Medicare and Medicaid Service (CMS) effective July 1, 2001.

Health Care Financing Administration Common Procedure Coding System. **(HCPCS)** – A three level coding system used to report medical services, procedures, and items. Level 1 consists of codes from the Current Procedure Terminology, fourth edition (CPT-4), which are used to report physician services. Level II codes apply nationally to non-physician services and supplies and equipment. Level III codes are for services, procedures, or supplies for which no national codes exist.

Health Care Professional – A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Check (EPSDT) Program – The program, operated for the Medicaid Program through the Office of Maternal and Child Health, to ensure the Medicaid eligible children, ages 0 through 20 years, receive a comprehensive range of preventive and primary health care services. Health Check has an outreach component with regional staff who provide technical assistance, computer generated schedules, follow-up for missed appointments, assistance with

transportation for eligible children, and other functions which support preventive and primary health care services.

Health Employer Data and Information Set (HEDIS) – A set of standard performance measures that provides information about the quality of care that a health plan provides. HEDIS measures include quality of care, access, cost, and other measures to compare managed care plans.

Health Insurance Portability and Accountability Act (HIPAA) – A Federal law that allows persons to qualify for comparable health insurance when they change jobs. This law also establishes standards for the electronic exchange and use of health care data to safeguard the privacy and security of an individual's personal health information.

Health Insuring Organization (HIO) – A county-operated entity that, in exchange for capitation payments, covers services for beneficiaries:

- Through payments to, or arrangements with, providers
- Under a comprehensive risk contract with the State
- Meets the following criteria
  - First became operational prior to January 1, 1986
  - Is described in Section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by Section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Home – The beneficiary's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

Home and Community Based Waiver for the Aged and Disabled (ADW) – Also known as the DHHR Medicaid Waiver Program for the Aged and Disabled, or simply the ADW Program.

Home Health Aides – Persons specially trained to assist sick, disabled, infirm, or frail persons at home when no family member is fully able to assume this responsibility. These aides are supervised by health professionals, and provided as part of a continuing medical care plan.

Home Health Care – Health care provided in the home to clients as an alternative to institutional care. The most common types of home care are skilled nursing services, speech, physical, and occupational therapy.

Homemaker – A care provider who provides in-home services to an eligible beneficiary of the program.

Homemaker Agency (HMA) – The agency responsible for assuring appropriate training of the homemaker, placing the homemaker in a client's home, and monitoring the client care and homemaker performance.

Homemaker Services – Direct care and support services that are necessary in order to enable an individual/client to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. Homemaker services in the ADW Program include assistance with personal hygiene, nutritional support, and environment maintenance.

Hospice – A public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals. A Hospice must meet the conditions specified in Title 42 of the Code of Federal Regulations (CFR) 418.50 to 418.100.

Individual – A person applying for Medicaid, or anyone referred to in a general way to connote the norm in health care delivery or standards.

Informal – Volunteer provider or family member who is not reimbursed for services.

Inpatient – A patient who has been admitted to a hospital or long-term care facility on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis.

Intermediate Care Facility (ICF) – A long-term care institution which meets licensing requirements according to State law, and/or is certified by Office of Health Facility Licensure and Certification (OHFLAC) to provide, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services which can be made available only through institutional facilities.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) – A facility certified by the West Virginia Department of Health and Human Resource's Office of Health Facility Licensure and Certification as meeting federal certification regulations as an Intermediate Care Facility for the Mentally Retarded or those with related conditions. These facilities must address the total needs of the resident including physical, intellectual, social, emotional, habilitation and provide "active treatment."

Intake – The process of interviewing a person to gather the necessary information to aid the client in obtaining the services available through the Aged and Disabled Waiver Program or a nursing facility.

Level of Care (LOC) – The number of homemaker hours of service for which a client is eligible, as determined by set criteria using the PAS-2000

Level of Care Requirements – The Bureau's requirement for payment on behalf of a beneficiary if that beneficiary were residing in a Bureau enrolled medical assistance institution.

Locality – The area surrounding the institution from which individuals are expected to come for medical services.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the following:

A Federally qualified HMO that meets the advance directive requirements of subpart I of part 489 of the Federal Register definition of a Federally Qualified HMO.

Any public or private entity that meets the advance directive requirements and is determined to also meet the following conditions:

Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area serviced by the entity.

Meets the solvency standards of Section 438.1176.

Mandatory Medicaid Benefits – Specific types of basic health services that a State must provide to categorically needy beneficiaries in order to have a valid Medicaid program. Some of the basic services are hospital inpatient and outpatient services, physician services, nursing facility services for individuals aged 21 years or older, home health care for persons eligible for nursing facility services, family planning services and supplies, laboratory and x-ray services, and pediatric and family nurse practitioner services.

Maximum Allowable Cost (for prescription drugs) (MAC) – Upper limits which may be established by the Federal government or the Federal Department of Health and Human Services.

Medicaid (aka Title XIX, Title 19) – A joint Federal and State program that pays for much or all of the health care services provided to eligible persons with low incomes and limited resources. Medicaid Programs are administered by the States with Federal guidelines and vary from state to state.

Medicaid State Plan – A comprehensive written agreement between the Bureau for Medical Services (BMS) and the Centers for Medicare & Medicaid Services (CMS) that includes eligibility requirements for clients and identifies the scope of medical services for which Federal reimbursement is made.

Medical Adult Day Care (MADC) – Is designed to be an alternative to institutional services, by providing participants with routine health and maintenance care combined with daily structured and supportive activities in a congregate daytime setting. MADCs are responsible for providing routine health and maintenance care combined with daily structured and supportive activities in a congregate daytime setting.

Medical Eligibility – The decision by the Bureau for Medical Services or its agent that the health care status and treatment requirements as prescribed by a medical practitioner substantiates the level of care and criteria for Medicaid benefits.

Medical Identification Card – An identification card issued monthly to each patient or family unit designed to give the provider of medical services the beneficiary identification information for billing purpose.

Medicaid Management Information System (MMIS) – Electronic information system designed and mandated by the Federal government to administer the West Virginia Medicaid Program in a manner that is consistent with all Federal requirements.

Medicaid Statistical Information System (MSIS) – An electronic file that a State submits quarterly to CMS providing specified data elements for the persons covered by Medicaid and paid claims for medical services. The purpose of MSIS is to collect, manage, and disseminate information about beneficiaries and the utilization of and payments for services.

Medical Patient – Any individual who is incapacitated due to injury, illness, disease or mental condition and requires continual medical supervision during transportation to or from an appropriate medical facility or any person who is a beneficiary of the services provided by emergency medical services***.***

Medical/Social Worker/Social Services – A service provided by a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed as a Social Worker.

Medically Appropriate – An effective service that can be provided, taking into consideration the particular circumstances of the beneficiary and the relative cost of any alternative services, which could be used for the same purpose, that is, the most economical service that meets the beneficiary's health needs.

Medically Necessary – Services or supplies that are proper and needed to diagnose or treat a medical condition.

Medically Needy – An individual whose income and resources exceed the levels for assistance established under a State or Federal plan, but whose income and resources are not enough to meet the costs of his/her health and medical services.

Medicare – The 1965 Amendments to the Social Security Act added a new Title (XVIII) Health Insurance for the Aged. Title XVIII, popularly known as Medicare, established a broad program of health insurance for the elderly and certain disabled individuals which is Federally administered through fiscal agents.

Medicare/Medicaid Patient – An individual eligible for Medicare; i.e., 65 years of age or older and certain disabled individuals also receiving medical or financial assistance from the Department of Human Services.

Member – An individual who is enrolled in a managed care plan.

Mental Status – Intellectual functioning, cognitive abilities and emotional status of the client.

Mobile Nonambulatory Patient – An individual that is able to move from place to place, and self exit a building, with the use of a device such as a walker, crutches, or a wheelchair.

MR/DD Waiver Program – The Waiver Program for Mentally Retarded and Developmentally Disabled persons.

MR/DD Waiver Program Services – Services provided under the MR/DD Waiver Program which include Service Coordination, Extended Physician Services (annual medical evaluation), Day Habilitation including Qualified Mental Retardation Professional (QMRP) services, Prevocational Training, Supported employment, Residential Habilitation, Transportation and Respite Care.

Multiple Patients – Transportation of more than one patient at a time is only reimbursable in an emergency transport and should only be used when no other ambulances are available for transport, i.e., mass casualty incident. If transporting more than one patient, the agency can only bill mileage once. It is not permissible to bill mileage for each patient that is being transported in the same ambulance at the same time. This does not include the following transport services which are designed for transporting multiple passengers at the same time:

- Specialized Multi-Patient Medical Transport (SMPMT)
- Specialized Multi-Passenger Van Provider (SMPV)
- Common Carrier Services.

Neuropsychological Evaluation – Full battery of tests used to develop a diagnosis. The evaluation is the sum of all the testing and diagnostic interview sessions. The components of the neuropsychological evaluation are: patient history; assessment of perceptual motor function; language functions; attention, member, learning, intellectual process, and level; and emotional, behavioral, and personality functioning. The evaluation must be accomplished by means of

appropriate psychological procedures administered by a qualified neuropsychologist. Appropriate psychological procedures include, but are not limited to, Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, and the Halstead-Reitan Neuropsychological Battery.

Non-Emergency Transport – Non-emergency services may be scheduled or unscheduled trips that do not meet the criteria for emergency regardless of the origin or destination. Trips for hospital discharge, to and from ESRD facilities for dialysis, to and from other outpatient facilities for chemotherapy, radiation therapy, or other diagnostic services are considered non-emergency services.

For non-emergency services the beneficiary must be bed confined at the time of the ambulance service is provided. The term "bed confined" is not synonymous with "bed rest" or "non-ambulatory." Bed confined is one factor to be considered but is not the sole criterion to determine medical necessity.

Bed confined requires all of the following criteria to be met:

- The beneficiary is unable to get up from bed without assistance
- The beneficiary is unable to ambulate
- The beneficiary is unable to sit in a chair or wheelchair.

Nonrisk Contract – A contract under which the contractor –

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in Section 447.362
- May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Nursing Facility (NF) – A nursing home or a distinct part of another facility licensed by the West Virginia Department of Health & Human Resources Office of Health Facility Licensure and Certification as meeting Federal and State licensure and certification regulations. A health facility that provides, on a regular basis, services to individuals who do not require the degree of care and treatment that a hospital is designed to provide but who require nursing and/or restorative services.

Nursing Facility Services – Services provided for individuals who need the professional judgment of skilled nursing or rehabilitation personnel and/or medical therapy and sterile techniques on a continuous basis.

Observation – Process in which an individual notes a client's condition, progress, behaviors, and environment.

Office of Emergency Medical Services (OEMS) – The division within the Department of Health and Human Resources responsible for assuring Emergency Medical Services (EMS) agencies and personnel are in compliance with West Virginia State Code §16-4C and West Virginia Health Legislative Rules §64 CSR 48 and §64 CSR 29 which includes licensure, certification, and annual inspections of EMS vehicles.

Office of Family Support – The Office in the Bureau for Children and Families in the West Virginia Department of Health & Human Resources that determines an individual's financial eligibility for Medicaid and other services.

Office of Health Facility Licensure and Certification (OHFLAC) – The office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Office of Surveillance and Utilization Review (OSUR) – The office within the West Virginia Department of Health & Human Resources that detects and examines any unusual patterns of payments and unnecessary or inappropriate utilization of care and services covered under the Medicaid Program. Activities of this Office may involve a multi-disciplinary approach in coordination with other Department offices and contractors.

Olmstead Act – In July 1999, the Supreme Court issued the Olmstead v. L. C. decision. The Court's decision in that case clearly challenges Federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective, community-based services. The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

Outpatient – A patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis.

Outpatient Hospital Service – Preventive, therapeutic, or palliative items or services furnished by or under the direction of a physician to an outpatient.

Outpatient Medical Benefits – Specific types of services that a State may include in its Medicaid Program and have part of the costs absorbed by the Federal government. Some of the most frequently covered optional services are clinic services; nursing facility services for beneficiaries under age 21, intermediate care facility/mentally retarded services, optometrist services and eyeglasses, prescribed drugs, and dental services.

Over-Utilization – Excessive use of the Medicaid Program by any provider or beneficiary.

Palliative Care – Any treatment which controls pain, manages symptoms, enhances comfort, and improves the quality of life.

Part A – The portion of the Medicare Program that covers hospital inpatient care, inpatient care in skilled nursing facilities, home health care, and hospice care.

Part B – Medicare Supplementary Medical Insurance. The part of the Medicare Program that covers physician services, hospital outpatient care, home health care, durable medical equipment, and certain other outpatient services.

Participating Common Carrier/Individual Volunteer Providers – A provider of non-medical, non-ambulance transportation of Medicaid beneficiaries. Such services may include; public railways, buses, cabs, airlines; or other firms, corporations, and entities who are certified pursuant to the regulations as established by the Public Service Commission and DHHR; and individual volunteers; all as defined herein.

Participating Ground Ambulance Provider – A provider of ground medical transportation services that has been granted certification, as defined herein, by the Office of Emergency Medical Services (OEMS) and Department of Health & Human Resources (DHHR) for the provision of medical transportation of Medicaid patients and who elects to participate in and

seeks reimbursement from DHHR Bureau for Medical Services, pursuant to the regulations herein.

Levels of ground medical transportation includes Advanced Life Support (ALS), Basic Life Support (BLS), Ambulance Medical Transport (AMT), and Specialized Multi-Patient Medical Transport Provider (SMPMT) as defined herein.

Participating Providers – Hospitals, nursing facilities, home health agencies and practitioners who are enrolled in the Medicaid Program to provide covered services to Medicaid beneficiaries.

PAS-2000 – Pre-Admission Screening form; comprehensive medical evaluation used to determine medical eligibility in the ADW Program.

Patient Management Services – Responsibility for management of the assigned enrollee's health care through direct service provision, arrangement by referral and/or approval of PAAS, including medical services and maintenance of a unified medical record.

Patient Transportation – Movement or transfer of a patient from one location to another by an approved and designated ambulance. EMS Rules §64 CSR 48.

Peer Review Organization (PRO) – Federally designed program charged with the responsibility of utilization and quality review of the necessary medical care provided Medicaid and Medicare patients.

Per Diem – A daily rate of reimbursement for services provided in a facility setting on an inpatient basis.

Physical Environment – Condition of the client's home and how well it meets the client's needs.

Physical Health – General physical condition and mental status of an individual and services which will improve or maintain a beneficiary's health.

Physical Therapy – Services prescribed by a physician and provided by or under the direct supervision of a "qualified physical therapist." A qualified physical therapist is a graduate of a program of physical therapy approved by the American Physical Therapy Association and the Council on Medical Education of the American Medical Association and is licensed or registered in the state.

Plan of Care (POC) – An agreement between the client and case management which identifies a client's problem goals and services to be provided by the ADW Program.

Preauthorization (Prior Approval) – Authorized in advance of the service as a condition for payment.

Prepaid Ambulatory Health Plan (PAHP) – An entity that:

- Provides medical service to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates,
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees
- Does not have a comprehensive risk contract.

Prepaid Inpatient Health Plan (PIHP) – An entity that:

- Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees
- Does not have a comprehensive risk contract.

Primary Care – The ongoing responsibility of directly providing routine medical care (including diagnosis and/or treatment and health education) to an enrollee and, as necessary, referring the enrollee to another provider for diagnosis and/or treatment.

Primary Care Case Management (PCCM) – A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid beneficiaries.

Primary Care Case Manager (PCCM) – A physician, a physician group practice, or an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

- A physician assistant
- A nurse practitioner
- A certified nurse-midwife.

Primary Care Practitioner or Clinic – A Medicaid participating provider of routine care for health promotion and maintenance. A primary care practitioner may be a practicing general or family physician, pediatrician, internist, gynecologist, general surgeon, certified adult or pediatric nurse practitioner, or physician's assistant.

Prior Authorization (PA) – Prior approval necessary for specified services to be delivered for an eligible client by a specified provider before services can be performed, billed, and payment made. A utilization review method used to control certain services which are limited in amount, duration, or scope.

Prior Authorization for Extended Hours – Request for approval of additional services in excess of the client's approved Level of Care.

Prior Authorization Request – Where not otherwise deemed in this manual, a prior-authorization request shall consist of a written request from the case management agency (prior to arranging for services to be delivered) that identifies the requested services. The client's name, Medicaid number, the condition to be treated, a description of requested treatment, anticipation length of treatment, anticipation cost, and a working prognosis must be included in the request.

Private Vehicle Transportation by Individuals – Individuals are permitted to transport Medicaid patients in private autos. Payments are processed by staff in the West Virginia Department of Health & Human Resources county offices and reimbursements made through the non-medical, non-ambulance Transportation Program.

Procedure Code – A code used to identify a medical service or procedure performed by a provider and billed to Medicaid on the CMS-1500 claim form.

Proficiency Testing – A method of quality control that periodically sends specimens to a laboratory for analysis and comparison with the findings for the original test.

Prospective Payment System (PPS) – A method that pays hospitals and nursing facilities a fixed amount to provide inpatient care to Medicaid beneficiaries. The amount is determined before services are provided. The amount for hospital inpatient care is for the entire stay; for nursing facility care, the amount is for one day of care.

Provider Number – A unique 10-digit number assigned by the Bureau for Medical Services to identify each provider of services and which identifies the service provider on the CMS-1500 claim form. The number is essential for billing purposes.

Psychological Services – The evaluation and therapy services provided by an independently practicing licensed psychologist.

Psychologist Under Supervision for Licensure – An individual who:

- Is an unlicensed psychologist with a documented, completed degree in psychology at the level of a Ph.D., Psy.D., Ed.D., M.A., or M.S.
- Has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision Program
- Is working towards licensure
- Is employed by and receives two hours of supervision per 40 hours of employment from a Medicaid enrolled psychologist.

Quality Improvement Project – A program designed to improve quality, which includes collection of baseline measures with development and implementation of appropriate interventions, followed by re-measurement.

Reassessment, Reevaluation – An update and review of the client's case to determine the appropriateness of the individualized Service Coordination Plan and Plan of Care.

Referral – The process of sending a patient from one practitioner to another for health care services. The Physician Assured Access System requires that the designated Primary Care Provider authorize a referral for coverage of specialty services.

Regional Office Review – The Centers for Medicare and Medicaid Services Regional Office must review and approve all Managed Care Organization, Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP) contracts, including those risk and nonrisk contracts.

Registered Nurse (RN) – A person who is professionally licensed by the State of West Virginia as a Registered Nurse.

Reported Charge – Total amount submitted for reimbursement on a claim form by a provider of services.

Residence – The beneficiary's full-time residence, but does not include a hospital, nursing facility, intermediate care facility or any other residential setting in which nursing services are

already available. Personal care services cannot be provided in a hospital, nursing facility, or Intermediate Care Facility.

Risk Adjustment – The dollar amount that is added to or subtracted from a payment rate because the person's health status is below or above the average.

Risk Contract – A contract under which the contractor:

- Assumes risk for the cost of the services covered under the contract
- Incurs a gain or loss depending on the cost of furnishing the services covered by the contract.

Resource Based Relative Value Scale (RBRVS) – A list of relative value unites (or weights) assigned to different types of physician services. The units indicate the cost of and amount paid for one service compared to the cost of and amount paid for the average services. A weight of 2.20 for a service means that the service is 200 percent as costly as the average services. If the average service cost is $30, the specific service would cost $66 = $30x2.20.

Resource Utilization Groups (RUG) – A system that is used to classify nursing home patients in groups based on their medical needs and functional and behavioral characteristics. Information from the Minimum Data Set is used to assign patients to these groups.

Retroactive Medicaid Eligibility – Medicaid eligibility in which a person was determined to be eligible for a period of time prior to the day on which the applicant's financial eligibility was entered into the Medicaid Management Information System (MMIS) for payment.

Rotary Wing Aircraft – The rotary wing air ambulance (helicopter) services are deemed appropriate when the beneficiary's medical condition is such that transport by ground ambulance is not appropriate. Transport by fixed wing may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. The fixed wing aircraft shall be designed, constructed or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in West Virginia Health Legislative Rules §64 CSR 48.

Rural Health Clinic (RHC) – Authorized by Section 1102 of the Social Security Act, September 19, 1978, established a class of providers known as Rural Health Clinics which were to be located in designated medical shortage areas, employing nurse practitioners and/or physician assistants under the supervision by physicians, reimbursed on cost-related basis per patient encountered at a rate determined by Medicare physical intermediaries.

Rural Health Clinic Services – Services furnished by a physician within the scope of practice of his/her profession under state law, and services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse under the supervision of a physician. Such services may be furnished in the rural health clinic location or away from the clinic by one of the above mentioned practitioners who has an agreement with the clinic that the practitioner will be paid by it for such services.

Service Coordination Plan (SCP) – An agreement between the client and case management agency which identifies client needs, goals, outcomes, and services to be provided by the Aged and Disabled Waiver.

Service Provider – Any individual or agency who coordinates or provides identified program services to individual clients.

Session – The time period used in a psychotherapy service or evaluation service and limited to increments of 20 minutes up to one and one-half hour, depending on the service modality and procedure code.

Single State Agency – The agency designated by the West Virginia Legislature to administer a particular State program. The Bureau for Medical Services is the single state agency that administers the West Virginia Medicaid Program.

Slot Allocation Methodology – A method to equitably distribute waiver allocations.

Specified Low-Income Medicare Beneficiaries (SLIMBs) – Medicare beneficiaries with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level but less than 120 percent of the Federal Poverty Level. The Medicaid Program pays their monthly Medicare Part B premiums.

Specialized Multi-Patient Medical Transport Provider (SMPMT) – A non-emergency transport service provided by an EMS agency licensed to provide this service by the Office of Emergency Medical Services (OEMS). This service is provided to beneficiaries who are ambulatory and/or mobile nonambulatory with a medical history, but have no apparent immediate need for any level of medical services while being transported to and from scheduled medical appointments. Vehicles and staff must comply with the rules and requirements set forth in West Virginia Health Legislative Rule §64 CSR 29.

Specialized Multi-Patient Medical Transport Vehicle – A vehicle owned and operated by a licensed emergency medical services agency used to provide transportation to ambulatory patients with a medical history but who have no apparent immediate need for any level of medical supervision while being transported to and from scheduled medical appointments.

Specialized Multi-Passenger Van Provider (SMPV) – An organization or entity which operates specialized multi-passenger vans equipped to transport ambulatory and/or mobile nonambulatory patients as described in the medical necessity attachment. SMPV vehicles and personnel shall meet the requirements set forth by these regulations. These vehicles and personnel are to provide safe, sanitary, and comfortable transportation to and from scheduled medical appointments and cannot be utilized for the transportation of Advanced Life Support or Basic Life Support medical patients. This category of transportation provider submits claims directly to the Medicaid Program.

Specialized Multi-Passenger Van Provider (SMPV) Certification – Certification of eligibility issued by the West Virginia Department of Health & Human Resources, Bureau for Medical Services, and the Office of Emergency Service or the Public Service Commission and any other federal governing agency or departments of the State of West Virginia to any individual, firm, corporation, association, county, municipality or other legal entity for the purposes of providing non-ambulance transportation services to eligible Medicaid beneficiaries in the State of West Virginia.

Spend Down – The process by which a person whose income is too high to qualify for Medicaid spends the excess amount on health care and subsequently may qualify for Medicaid benefits.

State Agency – The Bureau for Medical Services is the agency under the provision of Title XIX of the Social Security Act to administer the West Virginia Title XIX Medicaid Program.

State-Only Health Programs – Health benefits that the State provides to eligible persons that is funded entirely from State revenues—that is, the Federal government does not share in the cost of the program, as it does for Medicaid.

State Plan – A comprehensive written agreement between the state agency administering the Medicaid Program and the Centers for Medicare and Medicaid Services, which includes client eligibility requirements and identifies the scope of medical care for which reimbursement is available.

Supplemental Security Income (SSI) – A federal program that provides financial assistance to eligible aged, blind, and disabled persons.

Targeted Case Management Services – The services covered by the West Virginia Medicaid Program to provide targeted case management to Medicaid eligible individuals with mental illness, development disabilities, and substance abuse, pursuant to the case management option available to States under Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Terminally Ill – A medical prognosis, by a physician, has determined that an individual's life expectancy is 6 months or less if the illness runs its normal course.

Third Party – Any entity (including other government programs or insurance program) that is or may be liable for payment of all or part of the medical cost for injury, disease, or disability of a client of Medicaid services. Medicaid is always the payer of last resort.

Third Party Liability (TPL) – Financial resources available to the beneficiary to cover costs for medical care. The third party may be private health insurance, Medicare or Medicaid, or retiree health benefits.

Title XIX – The section of the Social Security Act that authorizes the Medicaid Program.

Title XVIII – The section of the Social Security Act that authorizes the Medicare Program.

Unduplicated Recipient/Beneficiary Count – The number of different persons who receive at least one service during a stated time period. Each person is counted once, regardless of the number of services received.

Unit – A standard measure of services provided to an eligible client.

Usual, Reasonable and Customary Charge – Amount providers charge the general public for services or supplies.

Waiver Program for Mentally Retarded and Developmentally Disabled Persons or MR/DD Waiver Program – West Virginia's home and community-based services program for individuals who have mental retardation and or developmental disabilities, administered by the Bureau for Medical Services of the Department of Health and Human Resources in collaboration with the Office of Behavioral Health Services pursuant to a Medicaid waiver option approved by the Center for Medicare and Medicaid Services. The MR/DD Waiver Program is a health care coverage program that reimburses for services to instruct/train, support, and assist individuals who have mental retardation and/or related conditions to achieve the highest level of independence and self-sufficiency possible in their lives. The MR/DD Waiver Program serves individuals who are eligible to receive services in an Intermediate Care Facility for Individuals

with Mental Retardation and Related Conditions (ICF/MR). The MR/DD Waiver Program provides services in homes and local communities instead of ICF/MRs.

West Virginia Department of Health and Human Resources (DHHR) – Cabinet-level department responsible for the administration of health and human services programs in West Virginia.

WVDHHR Title XIX Medicaid Waiver Program for the Aged and Disabled –The Aged and Disabled Home and Community–Based Services Waiver as defined in Chapter 501, Aged & Disabled Waiver Services.

X-Ray Technologist – Operations of equipment is by practitioner or by an x-ray technologist, under his/her direct supervision. An x-ray technologist is defined as an individual licensed under State law to make medical x-rays.

CHAPTER 300–PROVIDER PARTICIPATION REQUIREMENTS

CHANGE LOG

Replace	Title	Change Date	Effective Date
320.9	Medicaid Cost Report Submissions and Filing Deadlines – Correction to Mailing Address	6/14/2013	6/1/2010
320.9	Cost Report Filing Deadline: Correction to Table	2/1/2007	3/1/2007
New Section 320.9	Cost Report Filing Deadlines	10/1/2006	11/1/2006
New Section 320.10	Cost Report Filing Extensions	10/1/2006	11/1/2006
New Section 320.11	Cost Report Filing Exemptions	10/1/2006	11/1/2006
New Section 320.12	Cost Report Late Filing Penalties	10/1/2006	11/1/2006
310, 320, 330, 340, 350	Various	12/02/04	01/01/05
310, 340, 360	Various	12/02/04	01/01/05
310.2	Identification Numbers	12/02/04	01/01/05
310.5	Change in Practice Ownership	12/02/04	01/01/05
320.4	Bill Other Payers First	12/02/04	01/01/05
320.5	Document and Retain Records	12/02/04	01/01/05
320.6	Protect Member Privacy	12/02/04	01/01/05
340	Billing Procedures	12/02/04	01/01/05
340.6	Claim Submission Timelines	12/02/04	01/01/05

June 14, 2013

Section 320.9

Introduction: This manual addition provides a single location for identifying all cost report due dates and the filing address for those reports. In addition, it clearly instructs the providers regarding the extension, exemption, and Medicaid cost report late filing penalty policies.

Old Policy: 320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

Providers listed below are required to timely file their WV Medicaid cost reports for Title XIX services. A timely filed report for providers that are required to submit an annual cost report must be received in accordance with the "Cost Report Due Date" outlined in the chart below, or at the end of an approved extension. Cost reports are considered to be timely filed when received on or before the applicable due date at the following address:

WVDHHR - Office of Accountability & Management Reporting

ATTN: Division of Audit & Rate Setting

1900 Kanawha Blvd., East

State Capitol Complex

Building 3, Room 550

Charleston, WV 25305

New Policy: 320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

Providers listed below are required to timely file their WV Medicaid cost reports for Title XIX services. A timely filed report for providers that are required to submit an annual cost report must be received in accordance with the "Cost Report Due Date" outlined in the chart below, or at the end of an approved extension. Cost reports are considered to be timely filed when received on or before the applicable due date at the following address:

Cost Report & Settlement Coordinator

WV Department of Health & Human Resources

Office of Accountability and Management Reporting

One Davis Square, Suite 304

Charleston, WV 25301

March 1, 2007

Section 320.9

Introduction: The error contained in the cost report due date for Intermediate Care Facilities for the Mentally Retarded and Long Term Care Facilities has been corrected to reflect 60 days after

the end of the annual reporting period for ICF/MR and 60 days after the end of the 6 month reporting period for LTC instead of the last day of the second month following the 6 month reporting period previously listed.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Old Policy: ICF/MR and LTC facilities cost reports were indicated as due on the last day of the second month after the end of the six month reporting period.

New Policy: ICF/MR facilities cost reports are due sixty days after the end of the annual reporting period and LTC facilities are due sixty days after the end of each six month reporting period.

Section 320.9

Introduction: This manual addition provides a single location for identifying all cost report due dates and the filing address for those reports. In addition, it clearly instructs the providers regarding the extension, exemption, and Medicaid cost report late filing penalty policies.

Old Policy: Not applicable.

New Policy: 320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

Providers listed below are required to timely file their WV Medicaid cost reports for Title XIX services. A timely filed report for providers that are required to submit an annual cost report must be received in accordance with the "Cost Report Due Date" outlined in the chart below, or at the end of an approved extension. Cost reports are considered to be timely filed when received on or before the applicable due date at the following address:

WVDHHR - Office of Accountability & Management Reporting

ATTN: Division of Audit & Rate Setting

1900 Kanawha Blvd., East

State Capitol Complex

Building 3, Room 550

Charleston, WV 25305

Facility Type	Cost Report Format	Cost Report Due Date	Cost-Based Settlement
Acute Care Hospital (Hospital Portion and Non-cost settled distinct parts)	CMS-2552-96	Last day of the fifth month after the provider's FYE	No
Acute Care Hospital-Distinct Part(s) Subject to Cost Settlement	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes
Critical Access Hospital	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes
Federally Qualified Health Center	CMS-222-92	Last day of the fifth month after the provider's FYE	Yes
Rural Health Clinic	CMS-222-92	Last day of the fifth month after the provider's FYE	Yes
Intermediate Care Facilities for the Mentally Retarded	Financial and Statistical Report for ICF/MR (FASR-ICF/MR)	Last day of the second month after end of six month reporting period.	Settlements may occur upon audit or discovery of errors/omissions in FASR-ICF/MR
Long Term Care Facilities	Financial and Statistical Report for Nursing Homes (FASR-NH)	Last day of the second month after end of six month reporting period.	Settlements may occur upon audit or discovery of errors/omissions in FASR-NH

Residential Child Care - Children's Residential Services	Financial and Statistical Report for Residential Child Care Providers	Last day of the second month after end of six month reporting period	No
Inpatient Psych Facility-Acute Psych Under 21	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes
Inpatient Psychiatric Residential Treatment Facilities	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes

WVDHHR will accept the CMS 2552-96 and CMS 222-92 (Medicare) forms for Medicaid cost reporting purposes, however the cost report submitted must include an original signature on the settlement page and a statement certifying the cost report is intended to satisfy the Title XIX Medicaid cost reporting requirement.

The provider's election to electronically file the cost report with the Medicare intermediary does not negate the requirement to file a hard copy cost report as outlined above. WVDHHR will honor an extension granted by Medicare for Medicaid cost report filing purposes, however the provider must forward to the Office of Accountability and Management Reporting (at the above address) a copy of the Medicare granted extension prior to the original submission deadline.

Section 320.10

Old Policy: Not applicable

New Policy: 320.10 Cost Report Extensions

A. Provider may request an extension of up to thirty (30) days beyond the cost report due date for extenuating circumstances. A provider must submit a written request to the Office of Accountability and Management Reporting (OAMR) prior to the cost report due date. The request must include an explanation of the extenuating circumstances and a proposed new date for submission of the cost report to OAMR. If approved, the provider will be notified in writing of the new cost report due date. If rejected, the provider's cost report due date will remain the originally assigned date.

B. The Medicare program may issue extensions in filing cost reports due to various administrative causes. Generally, these extensions are issued as blanket extensions to

specified groups of providers due to software issues or late program changes. In instances where a provider files both with Medicare and with WV Medicaid, OAMR will extend the cost report due date to agree with the Medicare approved extension. A provider must notify OAMR of the Medicare extension.

C. Providers may file an extension request due to extenuating circumstances any time prior to the cost report deadline for filing. Each request will be evaluated by OAMR. The acceptance or rejection of the request will be based upon whether the late preparation of the report had been caused by circumstances within or outside of the provider's control. If the late filing is due to circumstances within the provider's control, the request will be denied.

Section 320.11

Old Policy: Not Applicable

New Policy: 320.11 Cost Report Exemptions

Low utilization exemptions requirements:

A. Providers that have low WV Medicaid utilization may qualify for an exemption in filing their annual WV Medicaid cost report. Providers that render services to five or less WV Medicaid recipients during the provider's fiscal year may request an exemption in filing their annual cost report. A provider that meets the low utilization criterion must file a written request for the exemption directly to the OAMR prior to the cost report's due date. If the request for and exemption is approved by OAMR, the provider will be notified in writing.

B. Providers that have no WV Medicaid utilization during their fiscal year must provide a written statement to OAMR confirming that fact prior to the cost report due date. Providers that meet the no utilization criterion will not be required to file an annual report with the WV Medicaid program.

C. The OAMR reserves the right approve or reject a provider's request for an exemption regardless of compliance with exemption criteria and require a complete and acceptable cost report.

Section 320.12

Old Policy: Not applicable.

New Policy: Cost Report Late Filing Penalties

Failure to file a cost report timely, or failure to file a cost report, may result in suspension of future payments, assessment of interest on program overpayment, or termination from the Medicaid program.

The OAMR will notify providers, by certified mail return receipt requested, whose cost reports are not received by the cost report due date. The notification will advise the provider that their cost report is now delinquent, as well as advise them of the consequences of continued delinquency.

A provider who fails to submit their delinquent cost report within thirty (30) days following the cost report due date will have their interim payments suspended beginning on the thirty-first day of delinquency. This action results in withholding of future payments pending receipt of the provider's cost report. Payments will be reinstated after an acceptable cost report is filed with OAMR. In addition to the full suspension of payments herein described, Nursing Homes and Intermediate Care Facilities / Mentally Retarded will be subject to a ten percent (10%) reduction in reimbursement in accordance the WV State Medicaid Plan. This penalty will be assessed for each day that the cost report is delinquent. Where continued delinquency occurs with regards to submission of the required cost report, a termination action will be initiated in accordance with Medicaid guidelines, Section 310.7.

Sections 310, 320, 330, 340, 350

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Sections 310, 340, 360

Introduction: The phone numbers and addresses of the Medicaid contracted claims agent has changed.

Directions: Replace the pages containing these sections.

Change: Replace old phone numbers and addresses with the new ones.

Sections 310.2

Introduction: Added location of PAAS agreement on the BMS website. Deleted and replaced paragraph 5.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 310.5

Introduction: Added a sentence to first paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 320.4

Introduction: Added language clarifying that Medicaid is to be payer of last resort.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 320.5

Introduction: Added language clarifying guidelines for signature and documentation of electronic records.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 320.6

Introduction: Deleted “At a minimum,” in the first paragraph and “Furthermore” in the second paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Section 340

Introduction: Deleted “or a reversal of a voided claim” at end of second paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Section 340.6

Introduction: Changed second sentence to “The time limit is 24 months from the date of service to adjust original clean claims.”

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

CHAPTER 300—PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER 300–PROVIDER PARTICIPATION REQUIREMENTS

300 INTRODUCTION

Chapter 300 presents an overview of the minimum requirements that health care providers must meet to enroll in and be reimbursed by the West Virginia (WV) Medicaid Program. Certain requirements apply to all providers. Requirements discussed in applicable provider manuals only apply to specific provider types.

310 ENROLLMENT PROCESS

To enroll in the WV Medicaid Program, a health care provider must meet all the requirements established by the Bureau for Medical Services (BMS). Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, dealers, individual practitioners, or groups. All group practices must comply with WV law applicable to group and corporate practice.

The Provider Enrollment Unit is responsible for enrolling qualified providers into the WV Medicaid Program. This unit determines whether the applicant is eligible to participate in the program based on information that the applicant submits.

If a provider wants to participate in the Physician Assured Access System (PAAS) Program as a PAAS Provider, the provider must complete and sign a separate agreement after enrolling in the traditional WV Medicaid Program.

310.1 ENROLLMENT PACKET

Health care providers who are currently licensed, certified, accredited, or registered under WV law, or under another state's law where their practice is located, may participate in the WV Medicaid Program. Health care providers who wish to participate can request an enrollment packet by contacting the Provider Enrollment Unit at: 1-304-348-3360 for out of state and Charleston, WV providers and 1-888-483-0793 for in-state and border providers.

The packet contains the following items:

- Cover letter with instructions for completing the application process
- Provider Enrollment Application
- Form W-9
- Electronic Remittance Voucher Download Authorization
- Electronic Claims Submission Agreement
- Program Instruction on mandatory electronic funds transfer policy
- Direct Deposit Authorization form.

The applicant must complete, sign, and return all applicable forms. Proof of current licensure, certification, accreditation or registration according to WV Medicaid provider enrollment criteria also must be submitted. The applicant must also indicate whether his/her license or other accreditation has been revoked or suspended in another state.

By signing the enrollment form, the applicant agrees to comply with all applicable laws, regulations, and policies of the WV Medicaid Program. This includes Title XIX of the Social

Security Act, the Code of Federal Regulations, the WV State Medicaid Plan, and all applicable state and federal laws, standards, guidelines, and program instructions.

Provision of false information during the application process will result in denial of participation, and the case will be referred to the appropriate legal authority.

310.2 IDENTIFICATION NUMBERS

A health care provider must have a Medicaid provider identification number in order to bill for services rendered to Medicaid members. The provider may also have a group practice Medicaid number and a managed care provider number. The provider may have more than one Medicaid number, depending on the types of services rendered. The provider also may have a Medicare identification number, as well as a Drug Enforcement Agency (DEA) and National Association of the Board of Pharmacies (NABP) number.

Medicaid Number. An applicant who is accepted into the Medicaid Program is assigned a unique 10-digit Medicaid provider identification number. The Provider Enrollment Unit notifies the applicant of his/her number. Medicaid payment will not be made if the provider's Medicaid number does not appear in the appropriate space on claims submitted for payment.

A practitioner who enrolls as a member of a group practice receives a unique Medicaid provider identification number. This number must be used with the group's Medicaid number when billing for services provided to Medicaid members.

For group practices, claims are processed using both the individual and group practice Medicaid provider identification number. Inaccurate or missing numbers will result in payment errors or delays. Also, there are provisions and procedures to differentiate between the "treating" provider number and the "pay to" provider number.

Pharmacy providers must submit their National Council for Prescription Drug Programs (NCPDP) number (formerly NABP number) when billing for prescriptions dispensed to Medicaid members. The 10-digit Medicaid provider number is to be used to bill Durable Medical Equipment (DME).

Medicare Number. A Medicare provider must have his/her Medicare provider number(s) on file with the WV Medicaid Program. Medicare numbers also must be reported on Medicaid enrollment application forms. This will help expedite prompt and accurate payment for services rendered to Medicaid members who are also eligible for Medicare benefits. For these "dual eligible" members, Medicare is the primary payer and Medicaid is the secondary payer, as explained in Section 340.1 below.

Additionally, to ensure accurate claims processing, providers must notify the Provider Enrollment Unit in writing of any change to their Medicare provider number or any Medicare number received subsequent to Medicaid enrollment. Erroneous or missing Medicare numbers may result in denials and inaccurate or delayed Medicaid payments.

Managed Care. Health Maintenance Organizations (HMOs) that participate in MHT are responsible for contracting and credentialing their participating providers. HMOs establish standards for providers that participate in their networks. HMO standards must meet or may exceed those for traditional Medicaid fee-for-service providers. If a provider wants to become a

participating provider with an HMO in Mountain Health Trust (MHT), the provider must contact the HMO directly.

The Office of Medicaid Managed Care, PAAS Program, is responsible for the enrollment of Primary Care Providers (PCPs) who wish to participate in the PAAS Program. All applicants must currently be WV participating Medicaid providers. Under contractual arrangements with BMS, outside vendors may assist with PCP recruitment and enrollment. More information about becoming a PAAS provider can be obtained by calling 1-888-483-0793. The PAAS agreement can be obtained from the website at http://www.wvdhhr.org/bms/oManagedCare/bms_ManCare-main.asp.

310.3 STATE LICENSURE

A health care provider must maintain a valid state license/certification number from either WV or another state where the provider practices. In addition, the health care provider may have to satisfy other credentialing requirements to continue participating in the WV Medicaid Program.

The provider's current license/certification must be on file at all times with the BMS Provider Enrollment Unit. It is the responsibility of the provider to ensure that licensing or certification information is kept current. BMS does not issue reminders or warnings.

The provider must mail or fax to the Provider Enrollment Unit a copy of any renewed license or other credential before the current credential expires. The fax number is 304-348-3380.

A provider's participation in the WV Medicaid Program may be suspended if the Provider Enrollment Unit cannot verify the current status of the provider's credentials.

310.4 REPORT NEW INFORMATION

The information that a provider submits at enrollment may change as time passes. Participating providers must notify the Provider Enrollment Unit immediately of changes related to any of the following items:

- Provider name
- Provider payment and mailing address
- Change in banking information (direct deposit)
- Provider office telephone number
- Provider legal status or practice name
- License or certification status
- Medicare provider identification number
- Practice ownership, including mergers, acquisitions, or consolidations
- Tax identification number
- Other pertinent information.

The notification must be sent in writing to the following address and must contain the provider's Medicaid provider identification number and original signature:

Unisys
P. O. Box 625
Charleston, WV 25322

Notification by fax or telephone is not acceptable. BMS requires the provider's original signature on the notification. Failure to notify the Provider Enrollment Unit may result in denied or delayed Medicaid payments, as well as important mailings and other correspondence being sent to incorrect addresses or business names.

310.5 CHANGE IN PRACTICE OWNERSHIP

A change in practice ownership automatically cancels the selling provider's enrollment in the WV Medicaid Program. The new provider must obtain an enrollment number to participate in the WV Medicaid Program. In addition, should the prior owner start a new practice independently or form a group, a new enrollment request must be completed. A new National Council for Prescription Drug Programs (NCPDP) number is required when there is a change in pharmacy ownership.

For income tax purposes, the Provider Enrollment Unit must be notified at least 30 days in advance about ownership changes that affect the provider's tax identification number. Early notice will help avoid payment delays, denials, and 1099 errors.

310.6 ENROLLMENT MAY BE DENIED

An applicant may be denied enrollment in the WV Medicaid Program if the following circumstances exist:

- The applicant previously failed to correct deficiencies in the operation of a business or enterprise subsequent to receiving written notice of the deficiencies from a state or federal licensing or auditing agency;
- One or more factors exist that directly impair the applicant's ability to render quality health care to Medicaid members, including actions by persons employed by or affiliated with the provider;
- The applicant's health care practitioner license was suspended or revoked in another state;
- The applicant's Medicaid provider identification number was suspended in another state;
- The applicant has been convicted of fraud related to billing for health care service;
- The applicant has been barred from participation in any federal health program.

An applicant may reapply for participation at any time after the cause for the denial is remedied satisfactorily.

310.7 VOLUNTARY AND INVOLUNTARY WITHDRAWAL

A provider's participation in the WV Medicaid Program may be discontinued voluntarily or involuntarily.

Voluntary Withdrawal. Health care providers may voluntarily discontinue Medicaid enrollment by mailing a signed letter to the Provider Enrollment Unit. A PAAS health care provider must give at least 60-days notice before terminating his or her participation and, where possible, assist in the reassignment of patients to other PAAS providers. In all cases, the letter of disenrollment must include the provider's Medicaid number and specify a termination date. The letter must possess the provider's original signature.

In the case of an emergency that renders the provider unable to continue as a Medicaid participant, BMS must be notified as soon as possible. The notice should include a brief explanation of the reason for disenrollment and must be signed by the provider or the provider's legal representative.

Involuntary Withdrawal. BMS may terminate a provider's enrollment in the WV Medicaid Program for one or more of the following reasons:

- Breaches of the provider agreement
- Demonstrated inability to perform under the terms of the provider agreement
- Failure to comply with applicable state and federal laws
- Loss of license or certification
- Failure to comply with WV Medicaid's regulations and policies, as well as those of the DHHS
- Involuntary termination of Medicare participation and enrollment
- Medicaid inactivity for 2 consecutive years.

320 REQUIREMENTS AND RESPONSIBILITIES

Health care providers who participate in the WV Medicaid Program must sign a "provider participation agreement" indicating that they will comply fully with the standards and rules established by the Department of Health and Human Services (DHHS), as well as all applicable state and federal laws and regulations governing the services rendered to Medicaid members.

BMS will issue a provider manual to all newly-enrolled providers, and will make the manual available at www.wvdhhr.org/bms. Participating providers are responsible for thoroughly familiarizing themselves with the manual's contents. If the provider is part of a large organization, several key members or directors need to have a working knowledge of the manual.

320.1 DISCRIMINATION PROHIBITED

Health care providers must comply with all applicable sections of Title VI of the Civil Rights Act of 1964, as amended by the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the Rehabilitation Act of 1973. This means that a provider who participates in the WV Medicaid Program may not discriminate in the provision of Medicaid benefits based on the member's race, color, national origin, creed, gender, religion, political ideas, marital status, age, or disability.

320.2 ACCEPT NEW PATIENT AS MEDICAID OR PRIVATE-PAY

The provider may accept a new member as all-Medicaid or all-private pay. The provider may not accept the member as a Medicaid patient for some covered services and as a private-pay patient for other covered services. In other words, selective participation is not permitted. Additionally, a provider may not impose, bill, or collect any fees in advance of services from the member, and monies collected after Medicaid payment is received, including co-payments due from other carriers must be returned to the member. Similarly, providers may not void claims and then subsequently bill members for services.

If a provider accepts the member as a Medicaid patient, the provider must bill WV Medicaid for covered services and must accept the Medicaid reimbursement amount as full payment. No

charge may be billed to a Medicaid member for a covered service unless a co-payment is applicable by regulation. However, the provider may bill the member for services not covered by the WV Medicaid Program if the parties agree in writing to this payment arrangement before such services are rendered.

To bill the member, the provider must inform or provide notice to the member prior to rendering services and obtain the member's signature when (1) the WV Medicaid Program does not cover the service, (2) the patient is being accepted as private-pay, not Medicaid, and (3) the member may be financially liable for the amount the provider charges for the service. The notice should be signed and dated by the provider and the member, and a copy given to the member. This procedure may help avoid problems that could arise concerning payment for medical bills.

If the member does not inform the provider of his/her Medicaid coverage status until after a service is rendered, the provider is not obligated to bill Medicaid for the service. Should the provider choose to bill Medicaid, the provider must return to the member any prior payments and forego any remaining balance after Medicaid payment is received.

Providers who treat Medicaid managed care members without appropriate authorization may bill members for services rendered if the member is informed prior to receiving the service that he/she is financially liable for the provider's charges. If appropriate authorization is received prior to rendering services, the above information in subtopic 320.2 applies. If a member is a member of an HMO, the rules of the HMO also apply.

320.3 OBTAIN PRIOR AUTHORIZATION

Various in-state and out-of-state services (for example, but not limited to, hospital inpatient care, nursing facility services, etc.) covered by the WV Medicaid Program must be approved in advance before payment can be made. Pre-service review and prior authorization may be required to initiate treatment or extend treatment beyond the amount, scope, or duration that is routinely allowed or was originally approved.

It is the responsibility of the provider of the service to secure prior approval before rendering the service. In addition, WV Medicaid does not guarantee reimbursement based solely on the issuance of a Prior Authorization number. Eligibility on the date of service, as well as claim submission information and documentation, is also considered in the claim adjudication process.

Several entities are responsible for performing medical necessity reviews, depending mainly on the service to be provided and the place of service. Information about the authorizing entity, and policies and procedures for obtaining prior authorization for particular types of services, is identified in applicable provider manuals.

Requests for prior authorization may be mailed or faxed. With the exception of a pharmacy, requests must be made on the provider's letterhead or the prescribed form. The request must include at least the following information:

- Provider name
- Provider identification number
- Member name and address
- Member WV Medicaid ID number

- Member diagnoses codes and prognosis
- Prescribed treatment, including applicable procedure codes
- Date treatment to begin and items to be furnished
- Duration of treatment
- Other information needed to make a determination.

The provider must submit written documentation demonstrating the medical necessity and appropriateness of the proposed treatment. Prior authorization should be requested sufficiently in advance (e.g., 10 days) so the decision can be reached and mailed to the provider before treatment is rendered. Approval of the request is based on medical necessity and appropriateness of treatment, and may specify the amount to be paid. The approval does not guarantee the patient's Medicaid eligibility for the authorized time period for the provision of service.

When prior authorization is obtained prior to receipt of documentation, payment will only be made subsequent to receipt of all required documentation by WV Medical Institute.

Chapter 100 and Chapter 800 contain additional general information about preadmission review and prior authorization. Applicable provider manuals identify services that require prior authorization by provider type.

320.4 BILL OTHER PAYERS FIRST

Before submitting a claim to the WV Medicaid Program, a health care provider must ask the Medicaid member whether he/she has Medicare or other health insurance coverage, pending litigation, or any other source of payment for services. The provider should also inquire about coverage related to an accident or benefits from the Workers' Compensation Division. The provider is responsible for billing all other third parties before billing the WV Medicaid Program. Medicaid is the payer of last resort. Providers that are denied payment from other payers must exhaust their administrative remedies with said payers prior to billing Medicaid. Providers must retain documentation that support their pursuit of administrative remedies and provide the documentation to Medicaid upon request.

When Medicare is the primary payer and Medicaid is the secondary or tertiary payer, claims must be submitted to Medicaid within one year of the Medicare pay date.

320.5 DOCUMENT AND RETAIN RECORDS

Health care providers must maintain complete, accurate, and legible records that substantiate fully the type, nature, scope, and medical necessity of the services that the member receives. All services billed to Medicaid must be medically necessary and patients' files must document and explain the medical necessity of the billed services. As circumstances permit, there must be an entry for each health care service with the date of service, a description of the service, a plan of care and treatment, information that substantiates the level of service billed, and the provider's signature. PAAS providers, as well as providers participating in Early Periodic Screening Diagnosis & Treatment (HealthCheck) (EPSDT) or other programs, must meet additional record-keeping requirements, as outlined in the PAAS agreement.

Appropriate information should be entered by the provider or countersigned by the provider in the medical record. The date of service must be the same as the date for which Medicaid is

billed. Results of diagnostic tests billed by the provider must be in the medical record. All records must be signed and dated.

The Bureau for Medical Services current interpretive guidelines for signature and documentation of electronic records were adopted from the Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS), Program Memorandum Intermediaries, Transmittal A-03-021, "Rural Health Clinics/Federally Qualified Health Centers Guidelines for Signature and Documentation of Medical Records."

The electronic medical records and signature guidelines follow:

- Only employees designated by the provider's agency may make entries in the member's record. All entries in the member's record must be dated and authenticated, and a method established to identify the author. The identification may include written signatures, computer keys, Private/Public Key Infrastructure (PKIs), rubber stamps, or other codes.
- When rubber stamps, computer codes, etc. are used, a signed statement should be completed by the agency's employee that the chosen method is under the sole control of the person using it.
    - A list of written signatures, computer codes, or other codes that can be verified.
    - All adequate safeguards must be maintained to protect against improper or unauthorized use of a rubber stamp, computer key, or other codes for electronic signatures.
    - Sanctions must be in place for improper or unauthorized use of a rubber stamp, computer key, or other code types of signatures.
- The section of the electronic record documenting the service provided must be authenticated by the employee who provided the described service. If a counter signature is required by the agency, a policy must be developed by the agency stating the rules and regulations.
- There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include:
    - Computerized systems that require the agency's employee to review the document on-line and indicate that it has been approved by entering a unique computer code capable of verification.
    - A system in which the agency's employee signs off against a list of entries that must be verified in the member's records.
    - A mail system that sends transcripts to the agency's employee for review. The agency's employee signs and returns a postcard identifying and verifying the accuracy of the record.
- A system of auto-authentication that authenticates a report before the transcription process is not consistent with the stated requirements. There must be a method to determine an agency's employee did, in fact, authenticate the document after it was transcribed from telephonic or other types of recording systems.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
    - Unique to the person using it
    - Capable of verification
    - Under the sole control of the person using it, and

- Linked to the data in such a manner that if the data is changed, the signature is invalidated.

The provider must retain the member's medical records for at least five years after the date of service. Any record that is disputed or under investigation must be maintained until the issue is resolved.

The provider must make all records and documentation available upon request to the BMS, the DHHS, the Medicaid Fraud Control Unit, or any other authorized governmental entity consistent with state and federal laws, regulations, and policies. A provider may not charge BMS for any costs incurred to furnish any requested records or supporting documentation.

320.6 PROTECT MEMBER PRIVACY

Health care providers must safeguard the member's privacy and confidentiality, as required by all applicable state and federal laws. The use and disclosure of individually identifiable information must be consistent with the HIPAA. PAAS providers must also comply with all confidentiality requirements outlined in the PAAS agreement.

As HIPAA permits, a participating provider does not have to obtain a member's consent or authorization for BMS or its business associates to release sensitive information about the member for purposes of health care operations or the payment of claims. At the time the member applies for Medicaid eligibility, he/she signs an authorization to release medical records to BMS or its designee.

320.8 DISCLOSE INFORMATION

Health care providers must comply with all disclosure requirements in 42 Code of Federal Regulations Part 455, subpart B, such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes. A provider also must disclose fully to BMS information about the services furnished to individual Medicaid members, as circumstances may warrant.

320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

Providers listed below are required to timely file their WV Medicaid cost reports for Title XIX services. A timely filed report for providers that are required to submit an annual cost report must be received in accordance with the "Cost Report Due Date" outlined in the chart below, or at the end of an approved extension. Cost reports are considered to be timely filed when received on or before the applicable due date at the following address:

Cost Report & Settlement Coordinator

WV Department of Health & Human Resources

Office of Accountability and Management Reporting

One Davis Square, Suite 304

Charleston, WV 25301

Facility Type	Cost Report Format	Cost Report Due Date	Cost-Based Settlement
Acute Care Hospital (Hospital Portion and Non-cost settled distinct parts)	CMS-2552-96	Last day of the fifth month after the provider's FYE	No
Acute Care Hospital-Distinct Part(s) Subject to Cost Settlement	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes
Critical Access Hospital	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes
Federally Qualified Health Center	CMS-222-92	Last day of the fifth month after the provider's FYE	Yes
Rural Health Clinic	CMS-222-92	Last day of the fifth month after the provider's FYE	Yes
Intermediate Care Facilities for the Mentally Retarded	Financial and Statistical Report for ICF/MR (FASR-ICF/MR)	60 days after end of annual reporting period.	Settlements may occur upon audit or discovery of errors/omissions in FASR-ICF/MR
Long Term Care Facilities	Financial and Statistical Report for Nursing Homes (FASR-NH)	60 days after end of six month reporting period.	Settlements may occur upon audit or discovery of errors/omissions in FASR-NH

Residential Child Care - Children's Residential Services	Financial and Statistical Report for Residential Child Care Providers	Last day of the second month after end of six month reporting period	No
Inpatient Psych Facility-Acute Psych Under 21	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes
Inpatient Psychiatric Residential Treatment Facilities	CMS-2552-96	Last day of the fifth month after the provider's FYE	Yes

WVDHHR will accept the CMS 2552-96 and CMS 222-92 (Medicare) forms for Medicaid cost reporting purposes, however the cost report submitted must include an original signature on the settlement page and a statement certifying the cost report is intended to satisfy the Title XIX Medicaid cost reporting requirement.

The provider's election to electronically file the cost report with the Medicare intermediary does not negate the requirement to file a hard copy cost report as outlined above. WVDHHR will honor an extension granted by Medicare for Medicaid cost report filing purposes, however the provider must forward to the Office of Accountability and Management Reporting (at the above address) a copy of the Medicare granted extension prior to the original submission deadline.

320.10 Cost Report Extensions

A Provider may request an extension of up to thirty (30) days beyond the cost report due date for extenuating circumstances. A provider must submit a written request to the Office of Accountability and Management Reporting (OAMR) prior to the cost report due date. The request must include an explanation of the extenuating circumstances and a proposed new date for submission of the cost report to OAMR. If approved, the provider will be notified in writing of the new cost report due date. If rejected, the provider's cost report due date will remain the originally assigned date.

B. The Medicare program may issue extensions in filing cost reports due to various administrative causes. Generally, these extensions are issued as blanket extensions to specified groups of providers due to software issues or late program changes. In instances where a provider files both with Medicare and with WV Medicaid, OAMR will extend the cost report due date to agree with the Medicare approved extension. A provider must notify OAMR of the Medicare extension.

C. Providers may file an extension request due to extenuating circumstances any time prior to the cost report deadline for filing. Each request will be evaluated by OAMR. The acceptance or rejection of the request will be based upon whether the late preparation of the report had been caused by circumstances within or outside of the provider's control. If the late filing is due to circumstances within the provider's control, the request will be denied.

320.11 Cost Report Exemptions

Low utilization exemptions requirements:

D. Providers that have low WV Medicaid utilization may qualify for an exemption in filing their annual WV Medicaid cost report. Providers that render services to five or less WV Medicaid recipients during the provider's fiscal year may request an exemption in filing their annual cost report. A provider that meets the low utilization criterion must file a written request for the exemption directly to the OAMR prior to the cost report's due date. If the request for and exemption is approved by OAMR, the provider will be notified in writing.

E. Providers that have no WV Medicaid utilization during their fiscal year must provide a written statement to OAMR confirming that fact prior to the cost report due date. Providers that meet the no utilization criterion will not be required to file an annual report with the WV Medicaid program.

F. The OAMR reserves the right approve or reject a provider's request for an exemption regardless of compliance with exemption criteria and require a complete and acceptable cost report.

320.12 Cost Report Late Filing Penalties

Failure to file a cost report timely, or failure to file a cost report, may result in suspension of future payments, assessment of interest on program overpayment, or termination from the Medicaid program.

The OAMR will notify providers, by certified mail return receipt requested, whose cost reports are not received by the cost report due date. The notification will advise the provider that their cost report is now delinquent, as well as advise them of the consequences of continued delinquency.

A provider who fails to submit their delinquent cost report within thirty (30) days following the cost report due date will have their interim payments suspended beginning on the thirty-first day of delinquency. This action results in withholding of future payments pending receipt of the provider's cost report. Payments will be reinstated after an acceptable cost report is filed with OAMR. In addition to the full suspension of payments herein described, Nursing Homes and Intermediate Care Facilities / Mentally Retarded will be subject to a ten percent (10%) reduction in reimbursement in accordance the WV State Medicaid Plan. This penalty will be assessed for each day that the cost report is delinquent. Where continued delinquency occurs with regards to submission of the required cost report, a termination action will be initiated in accordance with Medicaid guidelines, Section 310.7.

330 OUT-OF-STATE SERVICES

The WV Medicaid Program may pay for covered services furnished by out-of-state providers when (1) medically necessary services are not available in WV or (2) WV members are traveling outside the State and need emergency medical treatment, (3) services have been approved by the BMS Out-of-State Unit or designated contractor, and (4) services are rendered by a border provider. For payment purposes, out-of-state providers must be licensed or certified to practice in their respective states and must be enrolled in the WV Medicaid Program.

330.1 EMERGENCY CARE

WV Medicaid will consider for reimbursement all emergency health care services that out-of-state providers furnish to WV Medicaid members. The circumstances must be documented clearly as a medical emergency, and the services must be medically necessary. The provider must maintain complete documentation in the emergency room records and submit the information with the claim for reimbursement to both justify and document the emergency.

Emergency out-of-state outpatient services need not be prior authorized to be considered for reimbursement from the WV Medicaid Program. However, the bill for the service must clearly indicate that an emergency existed, and the emergency room records must be submitted with the bill directly to the BMS Out-of-State Unit.

If the emergency results in an inpatient admission, the hospital is required to obtain authorization from WV Medical Institute within 24 hours of admission.

330.2 NON-EMERGENCY CARE

Unless the service is prior authorized, WV Medicaid usually does not reimburse for non-emergency health care services that out-of-state providers furnish to WV Medicaid members.

Non-emergency, non-border services that out-of-state providers furnish to WV Medicaid members must be prior authorized for reimbursement from WV Medicaid. To be prior authorized, the service must not be available in WV. The WV referring physician, working with the Out-of-State Unit and the non-border, out-of-state provider, must arrange for the service. The referring provider is responsible for obtaining prior authorization for the service.

All out-of-state hospital inpatient services require preadmission review and prior approval. Pre-service review can be initiated by calling 1-800-982-6334.

This includes acute care hospitals, as well as rehabilitation hospitals and psychiatric facilities for Medicaid members under age 21 years. For documented emergencies, the member may be admitted without prior approval, but the request for authorization and documentation sent must be submitted within 24 hours of admission.

All non-emergency outpatient services provided by non-border, out-of-state providers require prior approval by the BMS Out-of-State Unit, which can be reached at 1-304-558-1700.

Requests for approval must be faxed using the provider's letterhead. The request must indicate whether the service is available in WV and explain why the service should be provided out-of-state. The fax number is 1-304-558-1776.

Chapter 600 explains BMS policies governing billing and reimbursement for Medicaid-covered services furnished by out-of-state providers.

340 BILLING PROCEDURES

To be reimbursed for services rendered to Medicaid members, health care providers must file claims on the proper forms. Claims must be completed accurately with all required information and signed by the provider or an authorized representative. The amount billed must represent the provider's usual and customary charge for the service. A separate claim is required for each member that receives a covered service. Providers must submit the original claim form and retain a copy for their records.

Paper claims that are returned should be corrected and resubmitted promptly, as should any claim with a denied line item. Claims paid based on erroneous information (e.g., incorrect procedure code or units of service) require the submission of a replacement, an adjustment claim.

340.1 PAYER OF LAST RESORT

Medicaid members may have third-party coverage of health expenses, such as Medicare, employment-related coverage, Medicare supplemental, private health insurance, long-term care insurance, automobile insurance, court judgments, or benefits from the Workers' Compensation Division. For members with multiple plan coverage, coordination of benefits is the process that involves determining the order in which insurers are billed for a given service.

As required by law, Medicaid is the "payer of last resort," meaning that other third parties must be billed before Medicaid can be billed for the service. In other words, the other party is the primary payer and Medicaid is the secondary or perhaps tertiary payer. All resources must be exhausted before Medicaid can consider payment. In addition, no Medicaid payment is made for services associated with a medical condition covered by benefits from the Workers' Compensation Division. When the Ryan White Fund is available to a Medicaid member, the Fund will act as the payer of last resort.

WV Medicaid cannot be billed for services that a member receives but the provider makes available at no charge to other individuals or groups.

Some WV Medicaid members who are age 65 or older, are disabled, or have End Stage Renal Disease also qualify for Medicare benefits. Medicare is therefore the primary payer for services covered by both Medicare and Medicaid. In such instances, WV Medicaid pays the Medicare deductible and coinsurance amount up to the Medicaid allowable amount.

If another third party is billed for a service and the one-year filing deadline for Medicaid billing is almost exhausted, the provider should bill Medicaid immediately, even though the third party has not furnished the provider with information about payment. The claim should be billed on paper, along with a note explaining the situation. A copy of all relevant documentation also must be attached to the claim when submitted to Medicaid. Even if Medicaid denies the claim, the submission will give the provider another year to file a claim with Medicaid while the primary payer processes the claim.

Third party information may appear on the member's Medicaid card. This information is subject to change and should be verified with the member at the time of service. The Third Party

Liability (TPL) Unit should be notified if other coverage has changed or been terminated. The TPL Unit can be reached at 1-304-558-1700.

340.2 INSTRUCTIONS AND PROCEDURES

A copy of WV Medicaid's billing instructions can be obtained by accessing www.wvdhhr.org/bms and clicking on the heading Special Topics, then clicking on MMIS, and then on Billing Instructions, go to the section Electronic Billing. Alternately, upon request, the Provider Relations Unit will mail an initial paper copy of the instructions at no cost and will help answer questions about proper Medicaid billing methods. BMS does not provide claim forms. The Provider Relations Unit can be reached at:

1-304-348-3360	Charleston Area
1-888-483-0793	In-State toll free
1-304-348-3360	Out-of-State

The instructions provide all necessary information to submit WV Medicaid health care claims electronically. The Electronic Data Interchange (EDI) help desk is available to answer questions about electronic health care claims and set up electronic billing for the provider. The EDI help desk can be reached at 1-888-483-0793.

For pharmacy electronic claims submission assistance, call 1-800-365-4944.

340.3 ELECTRONIC CLAIM SUBMISSIONS

Health care providers may submit paper claims or submit claims electronically. Paper submissions have declined noticeably because electronic submissions provide the following advantages:

- Faster adjudication
- Fewer claims denied for keying errors
- Improved cash flow
- Claims can be transmitted 24 hours a day, 7 days a week
- Reduced claims preparation and mailing costs
- Free software, support, and training
- Technical support, Monday - Friday, 8 a.m. to 6 p.m.

WV Medicaid and its fiscal agent support electronic submissions. Additional information is available from the EDI help desk at 1-888-483-0793.

340.4 ELECTRONIC REMITTANCE VOUCHER (ERV)

ERVs are available to health care providers in print image or American National Standards Institute (ANSI) format. ERVs alleviate delays that providers might otherwise experience in receiving paper Medicaid remittance vouchers. They are placed on a Bulletin Board System the first day after a weekend cycle and are available 24 hours a day, 7 days a week. ERVs remain posted for 30 days. Entry into the system requires a valid provider or group number and password. Participating providers may enroll for ERVs by completing the appropriate authorization form, which can be obtained by calling 1-888-483-0793.

340.5 ELECTRONIC FUNDS TRANSFER (EFT)

The WV Auditor's Office requires that claims for reimbursement be paid through EFT. EFT allows for direct deposit into providers' bank accounts. Electronic funds transfer expedites payments by reducing the time required to mail and cash paper checks.

A provider may enroll for EFT by completing the Direct Deposit Authorization form and mailing it to the address on the form, or fax to 1-304-348-3380.

A copy of the form can be obtained by telephoning the Provider Relations Unit at:

1-304-348-3360	Charleston Area
1-888-483-0793	In-State toll free
1-304-348-3360	Out-of-State

Assistance with EFT-related issues is available from the Provider Enrollment Unit at 1-304-348-3360.

340.6 CLAIM SUBMISSION TIMELINES

Claims for Medicaid payment must be submitted no later than 12 months after the date of service. The time limit is 24 months from the date of service to adjust original clean claims. A copy of the original claim remittance must accompany resubmission of a denied claim. Generally, claims submitted past the required time frame are denied. If there are special circumstances for the late submission, the provider may submit a written request to BMS to reconsider the claim. The request must be accompanied by documentation that explains the reasons for the late submission. Additional information is in Section 340.1 above.

Also, for consideration for payment, claims for members with backdated Medicaid cards, or with special circumstances (e.g., reversal of a third-party payment), may be submitted on paper with supporting documentation to the Provider Relations Unit at:

1-304-348-3360	Charleston Area
1-888-483-0793	In-State toll free
1-304-348-3360	Out-of-State

350 REIMBURSEMENT

Reimbursement for diagnosing and treating Medicaid members requires health care providers to comply with all applicable state and federal laws, regulations, guidelines, and program instructions. All services billed to WV Medicaid must be medically necessary and the patient's medical records must contain the appropriate documentation.

WV Medicaid does not pay for any service rendered by a provider who is not enrolled with the Medicaid Program on the day the service is furnished, except for medically necessary, documented emergencies. All reimbursable services must be consistent with the WV Medicaid benefit package and rendered according to all applicable state and federal laws and regulations.

The Medicaid payment amount depends on the type and level of service provided. The proper filing of the claim and applicable documentation affects a claim's processing time. Medicaid payment is made to the provider of the service or to a group practice for practitioners enrolled in a group. There are exceptions, however. Specifically, Medicaid payments may be made to:

- A practitioner's employer, if the practitioner is required as a condition of employment to turn over his/her fees to the employer

- The facility where the service is rendered, if the practitioner has a signed contract that requires the facility to submit the claim, or if required by Medicaid policy.

Additionally, a provider may designate that payment be sent to a government agency.

360 SUPPORT SERVICES

BMS makes available various services to support and facilitate a provider's participation in the WV Medicaid Program. Four such services are summarized under the following headings:

- Medicaid Forms
- Education Seminars
- Technical Assistance
- Newsletter.

Some support services are provided directly by BMS; others are furnished by vendors under contractual arrangements with BMS.

360.1 MEDICAID FORMS

Some WV Medicaid forms are available as attachments to applicable provider manual. Providers also may order forms directly from the Provider Relations Unit by calling 1-304-348-3360, or by downloading them from www.wvdhhr.org/bms. BMS does not provide or supply copies of claim forms.

360.2 EDUCATION SEMINARS

BMS conducts annual seminars that are designed specifically to address policy updates, program changes, and provider concerns. The seminars, which are a cooperative effort of the BMS and its fiscal agent, are presented in multiple geographical locations throughout the State. An open forum is conducted to answer questions raised by attendees. Seminars and their geographic locations are announced on the banner page of the remittance voucher. In addition, BMS and its fiscal agent participate in seminars conducted by other public agencies and provider groups.

360.3 TECHNICAL ASSISTANCE

BMS representatives may be made available to visit the provider's office to help resolve issues that cannot be remedied via telephone contact with the Provider Relations Unit, which can be reached at:

1-304-348-3360	Charleston Area
1-888-483-0793	In-State toll free
1-304-348-3360	Out-of-State

While not routine, representatives from providers' offices may meet with BMS or Provider Relations to resolve complex issues that may be too difficult to explain by telephone.

360.4 NEWSLETTER

As circumstances warrant, newsletters are mailed to Medicaid providers. The newsletters inform providers of recent developments, discuss billing and coding issues, and clarify medical coverage and payment policies.

All active Medicaid providers receive Medicaid newsletters, which are sent to the provider's correspondence address on file with BMS.

Newsletters are also posted at www.wvdhhr.org/bms.

CHAPTER 400–MEMBER ELIGIBILITY

CHANGE LOG

Replace	Title	Change Date	Effective Date
400, 420, 430, 440, 450,460, 470, 480	Various	12/02/04	01/01/05
430	Medicaid Managed Care	12/02/04	01/01/05
430.2	Mountain Health Trust (MHT), Health Maintenance Organization (HMO) Program	12/02/04	01/01/05
430.3	Enrollment Broker	12/02/04	01/01/05
440	Explanation of the Medicaid Member ID Card	12/02/04	01/01/05
450	Home and Community Based Waivers	12/02/04	01/01/05
470.2	Member Responsibilities	12/02/04	01/01/05
470.3	Member Liability	12/02/04	01/01/05

January 1, 2005

Sections 400, 420, 430, 440, 450, 460, 470, 480

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 430

Introduction: Added "Mountain Health Trust Program" to heading, removed "Temporary Assistance for Needy Families" as an eligibility category for Managed Care since there are no longer TANF cash assistance recipients who automatically receive Medicaid.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 430.2

Introduction: Deleted "Mountain Health Trust (MHT)" from heading, added "Mountain Health Trust Program" at beginning of first paragraph, added "dental" to third bullet, added a bullet "Transplant services", and changed last paragraph in section.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 430.3

Introduction: Deleted "and PAAS" in the first paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 450

Introduction: Specified that the first waiver program described is the Aged and Disabled Waiver Program. For further clarification in the MR/DD section, the statement "for members who require ICF/MR level of care" was added, replaced "require" with "qualify for" in the second paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 470.2

Introduction: Added a bullet, "Payment or required co-pays, if applicable".

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 470.3

Introduction: Fees for missed appointments added to list for which members can not be billed.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

CHAPTER 400—MEMBER ELIGIBILITY

TABLE OF CONTENTS

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CHAPTER 400–MEMBER ELIGIBILITY

400 INTRODUCTION

Medicaid pays for medical care for individuals who may not be able to afford other health care. Services are provided based on federal guidelines relating to individual or family income, assets, and health care needs. Individuals receiving Supplemental Security Income (SSI) automatically qualify for Medicaid. The Department of Health and Human Resources (DHHR) determines Medicaid eligibility through its local administrative offices. Individuals who wish to apply for medical assistance are referred to the office located in their county of residence. "Covered periods" for eligibility are indicated on the Medicaid identification card for each specific Medicaid member.

FOR VERIFICATION OF MEMBER ELIGIBILITY AND MANAGED CARE COVERAGE, PROVIDERS MAY UTILIZE THE MEDICAID VOICE RESPONSE SYSTEM AT 1-888-483-0793.

410 COVERAGE GROUPS AND CATEGORIES

The following are the primary categories of Medicaid coverage:

- Coverage Groups for Children and Their Caretakers
- Coverage Groups for Aged, Blind or Disabled Individuals or Married Couples
- Coverage Groups for Pregnant Women
- Coverage for Children Only
- Special Medicaid Coverage.

420 DUAL-ELIGIBLE MEMBERS

Members eligible for both Medicare and Medicaid are called dual-eligible members. Medicare is the primary payer for Medicare/Medicaid members. Medicare, a federal health insurance program for the aged and disabled, covers certain hospital, Part A, and medical benefits, Part B, for eligible members. Claims for Medicare/Medicaid members are filed with the Medicare Fiscal Intermediary or carrier on the appropriate Social Security Administration (SSA) claim form prior to billing Medicaid.

Some Medicare carriers cross claims over directly to Medicaid without a paper submission. If this is being done, do NOT bill on paper unless Medicare has denied the claim. There are instances in which Medicare claims are electronically forwarded to Medicaid for payment, but are not successful, because the provider's Medicare number is not on file with Medicaid. If this is the case, please contact Unisys Provider Services so the Medicaid provider files can be properly updated with the additional Medicare provider number(s).

430 MEDICAID MANAGED CARE – MOUNTAIN HEALTH TRUST PROGRAM

Managed care is a health system in which a network of health care providers agree to coordinate and provide health care to a population. This program is offered as an alternative to the traditional fee-for-service (FFS) Medicaid Program. Medicaid's Health Maintenance Organization (HMO) Program focuses on preventive health care, member education and outreach, and a guaranteed cost (premium) for the contracted services regardless of use.

WV Medicaid uses two different managed care models: the HMO model and the primary care management FFS model.

Managed care enrollment is mandatory for Medicaid members in certain eligibility categories; certain pregnant women, and children are required to enroll in managed care. The choices of managed care programs vary by geographical area. The two West Virginia (WV) Medicaid managed care programs are described below.

430.1 PHYSICIAN ASSURED ACCESS SYSTEM (PAAS) PROGRAM

PAAS is WV Medicaid's Primary Care Case Management (PCCM) Managed Care Program. The program is designed to enhance access to medical care and coordinate health care needs and services. Managing costs and ensuring quality care are both important factors of the program. The program encourages newly-eligible members to select a Primary Care Provider (PCP) that will be responsible for providing and coordinating their health care needs. Members who do not select a PCP are assigned one by the enrollment broker. By assigning PCP responsibility, the Bureau achieves desired levels of access, quality, cost savings, continuity of care, and member satisfaction. Participating providers accept the responsibility of directing all aspects of primary and preventive care. The PAAS Program allows the PCP to refer the member to another qualified provider if medically necessary.

Each provider participating in the PAAS Program is an active WV Medicaid provider with special enrollment in the PAAS Program. An enrollment broker is responsible for member enrollment. Members who do not respond to the enrollment efforts of the broker are assigned a primary care provider.

430.2 HEALTH MAINTENANCE ORGANIZATION (HMO) PROGRAM

Mountain Health Trust Program (MHT) began in 1996 as a managed care program that contracts with HMOs. The HMOs receive a monthly capitation payment from BMS for each member enrolled, based on an average projection of medical expenses for a typical member category and/or by age/sex.

HMO enrollment may be mandatory for eligible individuals, depending upon the county of residence. The Medicaid HMO Program focuses on preventive health care, member education and outreach.

MHT HMOs are responsible for providing directly, or under arrangements, the following covered services:

- Primary preventive services
- Acute care services
- Inpatient and outpatient medical/dental care services
- Emergency dental services
- Vision services
- Hearing services
- Durable medical equipment services
- Transplant services

Some services normally covered by Medicaid are excluded from MHT. Those enrolled in managed care may obtain excluded services through the traditional FFS Medicaid Program. The following are excluded services:

- Behavioral health services
- Pharmacy services
- Nursing facility services
- Non-emergency medical transportation services
- Children's preventive and restorative dental services.

MHT is available on a county-by-county basis within WV. In counties considered urban, where two or more MCOs will be available, and enrollment will be mandatory for managed care eligibles. In rural counties where only one HMO is available, the member will be provided a choice of providers within the MCO network. To identify the program (s) available in each county in WV, please utilize the website at http://www.wvdhhr.org/bms/county_map/county_map.html.

430.3 ENROLLMENT BROKER

The Bureau contracts with an enrollment broker to manage member enrollment. The enrollment broker performs county-specific outreach education and enrollment services to assist potential managed care members in their program choices and in the selection of a Managed Care Organization (MCO) or PCP. The enrollment broker provides coordination and information related to available PCPs in the MHT Programs. Field staff in targeted counties performs managed care education and enrollment functions.

The enrollment broker may be contacted at 1-800-449-8466.

430.4 FREEDOM OF CHOICE

Members have full freedom of choice of a participating medical service provider. Members covered by an HMO must use the HMO's provider network for full coverage. Choice also may be restricted with other waiver services.

440 EXPLANATION OF THE MEDICAID MEMBER ID CARD

Eligible members receive identification cards monthly. **Payment is made only for** medically necessary covered services rendered to eligible members; therefore, it is important that the provider carefully check the Medicaid identification card each time a service is rendered. It is also recommended that the voice response system be used each time to verify eligibility and managed care coverage (1-888-483-0793). Medicaid members who are members of an HMO also have eligibility cards issued by the HMO.

Those individuals participating within the Children with Special Health Care Needs Program are assigned an 11-digit identification number by that Program. The Children with Special Health Care Needs number begins with "99", and the last two digits are "01". These individuals may or may not also have a Medicaid identification card.

440.1 INDIVIDUALS WITHOUT MEDICAID IDENTIFICATION CARDS

Any person requesting services without a Medicaid identification card should be advised that he/she is financially liable for all services received until eligibility is verified. The member is responsible for furnishing his/her identification card to the provider. If the card is lost, eligibility may be verified through the Medicaid Voice Response System at 1-888-483-0793. Managed Care identification cards are only replaced on regularly scheduled issuance dates.

450 HOME AND COMMUNITY BASED WAIVERS

Aged and Disabled Waiver – Medicaid members who require a nursing home level of care, but who are able to access the care at home, may receive services such as case management, homemaker services, and adult day care. These services are considered an extension of Medicaid services for the aged and disabled. Current enrolled Medicaid members may seek enrollment in this waiver by completing an assessment form.

Mentally Retarded/Developmentally Disabled (MR/DD) Waiver – The MR/DD coverage group pays for health care and social needs of Medicaid members with mental retardation and developmental disabilities in the community setting rather than an ICF/MR facility or institution for members who qualify for ICF/MR level of care. Services in this program include: case management, adult companion care, comprehensive day and residential habilitation, in-home extended nursing care, respite care, and environmental adaptations or modifications to meet medical needs, such as ramp access to home.

460 SPECIAL PROGRAMS

The following programs exist within the framework of the Medicaid Program.

460.1 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

This program arranges for statewide direct care providers to deliver clinic and non-clinic services to children with special health care needs using physicians, staff nurses, social workers, and administrative support staff.

Potential members become eligible after completion and approval of a Specialty Care Intake Form (SCIF). Completion may be initiated by referral from a hospital, any health care professional, DHHR office, or any other private or public health-related entity.

Children who are eligible for this service also may be eligible for managed care coverage. If the member is a managed care member, the provider network must be used for services. Services not approved by the HMO may not be billed over the eligibility card; only those carved-out services defined previously may be billed over the eligibility card. Please follow the specific rules and regulations of the HMO when coordinating services.

460.2 EARLY & PERIODIC SCREENING, DIAGNOSIS, & TREATMENT (EPSDT)

HealthCheck is the EPSDT program for WV Medicaid. The purpose of the program is to ensure all covered children receive needed medical and dental services before health problems develop and become chronic, or irreversible damage occurs. The importance of preventive health services and early detection and treatment of diseases in children is emphasized in this program.

HealthCheck is applicable to all Medicaid members under 21 years of age. Medicaid-eligible children receive regularly scheduled health checkups or screens by enrolled providers under contract with the DHHR or a WV Medicaid-participating HMO. Providers must make application and receive approval from DHHR to conduct and receive Medicaid reimbursement for EPSDT screens. Screening providers must follow periodicity requirements that dictate age components of the screens and minimum frequency with which the screens should take place.

460.3 BIRTH TO THREE SERVICES

This program arranges for access to early intervention therapies for infants and toddlers that have developmental delays, or present significant risks for developmental delays. The program operates from the Office of Maternal Child and Family Health (OMCFH) within the Bureau for Public Health, DHHR. OMCFH provides services for education and training of family members, caregivers, and educators to develop a team to manage and correct the developmental delays of the children. This program is for children from birth to age three. The focus of the program is on the early identification and therapeutic management of speech, physical, or occupational delays of children.

460.4 VACCINES FOR CHILDREN

This program operates in conjunction with the Department of Health, Vaccines for Children Program (VFC) to provide specific vaccines to Medicaid-eligible children. This program provides vaccines to adults on a limited basis.

The vaccines for this program are purchased by the federal government and are made available to the states by the Centers for Disease Control and Prevention (CDC) within DHHS. The West Virginia DHHR, Bureau for Public Health, operates the program. Providers are required to register as participants in the VFC program and are furnished the covered vaccines at no cost.

470 MEMBER RIGHTS AND RESPONSIBILITIES

There are certain rights and responsibilities applicable to Medicaid members. They are described below.

470.1 MEMBER RIGHTS

Members are free to choose a participating medical service provider. This applies to all members as long as they do not have a restricted Medicaid card or are not enrolled in a managed care program.

Members enrolled in Medicaid managed care are free to choose a PCP from among those participating in the plan. Referral procedures must be followed in managed care programs. The contracted enrollment broker for BMS assures neutrality and member freedom of choice.

470.2 MEMBER RESPONSIBILITIES

The responsibilities of Medicaid members include, but are not limited to, the following:

- Notify providers promptly of changes in Medicaid coverage
- Notify providers of any other insurance coverage, such as Medicare or private health insurance

-
- Present a valid Medicaid identification card at each visit
- Notify providers of any change in Medicaid or other insurance coverage
- Forward money or denials received from other insurance payers to their Medicaid providers
- Inform their local DHHR office of any changes in address, income, etc.
- Payment or required co-pays, if applicable

470.3 MEMBER LIABILITY

Provider claims filed with the WV Medicaid Program are filed on an assignment basis. Therefore, a provider must accept Medicaid payment as payment in full for covered services. A claim is considered paid in full even when the actual Medicaid payment is zero dollars if the Medicaid payment has been reduced to zero due to payments from Medicare or private insurance.

Refer to Chapter 800 for information on Medicaid Cost Avoidance Requirements, including TPL/COB.

Providers are prohibited from imposing any additional charges on the member above the Medicaid allowable reimbursement amount. This does not include Medicaid co-payments if applicable.

Medicaid members must not be billed, or otherwise held responsible for:

Payments denied for provider error. For example:
- Claims filed more than one year after date of service
- Wrongful billing or missing information

Also:
- Billings denied because provider did not:
  - Follow procedures
  - Get approval from Medicaid or the managed care provider
  - Notify member before the service is provided that it is not covered by Medicaid
- Charges left after payments by insurance or Medicaid are made.
- Fees for missed appointments

Providers must follow the guidelines and procedures set forth by the WV Medicaid Program in relation to billing practices and the member's responsibility for charges.

470.4 MEMBER'S RESPONSIBILITY FOR CERTAIN CHARGES

Medicaid members, if given prior notice may be billed for:

1. Services received after Medicaid benefits are exhausted
2. Services not medically necessary elected by the member
3. Services not approved by the managed care provider (except for medical emergencies)

4. Convenience items not required for medical care
5. Services rendered when the member is not eligible
6. Prior to services being rendered by a provider, the provider informs or gives notice to the member that he/she will not bill Medicaid
7. Services provided when the member refuses to use other available insurance.

It is the responsibility of the member to follow all guidelines set forth by the Medicaid Program in connection with eligibility and payment of services rendered by providers.

470.5 SUBROGATION

If medical assistance is paid, or will be paid, to a provider of medical care on behalf of a member because of any sickness, injury, disease, or disability, and another person is legally liable for such expenses, either pursuant to contract, negligence, or otherwise, the DHHR shall have a right to recover full reimbursement from any award or settlement for medical assistance from any other person, or from the member of such assistance, if he/she has been reimbursed by the other person. The DHHR shall be legally assigned the rights of the member against the person so liable, but only to the extent of the reasonable value of the medical assistance paid and attributable to the sickness, injury, disease, or disability for which the member has received damages.

480 MEMBER FAIR HEARINGS AND APPEALS

WV Medicaid members can take advantage of the WV DHHR Fair Hearings process. Requests for a Fair Hearing must be submitted in writing to:

West Virginia DHHR	or	Bureau for Medical Services
c/o MMIS Contractor		Appeals Section
P.O. Box 2002		Room 251
Charleston, WV 25327-2002		350 Capitol Street
Consumer Review Unit		Charleston, WV 25301-3706

HMO enrollees have additional avenues of appeal concerning adverse decisions made within their HMOs and should call their respective customer service centers. The enrollment broker, who can be reached at 1-800-449-8466, also documents telephone calls involving complaints and appeals that concern managed care issues. The enrollment broker will forward them to the appropriate entity for evaluation.

Refer to Chapter 800 for details regarding Member Appeals.

CHAPTER 501–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	September 1, 2011	September 1, 2011
Section 501.3	Provider Certification	April 25, 2012	July 1, 2012
Section 501.3.3	Record Requirements – Member Records	April 25, 2012	July 1, 2012
Section 501.3.4	Provider Certification Reviews	April 25, 2012	September 1, 2011
Section 501.3.5	Staff requirements	April 25, 2012	September 1, 2011
Section 501.3.7	Criminal and Investigation Background Checks	April 25, 2012	July 1, 2011
Section 501.4.1	Incident Management Documentation & Investigation Procedures	April 25, 2012	July 1, 2012
Section 501.5.1.2	Initial Medical Evaluation	April 25, 2012	July 1, 2012
Section 501.5.1.3	Medical Reevaluation	April 25, 2012	July 1, 2012
Section 501.9	Plan of Care Development	April 25, 2012	September 1, 2011
Section 501.12.1	Personal Assistance/Homemaker (Direct Care Staff) Code, Unit, Limit and Documentation Requirements	April 25, 2012	September 1, 2012
Section 501.12.3	Nursing Services Code, Unit, Limit and Documentation Requirements	April 25, 2012	July 1, 2012
Section 501.12.3.1	Nursing Responsibilities	April 25, 2012	September 1, 2011
Section 501.12.4.1	Transportation Code, Unit, Limit and Documentation Requirements	April 25, 2012	September 1, 2011
Section 501.14	Member Rights and Responsibilities	April 25, 2012	September 1, 2011

July 1, 2012

Introduction: Section 501.3, Provider Certification

Old Policy: Only a provider agency certified by BoSS can serve as an ADW provider. A Certification Application must be completed and submitted to:

The Bureau of Senior Services
1900 Kanawha Blvd East
Charleston, WV 25305

An agency may provide both Case Management and Personal Assistance/Homemaker Services provided they maintain:

A. A separate certification and provider number for each service;
B. Separate staffing, for example, an agency Registered Nurse may not provide both Personal Assistance/Homemaker RN and Case Management Services for the same member; and,
C. Separate member files must be maintained for Case Management and Personal Assistance/Homemaker Services.

Conflicts of interest and self-referral are prohibited.

To be certified as an ADW provider, applicants must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
C. A competency based curriculum for required training areas for Personal Assistance/Homemaker direct care staff. (Refer to *Chapter 501.3.5* and its subparts)
D. An organizational chart
E. A list of the Board of Directors (if applicable)
F. A list of all agency staff, which includes their qualifications. (Refer to *Chapter 501.3.6* and its subparts)
G. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf).
H. A physical office that meets the criteria outlined in *Chapter 501.3.1*.
I. Written policies and procedures for processing member grievances.
J. Written policies and procedures for processing member and staff complaints.
K. Written policies and procedures for member transfers.
L. Written policies and procedures for the discontinuation of member services.

M. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Assistance/Homemaker Services).
N. Office space that allows for member confidentiality.
O. An Agency Emergency Plan (for members and office operations).

Agencies will be reviewed by BoSS within six months of initial agency certification, and annually thereafter. (Refer to *Chapter 501.3.4*).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

New Policy: Only a provider agency certified by BoSS can serve as an ADW provider. A Certification Application must be completed and submitted to:

The Bureau of Senior Services
1900 Kanawha Blvd East
Charleston, WV 25305

An agency may provide both Case Management and Personal Assistance/Homemaker Services provided they maintain:

A. A separate certification and provider number for each service;
B. Separate staffing, for example, an agency Registered Nurse may not provide both Personal Assistance/Homemaker RN and Case Management Services for the same member; and,
C. Separate member files must be maintained for Case Management and Personal Assistance/Homemaker Services.

Conflicts of interest and self-referral are prohibited.

To be certified as an ADW provider, applicants must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
   A competency based curriculum for required training areas for Personal Assistance/Homemaker direct care staff. (Refer to *Chapter 501.3.5* and its subparts)
C. An organizational chart
D. A list of the Board of Directors (if applicable)
E. A list of all agency staff, which includes their qualifications. (Refer to *Chapter 501.3.6* and its subparts)
F. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf).

G. A physical office that meets the criteria outlined in *Chapter 501.3.1*.
H. Written policies and procedures for processing member grievances.
I. Written policies and procedures for processing member and staff complaints.
J. Written policies and procedures for member transfers.
K. Written policies and procedures for the discontinuation of member services.
L. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Assistance/Homemaker Services).
M. Office space that allows for member confidentiality.
N. An Agency Emergency Plan (for members and office operations).

Agencies will be reviewed by BoSS within 6 months of providing services to an ADW member and annually thereafter. (Refer to Chapter 501.3.4).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

Directions: Replace Section 501.3

Introduction: **Section 501.3.3, Record Requirements – Member Record**

Old Policy: **Member records**:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original documentation for services provided to the member by the provider responsible for development of the document (for example the Case Management agency should have the original Service Plan and the Personal Assistance/Homemaker agency should have the original Plan of Care) including the Pre-Admission Screening (PAS), the complete Member Assessment, Contact Notes, RN Plan of Care, Personal Assistance/Homemaker Worksheets, Member Enrollment Confirmation, etc.
C. Original documentation on each member must be kept by the Medicaid provider for five years or three years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

New Policy: **Member records**:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original/required documentation for services provided to the member by the provider responsible for development of the document including the Service Plan, Pre-Admission Screening

(PAS), the complete Member Assessment, Contact Notes, RN Plan of Care, Personal Assistance/Homemaker Worksheets, Member Enrollment Confirmation, etc.

C. Original documentation on each member must be kept by the Medicaid provider for 5 years or 3 years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

Directions: Replace Section 501.3.3

Introduction: Section 501.3.4, Provider Certification Reviews

Old Policy: Providers are required to submit designated evidence to BoSS every 12 months to document continuing compliance with all Certification requirements as specified under *Chapter 501.3* and all of its subparts. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not provided within 30 days, a Provisional Certification will apply. Providers who receive a Provisional Certification will be required to have an onsite review by BoSS prior to full re-certification. If deficiencies are found by BoSS during document review, the provider must submit a corrective action plan within 30 days. If an approved corrective action plan and required documentation is not submitted within the required time frame BMS may hold provider claims until an approved corrective action plan is in place. A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

Certification reviews will also include a statewide representative sample of member records. BoSS will review member records using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. (These tools are available on BoSS' Web site at www.wvseniorservices.gov). The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers must respond to any corrective action within 30 calendar days after receipt of the completed report. Sanctions will be imposed as findings dictate.

New Policy: Providers are required to submit designated evidence to BoSS every 12 months to document continuing compliance with all Certification requirements as specified under *Chapter 501.3* and all of its subparts. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). *If appropriate documentation is not received by BoSS either prior to or on the established date, a pay hold may be placed on the provider's claims until documentation is received and the provider may be removed from all selection forms. A provisional certification will be issued; however, an on-site visit will be waived if required documentation is received within 30 days. If after 60 days documentation is not received, steps may be taken to execute an emergency transfer of ADW members. If the provider wants to resume/continue service provision, they must submit all required documentation and an on-site continuing certification review will be conducted by BoSS staff.*

BoSS will review all submitted certification documentation and provide a report to BMS. BMS may request payback for certification requirements not met. The provider must remove employees who do not meet requirements from provision of services until certification standards are met and required documentation is approved by BoSS. If the documentation is not received within 30 days of the request, BMS may:

- *Place a payment hold on all future claims until the provider can prove they meet all certification requirements;*
- *Remove the provider from all selection forms; and*
- *Terminate the provider's participation as an ADW provider if all issues are not resolved within 60 calendar days.*

A provider who is terminated from the ADW program for any of the reasons listed above may apply for recertification by contacting BoSS. Recertification includes a mandatory site visit by a BoSS monitor and a 6 month review.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

Certification reviews will also include a statewide representative sample of member records. BoSS will review member records using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. (These tools are available on BoSS' Web site at www.wvseniorservices.gov). The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers have 30 days to respond to draft review findings or to submit a corrective action plan if requested. Sanctions will be imposed as findings dictate.

Directions: Replace Section 501.3.4

Introduction: Section 501.3.5, Staff Requirements

Old Policy: Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

Personal Assistance/Homemaker direct care staff and Personal Options direct care staff must be at least 18 years of age and must have the following competency based training before providing services:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by the agency nurse, or a certified trainer from the American Heart Association or American Red Cross.
B. First Aid – may be provided by the agency nurse, a certified trainer or an approved internet provider.
C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
D. Personal Assistance/Homemaker Skills – training on assisting members with ADL's – must be provided by the agency RN.
E. Abuse, Neglect and Exploitation - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
F. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member special needs - must be provided by the agency nurse.

Prior to using an internet provider for training purposes ADW providers must submit the name, web address, and course name(s) to BoSS for review. BoSS will respond in writing whether this internet training meets the training criteria.

Personal Options members and their direct care employees may access a Resource Consultant for training materials and assistance.

New Policy: Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

Personal Assistance/Homemaker direct care staff and Personal Options direct care staff must be at least 18 years of age and must have the following competency based training before providing services:

A. *Cardiopulmonary Resuscitation (CPR) – must be provided by the agency nurse, or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by BoSS and can be found at http://www.wvseniorservices.gov/.*
B. First Aid – may be provided by the agency nurse, a certified trainer *or a qualified internet provider.*
C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
D. Personal Assistance/Homemaker Skills – training on assisting members with ADL's – must be provided by the agency RN.
E. Abuse, Neglect and Exploitation - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, *or a qualified internet training provider.*
F. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area *or a qualified internet training provider.*
G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, *or a qualified internet training provider.*
H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member special needs - must be provided by the agency nurse.

Personal Options members and their direct care employees may access a Resource Consultant for training materials and assistance.

Directions: Replace Section 501.3.5

Introduction: Section 501.3.7, Criminal and Investigation Background Checks

Old Policy: Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check which includes fingerprints must be conducted by the West Virginia State Police initially and again every three years for all ADW staff including direct-care personnel, case managers, RN's and anyone who has direct access to member(s). If the prospective employee has lived out of state within the last five years, the agency must also conduct a federal background check utilizing fingerprints through the National Crime Information Database (NCID).

Prior to providing any ADW services, the prospective employee or the employee must have initiated the fingerprint check process with the WV State Police. ADW providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure

Q. Healthcare fraud
R. Felony forgery

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All payments for services provided by excluded providers will be recovered by BMS.

New Policy: ***501.3.7 Criminal and Investigation Background Checks***

For the ADW Program the Criminal Investigation Background Check consists of three things:

1. *A fingerprint based criminal history check conducted by the WV State Police contracted entity and, in certain situations, an FBI fingerprint check through the National Crime Information Database (NCID);*
2. *A check of the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); and*
3. *A check of the WV DHHR Protective Services Record Check.*

At a minimum, a state level criminal investigation background check which includes fingerprints must be initially conducted by the West Virginia State Police contracted entity and again every three years for all ADW staff including direct-care personnel, case managers, RN's and anyone who has direct access to member(s). If the prospective employee has lived out of state within the last 5 years, the agency must also conduct an FBI I background check utilizing fingerprints through the NCID.

Prior to providing any ADW services, the prospective employee or the employer must have initiated the fingerprint check process with the WV State Police contracted entity. "Initiated" means the prospective employee has had a live fingerprint scan taken at an approved location, or, if submitting hard copies of fingerprints, the day the copies are mailed for processing. ADW providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery

C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

Results which include a history of Medicaid fraud or abuse or which may place members at risk of personal health and safety should be taken into consideration prior to employment.

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All ADW provider agency staff hired after the implementation date of this manual having direct contact with members must have a WVDHHR Protective Services Record Check. These must be initiated (sent to WVDHHR) on each individual upon hire. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families (BCF), Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of

the date that the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

All payments for services provided by excluded providers will be recovered by BMS.

Directions: Replace Section 501.3.7

Introduction: **Section 501.4.1, Incident Management Documentation and Investigation Procedures**

Old Policy: Any incidents involving an ADW member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director, designated RN, or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section *501.4*, all incidents involving abuse, neglect and/or exploitation must be reported to APS but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file.

Personal Assistance/Homemaker provider agencies must report to WVIMS monthly the number of hospitalizations which occurred during the month. In addition, providers are to report if there were no incidents.

For Personal Options, PPL must report any incidents in the WVIMS within one business day of learning of the incident. BoSS reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WVIMS.

New Policy: Any incidents involving an ADW member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director, designated RN, or Case Manager will

immediately review each incident report. All Critical Incidents must be investigated. As noted in Section *501.4*, all incidents involving abuse, neglect and/or exploitation must be reported to APS but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file. *Providers are to report monthly if there were no incidents.*

For Personal Options, PPL must report any incidents in the WVIMS within one business day of learning of the incident. BoSS reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WVIMS.

Directions: Replace Section 501.3.7

Introduction: **Section 501.5.1.2, Initial Medical Evaluation**

Old Policy: Following is an outline of the initial medical evaluation process (as directed in 2005 Cyrus decree):

A. An applicant shall initially apply for the ADW program by having his/her treating physician (M.D. or D.O. only) complete and sign a Medical Necessity Evaluation Request Form. The referring physician, applicant, family member, advocate or other interested party, may submit this form by fax, mail or electronically to APS Healthcare/IRG. APS Healthcare/IRG will not process any Medical Necessity Evaluation Request Form if the physician's signature is more than 60 days old. If the Medical Necessity Evaluation Request form is incomplete, it will be returned to the physician for completion and resubmission, and the applicant will be notified.
B. APS Healthcare/IRG will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification. If contact, is made, a notice shall be sent to the individual and/or contact person so noting scheduled home visit date and time.

C. APS Healthcare/IRG will make up to three attempts to contact the applicant. If unable to contact after three attempts, APS Healthcare/IRG will issue a potential referral closure letter to the applicant (or legal representative) and the referring entity. If no contact is made with APS Healthcare/IRG within five business days the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, or legal representative present to assist the applicant.
E. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

New Policy: Following is an outline of the initial medical evaluation process (as directed in 2005 Cyrus decree):

A. An applicant shall initially apply for the ADW program by having his/her treating physician (M.D. or D.O. only) complete and sign a Medical Necessity Evaluation Request Form. The referring physician, applicant, family member, advocate or other interested party, may submit this form by fax, mail or electronically to APS Healthcare/IRG. APS Healthcare/IRG will not process any Medical Necessity Evaluation Request Form if the physician's signature is more than 60 days old. If the Medical Necessity Evaluation Request form is incomplete, it will be returned to the physician for completion and resubmission, and the applicant will be notified.
B. APS Healthcare/IRG will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification. If contact, is made, a notice shall be sent to the individual and/or contact person so noting scheduled home visit date and time.
C. APS Healthcare/IRG will make up to three attempts to contact the applicant. If unable to contact after 3 attempts, APS Healthcare/IRG will issue a potential referral closure letter to the applicant (or legal representative) and the referring entity. If no contact is made with APS Healthcare/IRG within 5 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required.
D. *If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.*

E. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

Directions: Replace Sections 501.5.1.2

Introduction: Section 501.5.1.3, Medical Reevaluation

Old Policy: Annual reevaluations for medical eligibility for each ADW member must be conducted. The process is as follows (as directed in 2005 Cyrus decree):

A. A Medical Necessity Evaluation Request Form must be submitted to APS Healthcare/IRG dated and signed by the member (or legal representative). The forms may be faxed to APS Healthcare/IRG but a copy of the original form with the signatures must be maintained in the member's file. The Case Manager, or the member (or legal representative) must check the reevaluation line at the top of the form. A physicians signature is required only if there is a change in, or an additional, diagnosis.
B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for member appeal.
C. After receiving the reevaluation request, APS Healthcare/IRG will attempt to contact the member (or legal representative) to schedule an assessment, allowing at least two weeks notification.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, or legal representative, the assessment will not be scheduled without the guardian, or legal representative present to assist the applicant.
E. If APS Healthcare/IRG makes the contact, a letter is sent to the member (or legal representative), Case Management Agency or PPL, noting the date and time of the assessment.
F. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.
G. If APS Healthcare/IRG is unable to contact the member (or legal representative) within three attempts, a potential closure letter will be sent to the member (or legal representative), the Case Management Agency, or PPL.

H. If no contact is made with APS Healthcare/IRG within five business days of the date of the potential closure letter, APS Healthcare/IRG will send the final denial letter to the member and copy BoSS and the Case Management Agency or PPL. BoSS will close the case.

New Policy: Annual reevaluations for medical eligibility for each ADW member must be conducted. The process is as follows (as directed in 2005 Cyrus decree):

A. A Medical Necessity Evaluation Request Form must be submitted to APS Healthcare/IRG dated and signed by the member (or legal representative). The forms may be faxed to APS Healthcare/IRG but a copy of the original form with the signatures must be maintained in the member's file. The Case Manager, or the member (or legal representative) must check the reevaluation line at the top of the form. A physicians signature is required only if there is a change in, or an additional, diagnosis.
B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for member appeal.
C. After receiving the reevaluation request, APS Healthcare/IRG will attempt to contact the member (or legal representative) to schedule an assessment, allowing at least 2 weeks notification.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
E. If APS Healthcare/IRG makes the contact, a letter is sent to the member (or legal representative), Case Management Agency or PPL, noting the date and time of the assessment.
F. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.
G. If APS Healthcare/IRG is unable to contact the member (or legal representative) within three attempts, a potential closure letter will be sent to the member (or legal representative), the Case Management Agency, or PPL.
H. If no contact is made with APS Healthcare/IRG within 5 business days of the date of the potential closure letter, APS Healthcare/IRG will send the final denial letter to the member and copy BoSS and the Case Management Agency or PPL. BoSS will close the case.

Directions: Replace Section 501.5.1.3

Introduction: Section 501.9, Plan of Care Development

Old Policy: The Personal Assistance/Homemaker RN Assessment is used in conjunction with the PAS and the Member Case Management Assessment to develop the member's Plan of Care. The Plan of Care details how Personal Assistance/Homemaker services will be used to meet the direct care needs of the member.

Once the Personal Assistance/Homemaker RN has completed the Initial or Annual Personal Assistance/Homemaker RN Assessment AND has received the Service Plan from the Case Manager, he/she must develop the member's Plan of Care based on identified needs and member preferences within seven (7) calendar days and THEN initiate direct care services within three (3) calendar days.

A copy of all Personal Assistance/Homemaker RN Assessments and member Plans of Care must be provided to the member (or legal representative) and the Case Management Agency. The Personal Assistance/Homemaker Agency must have the original document in the member's file.

New Policy: The Personal Assistance/Homemaker RN Assessment is used in conjunction with the PAS, the Member Case Management Assessment, and the Service Plan to develop the member's Plan of Care. The Plan of Care details how Personal Assistance/Homemaker services will be used to meet the direct care needs of the member.

Once the Personal Assistance/Homemaker RN has completed the Initial or Annual Personal Assistance/Homemaker RN assessment AND has received the Service Plan from the Case Manager, he/she must develop the member's Plan of Care based on identified needs and member preferences and initiate direct care services within 10 calendar days.

A copy of all Personal Assistance/Homemaker RN Assessments and member Plans of Care must be provided to the member (or legal representative) and the Case Management Agency. The Personal Assistance/Homemaker Agency must have the original document in the member's file.

Directions: Replace Section 501.9

Introduction: Section 501.12.1 Personal Assistance/Homemaker (Direct Care Staff) Code, Unit, Limit and Documentation Requirements

Old Policy: **Procedure Code:** S5130

Service Unit: 15 minutes

Service Limits: Determined by Service Level Criteria and Service Level Limits (Refer to *Sections 501.5.1.1(a and b)*

Prior Authorization Required: Yes

Documentation Requirements: All services provided to a member must be documented on the Personal Assistance/Homemaker Worksheet and maintained within the member's record.

New Policy: **Procedure Code:** S5130

Service Unit: 15 minutes

Service Limits: Determined by Service Level Criteria and Service Level Limits (Refer to *Sections 501.5.1.1(a and b)*

Prior Authorization Required: Yes

Documentation Requirements*: All services provided to a member must be documented on the Plan of Care and maintained within the member's record.*

Directions: Replace Section 501.12.1

Introduction: **Section 501.12.3, Nursing Services Code, Unit, Limit and Documentation Requirements**

Old Policy: **Procedure Code:** T1002

Modifier: UD

Service Unit: 15 minutes

Service Level: 6 units per month

Prior Authorization Required: No

Documentation Requirements: All contacts with, or on behalf of, a member must be documented using the Personal Assistance/Homemaker RN Member Contact Form and maintained within the member's record. The RN Assessment and Plan of Care must be complete.

New Policy: **Procedure Code:** T1002

Modifier: UD

Service Unit: 15 minutes

Service Level: 6 units per month

Prior Authorization Required: No

Documentation Requirements: *All contacts (except for the 6 month and annual visits) with, or on behalf of, a member must be documented using the Personal Assistance/Homemaker RN Member Contact Form and maintained within the member's record. The RN Assessment and Plan of Care must be complete.*

Directions: Replace Section 501.12.3

Introduction: **Section 501.12.3.1, Nursing Responsibilities.**

Old Policy: The RN responsibilities are:

A. If requested by the member (or legal representative) attends the Initial Service Plan meeting.
B. Attend the six (6) month and Annual Service Plan meeting.
C. If requested by the member (or legal representative) attends the member's ADW medical eligibility appointments with APS Healthcare/IRG.
D. If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate homemaker services within three business days. (The Interim Plan of Care can only be used for a maximum of 21 days.)
E. Make a home visit with the member and Personal Assistance/Homemaker within 30 calendar days after Personal Assistance/Homemaker services begin.
F. Complete a Personal Assistance/Homemaker RN Assessment within six (6) months from the date of the Initial or annual Personal Assistance/Homemaker RN Assessment.
G. Based on clinical judgment, complete a Personal Assistance/Homemaker RN Assessment to determine the need for changes in the Plan of Care such as following discharge from an acute care hospital, nursing facility or other residential setting. The RN must notify the Case Manager if additional services or changes in services are needed.

H. Review the Personal Assistance/Homemaker Worksheets to assure services were provided as described in the Plan of Care before submitting billing under code S5130.
I. Review the Personal Assistance/Homemaker Worksheets to assure it has been completed per policy before submitting billing under code S5130.
J. Sign and date all accurately completed Personal Assistance/Homemaker Worksheets.
K. Provide member specific training to Personal Assistance/Homemakers.
L. Complete a home visit with the member to assess any change in needs. Documentation must substantiate the need for the visit using the Personal Assistance/Homemaker RN Member Contact Form.
M. Attend any member Dual Service planning meetings. (Refer to *Section 501.18*)
N. Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Service Level Change must be submitted to APS Healthcare/IRG. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than one month prior to, or one month following, the request for an increased Service Level. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Assistance/Homemaker staff without attached physician's documentation or discharge summary. The request must be signed by both the Personal Assistance/Homemaker RN and the member (or legal representative). Original signatures are required; i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level. Notice of the determination will be sent to the member (or legal representative) and the Personal Assistance/Homemaker Agency, or if a Personal Option member, to PPL. The Personal Assistance/Homemaker Agency must notify the appropriate Case Management Agency of the Service Level determination.

Members who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. APS Healthcare/IRG will not review a request for an increased Service Level for such members.

Administrative duties are not billable. These include but are not limited to:

A. Sending copies of any Personal Assistance/Homemaker RN Assessments or Plans of Care to the member (or legal representative) or the Case Management Agency.
B. Notifying the Case Management Agency if a member has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.
C. Being available to the Personal Assistance/Homemaker (direct care staff) for consultation and assistance at any time when the Personal Assistance/Homemaker (direct care staff) is providing services.
D. Completing and submitting required program reports to BMS, BoSS or APS Healthcare/IRG.
E. Telephone calls.

New Policy: The RN responsibilities are:

A. If requested by the member (or legal representative) attends the Initial Service Plan meeting.
B. Attend the 6 month and Annual Service Plan meeting.
C. If requested by the member (or legal representative) attends the member's ADW medical eligibility appointments with APS Healthcare/IRG.
D. *If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate homemaker services within three business days.*
E. Make a home visit with the member and Personal Assistance/Homemaker within 30 calendar days after Personal Assistance/Homemaker services begin.
F. *Complete a Personal Assistance/Homemaker RN Assessment within 6 months from the date of the Initial or annual Personal Assistance/Homemaker RN Assessment.*
G. Based on clinical judgment, complete a Personal Assistance/Homemaker RN Assessment to determine the need for changes in the Plan of Care such as following discharge from an acute care hospital, nursing facility or other residential setting. The RN must notify the Case Manager if additional services or changes in services are needed.
H. *Review the Plan of Care to assure services were provided as described in the Service Plan before submitting billing under code S5130.*
I. *Review the Plan of Care to assure it has been completed per policy before submitting billing under code S5130.*
J. *Sign and date all accurately completed Plans of Care.*
K. Provide member-specific training to Personal Assistance/Homemakers.
L. Complete a home visit with the member to assess any change in needs. Documentation must substantiate the need for the visit using the Personal Assistance/Homemaker RN Member Contact Form.
M. Attend any member Dual Service planning meetings. (Refer to *Section 501.18*)

N. Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Service Level Change must be submitted to APS Healthcare/IRG. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than 1 month prior to, or 1 month following, the request for an increased Service Level. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Assistance/Homemaker staff without attached physician's documentation or discharge summary. The request must be signed by both the Personal Assistance/Homemaker RN and the member (or legal representative). Original signatures are required; i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level. Notice of the determination will be sent to the member (or legal representative) and the Personal Assistance/Homemaker Agency, or if a Personal Option member, to PPL. The Personal Assistance/Homemaker Agency must notify the appropriate Case Management Agency of the Service Level determination.

Members who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. APS Healthcare/IRG will not review a request for an increased Service Level for such members.

Administrative duties are not billable. These include but are not limited to:

A. Sending copies of any Personal Assistance/Homemaker RN Assessments or Plans of Care to the member (or legal representative) or the Case Management Agency.
B. Notifying the Case Management Agency if a member has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.
C. Being available to the Personal Assistance/Homemaker (direct care staff) for consultation and assistance at any time when the Personal Assistance/Homemaker (direct care staff) is providing services.
D. Completing and submitting required program reports to BMS, BoSS or APS Healthcare/IRG.
E. Telephone calls.

Directions: Replace Section 501.12.3.1

Introduction: **Section 501.12.4.1, Transportation Code, Unit, Limit and Documentation Requirements**

Old Policy:

Procedure Code: A0160

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: No

Documentation Requirements: All transportation with, or on behalf of, a member must be included in the Personal Assistance/Homemaker RN Plan of Care and documented on the Homemaker Worksheet and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).

New Policy:

Procedure Code: A0160

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: No

Documentation Requirements: *All transportation with, or on behalf of, a member must be included in the Plan of Care and documented on the Plan of Care and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).*

Directions: Replace Section 501.12.4.1

Introduction: **Section 501.14, Member Rights and Responsibilities.**

Old Policy: At a minimum, Case Management Agencies or for Personal Options PPL must communicate in writing to each member (or legal representative)

Their right to:

A. Transfer to a different provider agency or to Personal Options.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).

E. Take part in decisions about their services.
F. Confidentiality regarding ADW services.
G. Access to all of their files maintained by agency providers.

And their responsibility to:

H. Notify the ADW Personal Assistance/Homemaker Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers or PPL promptly of changes in Medicaid coverage.
J. Comply with the Personal Assistance/Homemaker RN Plan of Care or for Personal Options Members the Participant Directed Service Plan.
K. Cooperate with all scheduled in-home visits
L. Notify the ADW agencies or PPL of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the ADW agencies or PPL of any change of medical status or direct care need.
N. Maintain a safe home environment for the agency or PPL to provide services.
O. Verify services were provided by initialing and signing the Personal Assistance/Homemaker Worksheet.
P. Communicate any problems with services to the provider agency or PPL.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL or the APS hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

New Policy: At a minimum, Case Management Agencies or for Personal Options PPL must communicate in writing to each member (or legal representative):

Their right to:

A. Transfer to a different provider agency or to Personal Options.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding ADW services.
G. Access to all of their files maintained by agency providers.

And their responsibility to:

H. Notify the ADW Personal Assistance/Homemaker Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers or PPL promptly of changes in Medicaid coverage.
J. Comply with the Plan of Care or for Personal Options Members, comply with the Participant Directed Service Plan.
K. Cooperate with all scheduled in-home visits
L. Notify the ADW agencies or PPL of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the ADW agencies or PPL of any change of medical status or direct care need.
N. Maintain a safe home environment for the agency or PPL to provide services.
O. Verify services were provided by initialing and signing the Plan of Care.
P. Communicate any problems with services to the provider agency or PPL.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL or the APS hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

Directions: Replace Section 501.14

CHAPTER 501–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES
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CHAPTER 501–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for the Aged and Disabled Waiver (ADW) Program provided to eligible West Virginia Medicaid members. Requirements for other West Virginia Medicaid services can be found in subsequent chapters of the provider manual.

The policies and procedures set forth herein are promulgated as regulations governing the provision of ADW services by ADW providers in the Medicaid Program administered by the West Virginia DHHR under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

All forms for this program can be found at http://www.dhhr.wv.gov/bms/hcbs/ADW/Pages/ADW.aspx.

501.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Acronyms and Definitions*, of the Provider Manual. In addition, the following definitions apply to the requirements for payment of services in the ADW Program described in this chapter.

Abuse: the infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Activities of Daily Living (ADL): activities that a person ordinarily performs during the ordinary course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

APS Healthcare/Innovative Resources Group (IRG) – serves as the Administrative Services Organization for the Aged and Disabled Waiver program which includes conducting the medical evaluations and determining medical eligibility for the program

Bureau of Senior Services (BoSS) – is the state agency which serves as the operating agency for the Aged and Disabled Waiver Program.

Community Integration: the provision of services which allows a person to live and participate in his/her community and the activities it offers to all citizens.

Competency Based Curriculum: a training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas.

Emergency Plan: a written plan which details who is responsible for what activities in the event of an emergency, whether it is a natural or man-made incident.

Environmental Maintenance: activities such as light housecleaning, making and changing the client's bed, dishwashing, and client's laundry.

Felony: a serious criminal offense punishable by imprisonment in the penitentiary.

Financial Exploitation: illegal or improper use of an elder's or incapacitated adult's resources. Obvious examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other document.

Fiscal Employer/ Agent (FE/A): under Personal Options which receives, disburses, and tracks funds based on participants' approved service plans and budgets; assists participants with completing participant enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies workers' information (i.e., social security numbers, citizenship or legal alien verification documentation). The FE/A also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes; processes and pays vendor invoices for approved goods and services, as applicable; generates reports for state program agencies, and participants; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

Home and Community Based Services (HCBS): services which enable individuals to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

Informals (Informal Supports): Family, friends, neighbors or anyone who provides a service to a member but is not reimbursed.

Instrumental Activities of Daily Living (IADL): skills necessary to live independently, such as abilities used to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

Legal Representative: a personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Misdemeanor: a less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail.

Molina Medicaid Solutions: the claims processing agent for the West Virginia BMS.

Neglect: "failure to provide the necessities of life to an incapacitated adult" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult" (§9-6-1). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Participant-Direction: the member, or his/her representative, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. Participant-Direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided.

Person-Centered Planning: a process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her lives, not on the systems that may or may not be available.

Public Partnerships, LLC (PPL): serves as the FE/A for participants who choose Personal Options. PPL also provides resource consultants to assist members.

Quality Management Plan: a written document which defines the acceptable level of quality, and describes how the project will ensure this level of quality in its deliverables and work processes.

Remediation: act of correcting an error or a fault.

Representative Sample: a small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Resource Consultant: assists ADW members who chose Personal Options with the responsibilities of self-direction; developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; developing and maintaining a directory of eligible employees; providing information and resources to help purchase goods and services; connecting with a network of peer supports; helping to complete required paperwork for Personal Options; and helping the member select a representative to assist them, as needed.

Scope of Services: the range of services deemed appropriate and necessary for an individual client. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

Sexual Abuse: any following act toward an incapacitated adult in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

1) Sexual intercourse/intrusion/contact; and
2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

501.2 PROGRAM DESCRIPTION

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

The ADW Program is defined as a long-term care alternative which provides services that enable an individual to remain at or return home rather than receive nursing home care. The program provides home and community-based services to West Virginia residents who are eligible to participate in the program. Members must also be at least 18 years of age and choose home and community-based services rather than nursing home placement. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with the Bureau of Senior Services (BoSS) to operate the program.

ADW services (reimbursable by Medicaid) are to be provided exclusively to the member, for necessary activities as listed in the Service Plan, the Plan of Care, or Personal Options Participant-Directed Service Plan. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the ADW Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.

ADW services include Case Management, Personal Assistance/Homemaker Services and Participant-Directed Goods and Services.

Within the ADW program, members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency. Members have individualized service hours based on their assessed level of need. In Personal Options, members are able to hire, supervise and terminate their own employees. Members are allocated a monthly budget based on their assessed level of need.

501.3 PROVIDER CERTIFICATION

Only a provider agency certified by BoSS can serve as an ADW provider. A Certification Application must be completed and submitted to:

The Bureau of Senior Services
1900 Kanawha Blvd East
Charleston, WV 25305

An agency may provide both Case Management and Personal Assistance/Homemaker Services provided they maintain:

A. A separate certification and provider number for each service;
B. Separate staffing, for example, an agency Registered Nurse may not provide both Personal Assistance/Homemaker RN and Case Management Services for the same member; and,
C. Separate member files must be maintained for Case Management and Personal Assistance/Homemaker Services.

Conflicts of interest and self-referral are prohibited.

To be certified as an ADW provider, applicants must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
C. A competency based curriculum for required training areas for Personal Assistance/Homemaker direct care staff. (Refer to *Chapter 501.3.5* and its subparts)
D. An organizational chart.
E. A list of the Board of Directors (if applicable).

F. A list of all agency staff, which includes their qualifications. (Refer to *Chapter 501.3.6* and its subparts)
G. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf)
H. A physical office that meets the criteria outlined in *Chapter 501.3.1*.
I. Written policies and procedures for processing member grievances.
J. Written policies and procedures for processing member and staff complaints.
K. Written policies and procedures for member transfers.
L. Written policies and procedures for the discontinuation of member services.
M. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Assistance/Homemaker Services).
N. Office space that allows for member confidentiality.
O. An Agency Emergency Plan (for members and office operations).

Agencies will be reviewed by BoSS within 6 months of providing services to an ADW member and annually thereafter. (Refer to *Chapter 501.3.4*).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

501.3.1 Office Criteria

ADW providers must designate and staff at least one physical office location. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. Be located in West Virginia.
B. An agency office site can serve no more than eight contiguous counties. (ADW providers wishing to make changes in the approved counties they serve **must** make the request in writing to BoSS. BoSS will make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by BoSS).
C. Meet ADA requirements for physical accessibility. (Refer to 28CFR36, as amended)
D. Be readily identifiable to the public.
E. Maintain a primary telephone that is listed under the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)
F. Maintain an agency secure (HIPAA compliant) e-mail address for communication with BMS and BoSS.
G. Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
H. Contain space for securely maintaining member and personnel records. (Refer to *Common Chapter 800*, *General Administration*, and *Common Chapter 300*, *Provider Participation Requirements*, for more information on maintenance of records).
I. Maintain a 24-hour contact method (Personal Assistance/Homemaker Agencies only).

Following the receipt of a completed Certification Application, BoSS will schedule an onsite review to verify that the applicant meets the certification requirements outlined in *Chapter 501.3*. BoSS will notify Molina, BMS claims agent, upon satisfactory completion of the onsite review. Molina will provide the applicant with an enrollment packet which includes the Provider Agreement. The applicant must return the Provider Agreement, signed by an authorized representative, to BMS. Once this process has been completed, Molina will assign a provider number. A letter informing the agency that it may begin providing and billing for ADW services will be sent to the agency and to BoSS.

Personal Options member employees enter into a simplified provider agreement facilitated and signed by Public Partnerships, LLC (PPL) which acts as the Fiscal Employer/Agent-Resource Consultant, a subagent to the BMS.

When a provider is physically going to move their agency to a new location or open a satellite office, they must notify BoSS **prior** to the move. BoSS will schedule an on-site review of the new location to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified by BoSS.

501.3.2 Continuing Certification

Once certified and enrolled as a Medicaid provider, ADW providers must continue to meet the requirements listed in *Chapter 501.3* and its subparts as well as the following:

A. Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the ADW Program.
B. Provide services based on each member's individual assessed needs, including evenings and weekends.
C. Maintain records that fully document and support the services provided.
D. Furnish information to BMS, or its designee, as requested. (Refer to *Common Chapter 800, General Administration*, and *Common Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
E. Maintain a current list of members receiving ADW services.
F. Comply with the Incident Management System (Refer to *Chapter 501.4* and its subparts) and maintain an administrative file of Incident Reports.

501.3.3 Record Requirements

Providers must meet the following record requirements:

Member records:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original/required documentation for services provided to the member by the provider responsible for development of the document including the Service Plan, Pre-Admission Screening (PAS), the complete Member Assessment, Contact Notes, RN Plan of Care, Personal Assistance/Homemaker Worksheets, Member Enrollment Confirmation, etc.

C. Original documentation on each member must be kept by the Medicaid provider for 5 years or 3 years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

Personnel Records:

A. Original or legible copies of personnel documentation including training records, licensure, confidentiality agreements, criminal investigation background checks (CIB) (Refer to *Chapter 501.3.7*), etc. must be maintained on file by the certified provider.
B. Minimum credentials for professional staff (RN, Social Worker, etc.) must be verified upon hire and thereafter based upon their individual professional license requirements.
C. All documentation on each staff member must be kept by the Medicaid provider in the designated office that represents the county where services were provided.
D. Verification that OIG Medicaid Exclusion List was checked as appropriate for the position.

Certified ADW providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the ADW program. Providers must also agree to make themselves, Board Members, their staff, and any and all records pertaining to member services available to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

501.3.4 Provider Certification Reviews

Providers are required to submit designated evidence to BoSS every 12 months to document continuing compliance with all Certification requirements as specified under *Chapter 501.3* and all of its subparts. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not received by BoSS either prior to or on the established date, a pay hold may be placed on the provider's claims until documentation is received and the provider may be removed from all selection forms. A provisional certification will be issued; however, an on-site visit will be waived if required documentation is received within 30 days. If after 60 days documentation is not received, steps may be taken to execute an emergency transfer of ADW members. If the provider wants to resume/continue service provision, they must submit all required documentation and an on-site continuing certification review will be conducted by BoSS staff.

BoSS will review all submitted certification documentation and provide a report to BMS. BMS may request payback for certification requirements not met. The provider must remove employees who do not meet requirements from provision of services until certification standards are met and required documentation is approved by BoSS. If the documentation is not received within 30 days of the request, BMS may:

- Place a payment hold on all future claims until the provider can prove they meet all certification requirements;
- Remove the provider from all selection forms; and

- Terminate the provider's participation as an ADW provider if all issues are not resolved within 60 calendar days.

A provider who is terminated from the ADW program for any of the reasons listed above may apply for recertification by contacting BoSS. Recertification includes a mandatory site visit by a BoSS monitor and a 6 month review.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

Certification reviews will also include a statewide representative sample of member records. BoSS will review member records using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. (These tools are available on BoSS' Web site at www.wvseniorservices.gov). The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers have 30 days to respond to draft review findings or to submit a corrective action plan if requested. Sanctions will be imposed as findings dictate.

501.3.5 Staff Requirements

Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

Personal Assistance/Homemaker direct care staff and Personal Options direct care staff must be at least 18 years of age and must have the following competency based training before providing services:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by the agency nurse, or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by BoSS and can be found at http://www.wvseniorservices.gov/.

B. First Aid – may be provided by the agency nurse, a certified trainer or a qualified internet provider.

C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.

D. Personal Assistance/Homemaker Skills – training on assisting members with ADL's – must be provided by the agency RN.

E. Abuse, Neglect and Exploitation - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

F. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area or a qualified internet training provider.

G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member special needs - must be provided by the agency nurse.

Personal Options members and their direct care employees may access a Resource Consultant for training materials and assistance.

501.3.5.1 Annual Staff Training

CPR, First Aid, OSHA, Abuse, Neglect, Exploitation and HIPAA training must be kept current.

A. CPR is current as defined by the terms of the certifying agency.

B. First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, is current as defined by the terms of that entity if provided by the agency RN, must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (Example: If First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.)

C. OSHA, Abuse, Neglect and Exploitation, and HIPAA must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)

In addition, 4 hours of training focusing on enhancing direct care service delivery knowledge and skills must be provided annually. Member specific on-the-job-training can be counted toward this requirement.

501.3.5.2 Training Documentation

Documentation for training conducted by the agency nurse, social worker/counselor, or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee or for Personal Options, the member (or legal representative). Training documentation for internet based training must include the person's name, the name of the internet provider and either a certificate or other documentation proving successful completion of the training. A card from the American Heart Association, the American Red Cross or other training entity is acceptable documentation for CPR and First Aid.

501.3.6 Professional Staff Qualifications

Professional Staff qualifications are defined below.

501.3.6.1 Registered Nurse Qualifications

A Personal Assistance/Homemaker Registered Nurse must be employed by a certified Personal Assistance/Homemaker agency and have a current West Virginia Registered Nurse license. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present. (For example – if an employee has been with the agency for 3 years – documentation of licensure must be present for all 3 years.) All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information,*) and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications. The Office of Inspector General (OIG) Medicaid Exclusion List must be checked for every RN employee prior to employment and monthly thereafter. An agency cannot employ an RN on the OIG Medicaid Exclusion List. This list can be obtained at http://exclusions.oig.hhs.gov.

501.3.6.2 Case Manager Qualifications

A Case Manager must be licensed in West Virginia as a Social Worker, Counselor, or Registered Nurse. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present (example: If an employee has been with your agency for 3 years, the documentation of licensure must be present for all 3 years). All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information*,), and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications. The OIG Medicaid Exclusion List must be checked for every case manager employee prior to employment and monthly thereafter. An agency cannot employ a case manager on the OIG Exclusion Exemption List. This list can be obtained at http://exclusions.oig.hhs.gov.

501.3.7 Criminal and Investigation Background Checks

For the ADW Program the Criminal Investigation Background Check consists of three things:

1. A fingerprint based criminal history check conducted by the WV State Police contracted entity and, in certain situations, an FBI fingerprint check through the National Crime Information Database (NCID);
2. A check of the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); and
3. A check of the WV DHHR Protective Services Record Check.

At a minimum, a state level criminal investigation background check which includes fingerprints must be initially conducted by the West Virginia State Police contracted entity and again every

three years for all ADW staff including direct-care personnel, case managers, RN's and anyone who has direct access to member(s). If the prospective employee has lived out of state within the last 5 years, the agency must also conduct an FBI I background check utilizing fingerprints through the NCID.

Prior to providing any ADW services, the prospective employee or the employer must have initiated the fingerprint check process with the WV State Police contracted entity. "Initiated" means the prospective employee has had a live fingerprint scan taken at an approved location or, if submitting hard copies of fingerprints, the day the copies are mailed for processing. ADW providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

Results which include a history of Medicaid fraud or abuse or which may place members at risk of personal health and safety should be taken into consideration prior to employment.

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All ADW provider agency staff hired after the implementation date of this manual having direct contact with members must have a WVDHHR Protective Services Record Check. These must be initiated (sent to WVDHHR) on each individual upon hire. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families (BCF), Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date that the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

All payments for services provided by excluded providers will be recovered by BMS.

501.3.8 Voluntary Agency Closure

A provider may terminate participation in the ADW Program with 30 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS claims agent and to BoSS. The provider must provide BoSS with a complete list of all current ADW members that will need to be transferred.

BoSS will provide selection forms to each of the agency's members, along with a cover letter explaining the reason a new selection must be made.

If at all possible, a joint visit with the member will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by BoSS.

The agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible.

A Personal Options provider and/or member must notify the PPL when an employee terminates participation as a Personal Options provider.

501.3.9 Involuntary Agency Closure

BMS may administratively terminate a provider from participation in the ADW program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the ADW program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to Common Chapter 800, General Administration, for more information on this procedure.

501.3.10 Additional Sanctions

If BMS or BoSS receives information that clearly indicates a provider is unable to serve new members due to staffing issues, member health and safety risk, etc., or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the Provider Selection Forms and from the provider information on the BoSS website until the issue(s) are addressed to the satisfaction of BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

501.4 INCIDENT MANAGEMENT OVERVIEW

ADW providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. Incidents shall be classified by the provider as one of the following:

- **Anyone** providing services to an ADW member who suspects an incidence of abuse or neglect, as defined in Section 501.1, must report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-372-6513, 7 days a week, 24 hours day. This initial report must then be followed by a written report, submitted to the local Department of Health and Human Resources, within 48 hours following the verbal report. An Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

- Critical incident are incidents with a high likelihood of producing real or potential harm to the health and welfare of the ADW member. These incidents might include, but are not limited to, the following:
  - Attempted suicide, or suicidal threats or gestures. Suspected and/or observed criminal activity by members themselves, members' families, health care providers, concerned citizens, and public agencies that does not compromise the health or safety of the member.
  - An unusual event such as a fall or injury of unknown origin requiring medical intervention if abuse and neglect is not suspected.
  - A significant interruption of a major utility, such as electricity or heat in the member's residence, but does not compromise the health or safety of the member.
  - Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that does not compromise the health or safety of the member.
  - Fire in the home resulting in relocation or property loss that does not compromise the health or safety of the member.
  - Unsafe physical environment in which the homemaker and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.

- Disruption of the delivery of ADW services, due to involvement with law enforcement authorities by the ADW member and/or others residing in the member's home that does not compromise the health or safety of the member.
- Medication errors by a member or his/her family caregiver that do not compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that does not compromise the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, but does not compromise the health or safety of the member.
- Any incident attributable to the failure of ADW provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services (APS).

- Simple incidents are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:
  - Minor injuries of unknown origin with no detectable pattern
  - Dietary errors with minimal or no negative outcome

501.4.1 Incident Management Documentation and Investigation Procedures

Any incidents involving an ADW member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director, designated RN, or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section *501.4*, all incidents involving abuse, neglect and/or exploitation must be reported to APS but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file. Providers are to report monthly if there were no incidents.

For Personal Options, PPL must report any incidents in the WVIMS within one business day of learning of the incident. BoSS reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WVIMS.

501.4.2 Incident Management Tracking and Reporting

Providers must review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the agency Quality Management Plan. The Quality Management Plan must be made available to BoSS monitoring staff at the time of the provider monitoring review or upon request.

PPL has a tracking/reporting responsibility defined in their contract with BMS

501.5 MEMBER ELIGIBILITY

Applicants for the ADW Program must meet all of the following criteria to be eligible for the program:

A. Be 18 years of age or older.
B. Be a permanent resident of West Virginia. The individual may be discharged or transferred from a nursing home in any county of the state, or in another state, as long as his/her permanent residence is in West Virginia.
C. Be approved as medically eligible for nursing home level of care.
D. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
E. Choose to participate in the ADW Program as an alternative to nursing home care.

Even if an individual is medically and financially eligible, a slot must be available for him/her to participate in the program.

501.5.1 Medical Eligibility

APS Healthcare/IRG is the contracted entity that is responsibility for conducting medical necessity assessments to confirm a person's medical eligibility for waiver services.

The purpose of the medical eligibility review is to ensure the following:

A. New applicants and existing members are medically eligible based on current and accurate evaluations.
B. Each applicant/member determined to be medically eligible for ADW services receives an appropriate Service Level that reflects current/actual medical condition and short- and long-term service needs.
C. The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

501.5.1.1 Medical Criteria

An individual must have five deficits as described on the Pre-Admission Screening Form (PAS) to qualify medically for the ADW Program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. Continence, bowel Continence, f. Bladder		Level 3 or higher; must be incontinent.
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.	
#28	Individual is not capable of administering his/her own medications.	

501.5.1.1(a) Service Level Criteria

There are four Service Levels for Personal Assistance/Homemaker services. Points will be determined as follows based on the following sections of the PAS:

Section	Description of Points
#23	Medical Conditions/Symptoms – 1 point for each (can have total of 12 points)
#24	Decubitus - 1 point
#25	1 point for b., c., or d.
#26	Functional Abilities: Level 1 - 0 points Level 2 - 1 point for each item **a** through **i**. Level 3 - 2 points for each item **a** through **m** **i** (walking) must be at Level 3 or Level 4 in order to get points for **j** (wheeling)

Section	Description of Points
	Level 4 – 1 point for **a**, 1 point for **e**, 1 point for **f**, 2 points for **g** through **m**
#27	Professional and Technical Care Needs - 1 point for continuous oxygen.
#28	Medication Administration - 1 point for b. or c.
#34	Dementia - 1 point if Alzheimer's or other dementia
#35	Prognosis – 1 point if Terminal

Total number of points possible is 44.

501.5.1.1(b) Service Level Limits

Traditional Service Levels

Level	Points Required	Range of Hours Per Month (for Traditional Members)
A	5-9	0 - 62
B	10-17	63 - 93
C	18-25	94 -124
D	26-44	125 -155

A member does not have to utilize the number of hours specified in their Service Level if their needs are being met through other means, such as informals. (Example: A member who is a Level C may only choose to access Level B hours of service due to informal supports that assist him/her.) This must be documented on the Service Plan and the Case Manager must monitor that all services on the Service Plan, including informal supports, are delivered.
The total number of hours may be used flexibly within the month, but must be justified and documented on the Plan of Care.

Personal Options Service Limits

Personal Options members have a monthly budget based on their Service Level. The Personal Options monthly budget can be used flexibly within the month but must be justified and documented on the approved Participant-Directed Service Plan/Spending Plan.

501.5.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process (as directed in 2005 Cyrus decree):

A. An applicant shall initially apply for the ADW program by having his/her treating physician (M.D. or D.O. only) complete and sign a Medical Necessity Evaluation Request Form. The referring physician, applicant, family member, advocate or other interested party, may submit this form by fax, mail or electronically to APS Healthcare/IRG. APS Healthcare/IRG will not process any Medical Necessity Evaluation Request Form if the physician's signature is more than 60 days old. If the Medical Necessity Evaluation Request form is incomplete, it will be returned to the physician for completion and resubmission, and the applicant will be notified.
B. APS Healthcare/IRG will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification. If contact, is made, a notice shall be sent to the individual and/or contact person so noting scheduled home visit date and time.
C. APS Healthcare/IRG will make up to three attempts to contact the applicant. If unable to contact after 3 attempts, APS Healthcare/IRG will issue a potential referral closure letter to the applicant (or legal representative) and the referring entity. If no contact is made with APS Healthcare/IRG within 5 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
E. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

501.5.1.2(a) Results of Initial Medical Evaluation

A. Approval

If the applicant is determined medically eligible and a slot is available, then a notice of approved medical eligibility, which includes the maximum number of personal assistance/homemaker hours the person may receive and a copy of the PAS, is sent to the applicant (or legal representative) and the referring physician.

Additionally, APS Healthcare/IRG sends a Service Delivery Model Selection Form advising the applicant to choose either Traditional or Personal Options. A Freedom of Choice Case Management Selection Form and a Freedom of Choice Personal Assistance/Homemaker Selection Form are also provided to the applicant (or legal representative), advising him/her to choose a Case Management Agency and a Personal Assistance/Homemaker Agency if he/she choose the Traditional Model. The forms are to be returned to APS Healthcare/IRG once selections are made.

APS Healthcare/IRG will notify both of the agencies selected, and provide them with a copy of the applicant's PAS. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Chapter 501.5.2*), Member Enrollment (Refer to Section 501.6)

and the required 7 day contact (Refer to *Chapter 501.7*). If Personal Options has been selected APS Healthcare/IRG will notify BoSS and provide them with a copy of the PAS.

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant (or legal representative) and the referring entity informing them a slot is not currently available and they will be contacted when one becomes available.

B. Denial

If it is determined that the applicant does not meet medical eligibility, the applicant (or legal representative) and the referring physician will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found. A copy of the PAS and ADW policy will also be included with the Potential Denial letter. The applicant will be given 2 weeks to submit supplemental medical information to APS Healthcare/IRG. Information submitted after the 2 week period will not be considered.

If the review of the supplemental information by APS Healthcare/IRG determines the applicant is not medically eligible, the applicant (or legal representative) and the referring physician will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable ADW policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision.

If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, the date of eligibility can be no earlier than the date of the hearing decision.

501.5.1.3 Medical Reevaluation

Annual reevaluations for medical eligibility for each ADW member must be conducted. The process is as follows (as directed in 2005 Cyrus decree):

A. A Medical Necessity Evaluation Request Form must be submitted to APS Healthcare/IRG dated and signed by the member (or legal representative). The forms may be faxed to APS Healthcare/IRG but a copy of the original form with the signatures must be maintained in the member's file. The Case Manager, or the member (or legal representative) must check the reevaluation line at the top of the form. A physicians signature is required only if there is a change in, or an additional, diagnosis.
B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for member appeal.

C. After receiving the reevaluation request, APS Healthcare/IRG will attempt to contact the member (or legal representative) to schedule an assessment, allowing at least 2 weeks notification.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
E. If APS Healthcare/IRG makes the contact, a letter is sent to the member (or legal representative), Case Management Agency or PPL, noting the date and time of the assessment.
F. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.
G. If APS Healthcare/IRG is unable to contact the member (or legal representative) within three attempts, a potential closure letter will be sent to the member (or legal representative), the Case Management Agency, or PPL.
H. If no contact is made with APS Healthcare/IRG within 5 business days of the date of the potential closure letter, APS Healthcare/IRG will send the final denial letter to the member and copy BoSS and the Case Management Agency or PPL. BoSS will close the case.

501.5.1.3(a) Results Of Medical Reevaluation

A. Approval

If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member (or legal representative), the Case Management Agency or PPL, if Personal Options is chosen. For members enrolled in the Traditional Model, this notice includes the approved Service Level and the maximum number of hours of service per month. For members enrolled in Personal Options, this notice includes the approved Service Level and the maximum budget level. All members also receive a notice of free legal services, and a Request for Hearing Form.

The Case Management Agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Assistant/Homemaker Agency.

B. Denial

If it is determined that the member does not meet medical eligibility, the member (or legal representative), the referring physician, the Case Management Agency, or for Personal Options, PPL, will be notified by a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS and ADW policy will also be included with the Potential Denial Letter. The member will be given 2 weeks to submit supplemental medical information to APS Healthcare/IRG; supplemental information received by APS Healthcare/IRG is given to the reviewing RN. Information submitted after the 2 week period will not be considered.

If the review of the supplemental information by APS Healthcare/IRG determines that there is still no medical eligibility, the member (or legal representative), referring physician, BoSS and the Case Management Agency or PPL will be notified with a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision.

If the member elects to appeal any adverse decision, benefits shall continue at the current level only if the appeal is mailed within 13 calendar days of the notice date, and shall continue only until a final decision is rendered by the administrative Hearing Officer. If the hearing decision affirms the denial of medical eligibility ADW services shall be terminated immediately.

Medicaid will not pay for services provided to a medically ineligible member.

501.5.2 Financial Eligibility

The financial eligibility process starts once an applicant is determined to be medically eligible for ADW services and has returned the Service Delivery Model Selection Form to APS Healthcare/IRG. If the applicant selects the Traditional Model they must also return the Freedom of Choice Case Management Selection Form and the Personal Assistance/Homemaker Selection Form to APS Healthcare/IRG.

If the applicant has chosen Traditional Model, the Case Management Agency that has been selected by the applicant will be notified, and a copy of the PAS will be provided. Within 3 business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant. The applicant and/or Case Manager must submit a DHS-2 form to the county DHHR office to determine financial eligibility based on ADW criteria. A copy of the Eligibility Determination page of the PAS must be attached to the DHS-2 form. Financial eligibility cannot be initiated without both documents.

If the applicant has chosen Personal Options, BoSS will mail the applicant a financial packet that includes instructions on how to contact his/her local DHHR office and schedule a financial determination appointment, a copy of page 6 of the PAS, and a Personal Options DHS-2 form.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant/member's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the ADW Program. Some assets of a couple are protected for the spouse who does not need nursing home or home and community based care and these assets are not counted to determine eligibility for the individual who needs care in the home.

The financial eligibility process must be initiated within 60 calendar days from the date the case management agency or the applicant receives the notification of selection letter. Case Managers, or in the case of Personal Options the applicant, must notify BoSS when the financial

eligibility process has been initiated. If the financial eligibility process is not initiated within the 60 calendar days, BoSS will close the referral. If the applicant wants ADW services after the closure, a new Medical Request for Evaluation to APS Healthcare/IRG is required.

ADW services cannot be paid until an applicant's financial eligibility is established and the enrollment process has been completed with BoSS. (Refer to *Chapter 501.6*). If the member has been a member of another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program. The only exception is Case Management which may bill 30 days prior to discharge.

Termination of the Medicaid benefit itself (e.g., the medical card) always requires a 13 calendar day advance notice prior to the first of the month Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples: 1) Advance notice for termination is dated January 27, Medicaid would end February 28. 2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when ADW services end.

501.6 MEMBER ENROLLMENT

Once an applicant has been found medically and financially eligible, the Case Manager or Personal Options Program Manager must request Member Enrollment from BoSS by completing a Member Enrollment Request Form. BoSS will complete the Member Enrollment and provide a Confirmation Notice to the Case Management Agency and the Personal Assistance/Homemaker agency, or Personal Options Program Manager.

No Medicaid reimbursed ADW services may be provided until the Case Management Agency or the Personal Options Program Manager is in receipt of the Member Confirmation Notice. For monthly reporting purposes (Refer to *Chapter 501.11.4*) agencies are to report members as active the month they receive their Confirmation Notice for that member.

The Case Management Agency is responsible for maintaining a copy of the Member Enrollment Request Form and the Member Enrollment Confirmation Notice in the member file. The Personal Assistance/Homemaker agency is responsible for maintaining a copy of the Member Enrollment Confirmation Notice in the member file.

The Personal Options Program Manager sends the Member Enrollment Confirmation with the complete member referral to PPL. PPL will maintain a file which contains the Member Enrollment Confirmation Notice for Personal Options members.

501.7 MEMBER ASSESSMENT

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan and Plan of Care. A secondary purpose of the assessment is to provide the member a good understanding of the program, services, and expectations. There are 2 components to the Member Assessment: Case Management

and RN Assessment. Whenever possible both of these assessments should be scheduled together.

Once Member Enrollment has been completed with BoSS, the Case Manager and the Personal Assistance/Homemaker RN will schedule a home visit within 7 calendar days to complete the Member Assessment.

The Case Manager and Personal Assistance/Homemaker RN must work together to ensure that the program meets the member's needs. They must communicate and share information/documentation including the Case Management Member Assessment and the Personal Assistance/Homemaker RN Member Assessment. Both providers are to maintain a copy of the entire Member Assessment (Case Management Assessment and Personal Assistance/Homemaker RN Assessment) in the member's record.

The Personal Assistance/Homemaker RN must complete a Personal Assistance/Homemaker RN Assessment at least every 6 months from the date of the Initial Personal Assistance/Homemaker RN Assessment or the Annual Personal Assistance/Homemaker RN Assessment.

The Personal Assistance/Homemaker RN must complete an Annual Personal Assistance/Homemaker RN Assessment. It can be completed no sooner than 60 calendar days before the 1 year anniversary of the current assessment.

A new assessment must be completed when a member's needs change. Changes in a member's needs are to be incorporated into the Service Plan and the Plan of Care. Case Managers are to share any changes in a member's assessment with the Personal Assistance/Homemaker Agency. The Personal Assistance/Homemaker Agency is to share any changes in the member's RN Assessment with the case manager.
A copy of all Member Assessments must be provided to the member (or legal representative).

501.8 SERVICE PLAN DEVELOPMENT

In the Traditional Model, the Case Manager is responsible for development of the person-centered Service Plan in collaboration with the member (or legal representative). Participation in the development of the Initial Service Plan is mandatory for the member (or legal representative) and Case Manager. The member (or legal representative) may choose to have whomever else they wish to participate in the process (Personal Assistance/Homemaker RN, other service providers, informal supports, etc.).

The Service Plan meeting must be scheduled within 7 calendar days of the Case Management Member Assessment.

The Service Plan must detail all services (service type, provider of service, frequency) the member is receiving, including any informal supports that provide assistance (family, friends, etc.) and address all needs identified in the PAS, the Member Assessment (Case Management Member Assessment and the Personal Assistance/Homemaker RN Assessment). The Service

Plan must also address the member's preferences and goals. It is the Case Manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Service Plan.

A copy of all Service Plans must be provided to the member (or legal representative) and the Personal Assistance/Homemaker Agency. The Case Management Agency must have the original document in the member's file.

In Personal Options, the member (or legal representative) is responsible for the development of the Participant-Directed Service Plan. Participation in the development of the Initial Participant-Directed Service Plan, the 6 month Service Plan Update and the Annual Participant-Directed Service Plan is mandatory for the member (or legal representative) and the Resource Consultant. The member (or legal representative) may choose to have whomever else they wish to participate in the process (direct care staff, other service providers, informal supports, etc.)
The member's Service Plan or Personal Options Participant-Directed Service Plan must contain reference to any other service(s) received by the member, regardless of the source of payment. An ADW agency that provides private-pay services to a member must ensure that documentation is maintained separately.

501.8.1 Six-Month and On-Going Service Plan Development

Participation in the 6 month Service Plan and Annual Service Plan development are mandatory for the member (or legal representative), the Case Manager, and the Personal Assistance/Homemaker RN. The member (or legal representative) may choose to have whomever else they wish to participate in the process (direct care staff, family members, other service providers, informal supports, etc.).

501.8.2 Interim Service Plan Development

In order to begin services immediately to address any health and safety concerns, an Interim Service Plan may be developed and implemented upon the completion of Member Enrollment. The Interim Service Plan can be in effect up to 21 calendar days from the date of Member Enrollment Confirmation to allow time for assessments to be completed, the Service Plan meeting to be scheduled and the Service Plan to be developed.

If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate direct care services within 3 business days. (The Interim Plan of Care can only be used for a maximum of 21 days.)

501.9 PLAN OF CARE DEVELOPMENT

The Personal Assistance/Homemaker RN Assessment is used in conjunction with the PAS, the Member Case Management Assessment, and the Service Plan to develop the member's Plan of

Care. The Plan of Care details how Personal Assistance/Homemaker services will be used to meet the direct care needs of the member.

Once the Personal Assistance/Homemaker RN has completed the Initial or Annual Personal Assistance/Homemaker RN assessment AND has received the Service Plan from the Case Manager, he/she must develop the member's Plan of Care based on identified needs and member preferences and initiate direct care services within 10 calendar days.

A copy of all Personal Assistance/Homemaker RN Assessments and member Plans of Care must be provided to the member (or legal representative) and the Case Management Agency. The Personal Assistance/Homemaker Agency must have the original document in the member's file.

501.10 COVERED SERVICES

The following services are available to ADW members if they are deemed necessary and appropriate during the development of their Service Plan and Plan of Care:

A. Case Management (Section 501.11)
B. Personal Assistance/Homemaker Services (501.12)
    a. Direct Care Staff (501.12.1)
    b. RN Assessment (501.12.2)
    c. Nursing Services (501.12.3)
    d. Transportation (501.12.4)
C. Participant-Directed Goods and Services (Personal Options Members Only) (*Chapter 501.13*)

501.11 CASE MANAGEMENT DEFINITION

Case management activities are indirect services that assist the member in obtaining access to needed ADW services, other State Plan services, as well as medical, social, educational and other services, regardless of the funding source. Case management responsibilities also include the development of the member's Service Plan, the ongoing monitoring of the provision of services included in the member's Service Plan, initiating the process to re-evaluate the member's medical eligibility, member health and welfare, and advocacy.

Applicants who chose Personal Options can either assume the responsibilities of the Case Manager or can purchase this service from a certified provider.

Case management includes the coordination of services that are individually planned and arranged for members whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The Case Manager takes an active role in service delivery; although services are not provided directly by the Case Management Agency, the Case Manager serves as an advocate and coordinator of care for the member. This involves collaboration with the ADW member, family

members, friends, informal supports, and health care and social service providers. Case Managers are to:

A. Evaluate social, environmental, service, and support needs of the individual.
B. Develop and write an individualized Service Plan which details all services that are to be provided including both formal and informal (if available) services that will assist the member to achieve optimum function.
C. Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
D. Proactively identify problems and coordinate services that provide appropriate high quality care to meet the individualized and often complex needs of the member.
E. Provide advocacy on behalf of the member to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services.
F. Ensure that a member's (or legal representative) wishes and preferences are reflected in the development of the Service Plan and Plan of Care by working directly with the member (or legal representative) and all service providers.
G. Assure that a member's legal and human rights are protected.

501.11.1 Case Management Code, Unit, Limit and Documentation Requirements

Procedure Code: G9002

Service Unit: All Case Management services provided within 1 month

Service Limit: **1 Unit per month.** Reimbursed at a monthly rate

Prior Authorization Required: No

Documentation Requirements: All contacts with, or on behalf of a member, must be documented within the member's record, including date and time of contact, a description of the contact, and the signature of the Case Manager. At a minimum, the Case Manager or Resource Consultant must make contact with the member (or legal representative) once per month and document the contact on the Case Management Monthly Contact Form or the Resource Consultant Monthly Contact Form. Case Management Agencies may not bill for transportation services.

501.11.2 Case Management Case Loads

Each provider must assure that there is an adequate number of qualified Case Managers for the number of members served. A full-time-equivalent Case Manager can serve no more than 75 active members; however, in situations where a provider has a vacancy due to staff turnover, a higher case load may not be sustained for more than 3 months.

501.11.3 Ongoing Case Management Services

The Case Manager is responsible for follow-up with the member to ensure that services are being provided as described in the Service Plan. Initial contact, via telephone or face-to-face,

must be made within 7 calendar days after direct care services have begun by the Personal Assistance/Homemaker Agency. At a minimum, a monthly telephone contact and a home visit every 6 months must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the member.

If a member (or legal representative) cannot be reached by telephone for the monthly contact, a home visit must be made. At a minimum, the Case Manager must complete a 6 month Case Management Member Assessment and Service Plan. This must be a face-to-face home visit with the member.

Specific activities to assure that needs are being met also include:

A. Assure financial eligibility remains current.
B. Assure the health and welfare of the member.
C. Address changing member needs as reported by the member (or legal representative), Personal Assistance/Homemaker direct care staff and/or RN, or informal support.
D. Address changing needs determined by the monthly member contact.
E. Refer and procure any additional services the member may need that are not services the Personal Assistance/Homemaker Agency can provide.
F. Coordinate with all current service providers to develop the 6 month Service Plan and the Annual Service Plan (or more often as necessary). It is mandatory that the member (or legal representative), the Case Manager and the Personal Assistance/Homemaker Agency RN be present at the 6 month Service Plan meeting and the Annual Service Plan meeting.
G. Provide the Service Plan to all applicable service providers that are providing services to the member (or legal representative).
H. Provide copies of all necessary documents to the Personal Assistance/Homemaker Agency such as Member Enrollment, PAS, Assessments, etc.
I. Annually submit a Medical Necessity Evaluation Request to APS Healthcare/IRG.

501.11.4 Reporting

The Case Management Agency will complete and submit required administrative and program reports as requested by either BMS or BoSS. Monthly reports must be submitted by Case Management agencies to BoSS by the 6th business day of every month.

501.12 PERSONAL ASSISTANCE/HOMEMAKER

Personal Assistance/Homemaker services are defined as long-term direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing home, or to enable an individual to return home from a nursing home.

The components of the Personal Assistance/Homemaker Service include Personal Assistance/Homemaker Direct Care Services, RN Assessment, Nursing and Transportation.

More than one Personal Assistance/Homemaker Agency can provide direct care services to a member. The agency the member selected on their Freedom of Choice Personal Assistance/Homemaker Selection Form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. Billable nursing units must be coordinated by the primary agency. There cannot be a duplication of services.

501.12.1 Personal Assistance/Homemaker (Direct Care Staff) Code, Unit, Limit and Documentation Requirements

Procedure Code: S5130

Service Unit: 15 minutes

Service Limits: Determined by Service Level Criteria and Service Level Limits (Refer to *Sections 501.5.1.1(a and b)*

Prior Authorization Required: Yes

Documentation Requirements: All services provided to a member must be documented on the Plan of Care and maintained within the member's record.

501.12.1.1 Personal Assistance/Homemaker (Direct Care Staff) Qualifications and Training

All documented evidence of Personal Assistance/Homemaker direct care staff qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file by the provider. The provider must have an internal review process to ensure that Personal Assistance/Homemaker direct care staff providing ADW services meets the minimum qualifications as required by policy (Refer to *Chapter 501.3* and its subparts).

In Personal Options, all documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality statements, and references shall be maintained on file by PPL.

501.12.1.2 Personal Assistance/Homemaker (Direct Care Staff) Responsibilities

The functions of the Personal Assistance/Homemaker direct care staff include providing direct care services as defined by the member's Plan of Care or the Spending Plan for Personal Options members, recording services and time spent with the member, communicating to the RN any member changes and completing all ADW training requirements.

Personal Assistance/Homemaker direct care staff duties and responsibilities as described in the Plan of Care may include:

A. Assist member with Activities of Daily Living (ADL).
B. Assist member with environmental tasks necessary to maintain the member in the home.

C. Assist member with completion of errands that are essential for the member to remain in the home (IADLs) — Examples: grocery shopping, medical appointments, laundromat, and trips to the pharmacy. The member may accompany the Personal Assistance/Homemaker direct care staff on these errands.
D. Assist member in community activities. Activities provided in the community should be determined by the member and the Case Manager at the Service Plan meeting and are limited to 30 hours per month. (Examples of community activities — visiting friends/relatives, going to a local community activity, etc.) Community activities must be documented on the Plan of Care. Prior authorization of additional units of Personal Assistance/Homemaker services will not be available to provide community activities.
E. Report significant changes in members' condition to the Personal Assistance/Homemaker RN or for Personal Options to PPL. Report any incidents to the Personal Assistance/Homemaker RN or for Personal Options, PPL. (Examples: member falls (whether direct care staff was present or not), bruises (whether direct staff knows origin or not), etc.)
F. Report any environmental hazards to the Personal Assistance/Homemaker RN or for Personal Options to PPL. (Examples: no heat, no water, pest infestation or home structural damage).
G. Prompt for self-administration of medications.
H. Maintain records as instructed by the Personal Assistance/Homemaker RN or PPL.
I. Perform other duties as assigned by Personal Assistance/Homemaker RN within program guidelines.
J. Accurately complete Personal Assistance/Homemaker worksheet and other records as instructed by the Personal Assistance/Homemaker RN or PPL.

Personal Assistance/Homemaker staff cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's Plan of Care or for members enrolled in Personal Options the Participant-Directed Service Plan. Functions/tasks that cannot be performed include, but are not limited to, the following:

A. Care or change of sterile dressings.
B. Colostomy irrigation.
C. Gastric lavage or gavage.
D. Care of tracheostomy tube.
E. Suctioning.
F. Vaginal irrigation.
G. Give injections, including insulin.
H. Administer any medications, prescribed or over-the-counter.
I. Perform catheterizations, apply external (condom type) catheter.
J. Tube feedings of any kind.
K. Make judgments or give advice on medical or nursing questions.
L. Application of heat.

If at any time a Personal Assistance/Homemaker is witnessed to be, or suspected of, performing any prohibited tasks, the Personal Assistance/Homemaker RN or PPL must be notified immediately.

501.12.2 RN Assessment Code, Unit, Limit and Documentation Requirements

Procedure Code: T1001

Modifier: UD

Service Limits: 1 event per calendar year (January - December)

Prior Authorization Required: No

Documentation Requirements: The Personal Assistance/Homemaker RN Initial and Annual Member Assessment and the member Plan of Care

501.12.3 Nursing Services Code, Unit, Limit and Documentation Requirements

Procedure Code: T1002

Modifier: UD

Service Unit: 15 minutes

Service Level: 6 units per month

Prior Authorization Required: No

Documentation Requirements: All contacts (except for the 6 month and annual visits) with, or on behalf of, a member must be documented using the Personal Assistance/Homemaker RN Member Contact Form and maintained within the member's record. The RN Assessment and Plan of Care must be complete.

501.12.3.1 Nursing Responsibilities

The RN responsibilities are:

A. If requested by the member (or legal representative) attends the Initial Service Plan meeting.
B. Attend the 6 month and Annual Service Plan meeting.
C. If requested by the member (or legal representative) attends the member's ADW medical eligibility appointments with APS Healthcare/IRG.
D. If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate homemaker services within three business days.
E. Make a home visit with the member and Personal Assistance/Homemaker within 30 calendar days after Personal Assistance/Homemaker services begin.
F. Complete a Personal Assistance/Homemaker RN Assessment within 6 months from the date of the Initial or annual Personal Assistance/Homemaker RN Assessment.

G. Based on clinical judgment, complete a Personal Assistance/Homemaker RN Assessment to determine the need for changes in the Plan of Care such as following discharge from an acute care hospital, nursing facility or other residential setting. The RN must notify the Case Manager if additional services or changes in services are needed.
H. Review the Plan of Care to assure services were provided as described in the Service Plan before submitting billing under code S5130.
I. Review the Plan of Care to assure it has been completed per policy before submitting billing under code S5130.
J. Sign and date all accurately completed Plans of Care.
K. Provide member-specific training to Personal Assistance/Homemakers.
L. Complete a home visit with the member to assess any change in needs. Documentation must substantiate the need for the visit using the Personal Assistance/Homemaker RN Member Contact Form.
M. Attend any member Dual Service planning meetings. (Refer to *Section 501.18*)
N. Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Service Level Change must be submitted to APS Healthcare/IRG. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than 1 month prior to, or 1 month following, the request for an increased Service Level. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Assistance/Homemaker staff without attached physician's documentation or discharge summary. The request must be signed by both the Personal Assistance/Homemaker RN and the member (or legal representative). Original signatures are required; i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level. Notice of the determination will be sent to the member (or legal representative) and the Personal Assistance/Homemaker Agency, or if a Personal Option member, to PPL. The Personal Assistance/Homemaker Agency must notify the appropriate Case Management Agency of the Service Level determination.

Members who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. APS Healthcare/IRG will not review a request for an increased Service Level for such members.

Administrative duties are not billable. These include but are not limited to:

A. Sending copies of any Personal Assistance/Homemaker RN Assessments or Plans of Care to the member (or legal representative) or the Case Management Agency.
B. Notifying the Case Management Agency if a member has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.

C. Being available to the Personal Assistance/Homemaker (direct care staff) for consultation and assistance at any time when the Personal Assistance/Homemaker (direct care staff) is providing services.
D. Completing and submitting required program reports to BMS, BoSS or APS Healthcare/IRG.
E. Telephone calls.

501.12.4 Transportation

Transportation provides reimbursement for Personal Assistance/Homemaker direct care staff that performs essential errands for or with a member or community activities with a member.

501.12.4.1 Transportation Code, Unit, Limit and Documentation Requirements

Procedure Code: A0160

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: No

Documentation Requirements: All transportation with, or on behalf of, a member must be included in the Plan of Care and documented on the Plan of Care and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).

501.12.4.2 Transportation Services

The member may be transported by the Personal Assistance/Homemaker in order to gain access to services and activities as specified in the Plan of Care. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. Mileage can be charged for essential errands [Refer to *Chapter 501.12.1.2(C)*] activities related to the Service Plan and community activities [Refer to *Chapter 501.12.1.2(D)*].

501.13 PARTICIPANT-DIRECTED GOODS AND SERVICES CODE, UNIT, LIMIT AND DOCUMENTATION REQUIREMENTS

Procedure Code: T2028

Service Unit: As specified on Participant-Directed Service Plan

Service Limit: $1000 Annually

Prior Authorization Required: No

Documentation Requirement: Participant Directed Goods and Services receipts and other approved documentation per the PPL contract with BMS must be maintained on file with PPL. Must be in the Participant-Directed Spending Plan.

501.13.1 Participant-Directed Goods and Services

Participant-Directed Goods and Services are equipment, services or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the Participant-Directed Service Plan. The member must budget for their approved good or service within their allocated budget.

The following are non-allowable services, equipment or supplies: gifts for staff/family/friends, payments to someone to serve as a representative, clothing, food and beverages, electronic entertainment equipment, utility payments, swimming pools and spas, costs associated with travel, comforters, linens, drapes, furniture, vehicle expenses including routine maintenance and repairs, insurance and gas money, medications, vitamins, herbal supplements, monthly internet service, yard work, illegal drugs or alcohol, household cleaning supplies, home maintenance and repair, pet care, respite services, spa services, experimental or prohibited treatments, education, personal hygiene, discretionary cash, and any other good or service that does not address an identified need in the Participant-Directed Service Plan, decrease the need for other Medicaid services, and/or increase the person's safety in the home and /or improve and maintain the member's opportunities for full membership in the community.

501.14 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, Case Management Agencies or for Personal Options PPL must communicate in writing to each member (or legal representative)

Their right to:

A. Transfer to a different provider agency or to Personal Options.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding ADW services.
G. Access to all of their files maintained by agency providers.

And their responsibility to:

H. Notify the ADW Personal Assistance/Homemaker Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers or PPL promptly of changes in Medicaid coverage.
J. Comply with the Plan of Care or for Personal Options Members, comply with the Participant Directed Service Plan.
K. Cooperate with all scheduled in-home visits

L. Notify the ADW agencies or PPL of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the ADW agencies or PPL of any change of medical status or direct care need.
N. Maintain a safe home environment for the agency or PPL to provide services.
O. Verify services were provided by initialing and signing the Plan of Care.
P. Communicate any problems with services to the provider agency or PPL.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL or the APS hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

501.15 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance. All ADW agencies will have a written member grievance procedure. The APS Healthcare/IRG RN will explain the grievance procedure to all applicants/members at the time of initial application/reevaluation. Applicants/members (or legal representative) will be provided with a Member Grievance Form at that time. Service providers will only afford members a grievance procedure for services that fall under the particular service provider's authority; for example, a Case Management Agency will not conduct a grievance procedure for Personal Assistance/Homemaker Agency activities, nor will a Personal Assistance/Homemaker Agency conduct a grievance procedure for Case Management Agency activities. A member may by-pass the level one grievance if he/she chooses.
The grievance procedure consists of two levels:

A. **Level One: ADW Provider**

An ADW provider has 10 business days from the date they receive a Member Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency director or their designee with the member (or legal representative). The agency has 5 days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to BoSS for a Level Two review and decision.

B. **Level Two: BoSS**

If an ADW provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, BoSS will, within 10 business days of the receipt of the Member Grievance Form, contact the member (or legal representative) and the ADW provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

501.16 TRANSFER TO DIFFERENT AGENCY OR TO PERSONAL OPTIONS

An ADW member may request a transfer to another agency or to Personal Options at any time. If a member wishes to transfer to a different agency a Member Request to Transfer form must be completed and signed by the member or legal representative. The form may be obtained from the current provider, the new providers, BoSS or other interested parties. Once completed and signed by the member, the form must be submitted to BoSS. BoSS will then coordinate the transfer and set the effective date based on when required transfer documents are received. For case management transfers, the effective date of transfer will be the first date of the next month if the transfer is received by the 17th of the month.

At no time should the transfer take more than 45 calendar days from the date that the member signed transfer request is received at BoSS, unless there is an extended delay caused by the member in returning necessary documents.

Transferring Agency Responsibilities:

A. To continue providing services until BoSS notifies them that the transfer has been completed.
B. If it is a Case Management transfer, to provide the receiving agency, on the day of the transfer, a copy of the current PAS, DHS-2, the Service Plan, a copy of the Member Enrollment Confirmation and any other pertinent documentation.
C. If it is a Personal Assistance/Homemaker transfer, to provide the receiving agency, on the day of the transfer, with a copy of the current PAS, DHS-2, the Plan of Care and any other pertinent documentation.
D. To maintain all original documents for monitoring purposes.

Receiving Agency Responsibilities:

A. If it is a Personal Assistance/Homemaker transfer, a Personal Assistance/Homemaker Member RN assessment must be conducted within 7 business days of the transfer effective date. When a member transfers agencies, the receiving agency Personal Assistance/Homemaker RN cannot bill for an Initial Assessment (billing code T1001, Modifier UD) if one has been completed within the calendar year). They can bill for a Personal Assistance/Homemaker RN Assessment using T1002.
B. Develop the Personal Assistance/Homemaker RN Plan of Care within 7 business days of the transfer effective date.
C. If it is a Case Management transfer, a Case Management Member Assessment must be conducted within 7 business days of the transfer effective date.
D. Develop the Service Plan within 7 business days of the transfer effective date.

The Service Plan and existing Plan of Care from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new plan to prevent a gap in services.

Personal Option transfers are processed by BoSS.

501.16.1 Emergency Transfers

A request to transfer that is considered an emergency, such as when a member suffers abuse, neglect, or harm, will be reviewed by BoSS, and BoSS will take appropriate action. The Case Management Agency, the Personal Assistance/Homemaker Agency that the member is transferring from or the Personal Options member/representative must submit supporting documentation that explains why the member is in emergency status. BoSS will expedite the request as necessary, coordinating with the member and agencies involved.

501.17 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved BoSS:

A. No services have been provided for 100 continuous days – example, an extended placement in long-term care or rehabilitation facility.
B. Unsafe Environment – an unsafe environment is one in which the personal assistance/homemaker and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
    1) The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal assistance/homemaker or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
    2) The member or other household members display an abusive use of alcohol and/or drugs.

Note: When BoSS receives an unsafe closure request, they will attempt to process the request as a transfer. To do so, BoSS will require the member (or legal representative) to sign Consent for Release of Information Form. This will permit all information regarding the unsafe circumstances to be disclosed to other agencies and APS Healthcare/IRG. If another agency is not willing to accept the member due to unsafe circumstances, the case will be closed.

C. The member is persistently non-compliant with the Plan of Care.
D. Member no longer desires services

The Request for Discontinuation of Services Form must be submitted to BoSS. BoSS will review all requests for a discontinuation of services. If it is an appropriate request, and BoSS approves the discontinuation, BoSS will send notification of discontinuation of services to the member (or legal representative) with a copy to the Case Management Agency or F/EA. Fair hearing rights will also be provided except if the member (or legal representative) no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the BoSS notification letter, if the member (or legal representative) does not request a hearing. If it is an unsafe environment services may be discontinued immediately.

All discontinuation of services (closures) must be reported on the Case Management Monthly Report to BoSS.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Case Management Monthly Report:

A. Death
B. Moved Out of State
C. Medically Ineligible
D. Financially Ineligible

501.18 DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES

Approval of the provision of both ADW and PC services to the same person will be considered if the following criteria are met:

A. Any PC services provided to an active ADW member must be approved by the reviewing agencies (Refer to H below), including the initial 60 hours. The Dual Service Provision Request must be completed.
B. An ADW member must be receiving services at Service Level D. (Otherwise, additional hours of Personal Assistance/Homemaker direct care services may be requested through a Request for Service Level Change.)
C. All policy set forth in *Chapter 517, Personal Care Services*, must be followed. PC policy supersedes ADW policy for this request.
D. There must be a PC RN Plan of Care and a Personal Assistance/Homemaker RN Plan of Care. For Personal Options, there must be a PC RN Plan of Care and a Participant-Directed Service Plan. These plans must be coordinated to ensure that services are not duplicated. PC and Personal Assistance/Homemaker services cannot be provided during the same hours on the same day. A service planning meeting between the Case Manager Personal Assistance/Homemaker RN, and PC RN must be held with the member or the legal representative in the member's residence and documented on the Request for Dual Service Provision. For Personal Options, the meeting must include PPL and the member.
E. There must be a valid ADW PAS and a valid PC Medical Eligibility Assessment (PCMEA) that documents the need for both services.
F. The ADW Case Manager is responsible for the coordination of the two services. For Personal Options, the member is responsible for the coordination of the 2 services.
G. Dual Service Provision Request Forms must be signed by the Case Manager, ADW RN, PC RN and the member (or legal representative). For Personal Options, the Dual Service Provision Request Form must be signed by the member (or legal representative) and the PC RN. Original signatures are required; i.e., "signature of member on file" is not acceptable.
H. All PC providers should submit requests to:

Innovative Resource Group (IRG)
100 Capitol Street
Suite 600
Charleston, WV 25301

I. Documentation submitted must include a copy of the ADW PAS and the PCMEA, ADW PAS and PC RN Plans of Care (for Personal Options the Participant-Directed Service Plan), current RN assessments (if applicable for Personal Options) from both agencies, and any documentation that substantiates the request. Additionally, a narrative describing how services will be utilized and verification that ADW and PC services will not be duplicated must be submitted. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member (or legal representative), PC RN, Personal Assistance/Homemaker RN, Case Manager or PPL will receive notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

J. BMS will conduct post-payment review of these combined services for duplication or inappropriate services. BoSS and BMS will review compliance during the agency monitoring process.

501.19 EXCLUDED SERVICES AND NON-REIMBURSABLE SITUATIONS

Medicaid will only reimburse agencies for ADW services that are defined as required services on the member's Service Plan or Participant-Directed Service Plan (Refer to *Common Chapter 300, Provider Participation Requirements*, for more information about reimbursement.) The following services are not reimbursable:

A. Services provided for other member(s) of the ADW member's household or to anyone who is not an ADW Program member.

B. Services provided by a Case Management Agency or Personal Assistance/Homemaker that are not included in the Service Plan, Plan of Care or Participant-Directed Service Services provided to an individual who is not medically and financially eligible on the date(s) that service is provided.

CHAPTER 502 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH CLINIC SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter		July 1, 2014

CHAPTER 502 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH CLINIC SERVICES

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CHAPTER 502–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH CLINIC SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary behavioral health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal regulations. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the West Virginia Bureau for Medical Services (BMS).

This chapter sets forth BMS's requirements for payment of Behavioral Health Clinic Services provided by Behavioral Health Clinic providers to eligible West Virginia (WV) Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Behavioral Health Clinic Services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (WVDHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

The Bureau of Medical Services has a joint goal with Medicaid Enrolled Providers to ensure effective services are provided to Medicaid Members.

Medicaid Enrolled Providers should give priority to children that have been identified as being in the foster care system. To uphold our responsibility to children in foster care, addressing children's needs must begin at entry and by making these foster children a priority especially with the assessment services stated in this manual. Medicaid Enrolled Providers should make a good faith effort to complete assessments in a timely manner as well as work with Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid Members have the right to freedom of choice when choosing a provider for treatment. A Medicaid Member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid Members are in violation of their provider agreement.

All Medicaid Enrolled Providers should coordinate care if a Medicaid Member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is the forefront of the Member's treatment. Appropriate Releases of Information should be signed in order that HIPAA Compliant Coordination of Care takes place.

502.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to *Chapter 200, Definitions of the Provider* Manual. In addition, the following definitions also apply to the requirements for payment of Behavioral Health Clinic Services described in this chapter.

Abuse and Neglect: as defined in **West Virginia Code §49-1-3**

Advanced Alcohol & Drug Counselor (AADC): professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Advanced Practice Registered Nurse (APRN): As defined in **West Virginia Code §30-7-1**: A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

Alcohol & Drug Counselor (ADC): professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Alcohol & Drug Clinical Supervisor (ADC-S): certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Administrative Service Organization (ASO): the contracted agent of BMS

Behavioral Health Clinic Services: services that are federally defined as those that are preventative, diagnostic, therapeutic, or palliative items or services provided to members on an outpatient basis under the direction of a physician. These services must be provided by a facility which is not part of a hospital, but is organized and operated to provide medical care on an outpatient basis. Clinic services must be provided at the clinic with the only exception being services provided to the homeless population.

Behavioral Health Condition: a mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment.

Coordination of Care: Sharing information between relevant parties to plan, arrange, implement, and monitor provision of services to Medicaid Members.

Critical Juncture: any time there is a significant event or change in the member's life that requires a treatment team meeting. The occurrence constitutes a change in the member's needs that require services, treatment, or interventions to be decreased, increased or changed. The member's needs affected would be related to their behavioral health, physical health, change in setting or crisis.

Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

External Credentialing: a process by which an individual's external credential is verified to provide Medicaid Clinic Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Freedom of Choice: The guaranteed right of a beneficiary to select a participating provider of their choice.

Homeless: An individual meeting the current federal definition of homelessness as defined in **42 USC § 11302.**

Foster Child: The West Virginia Department of Health and Human Resources defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Human Services Degree: A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:

- Psychology
- Criminal Justice
- Nursing
- Sociology
- Social Work
- Counseling/Therapy
- Teacher Education
- Behavioral Health
- Other Degrees approved by the West Virginia Board of Social Work.

(Note: Some services require specific degree as listed in the manual see specific services for detailed information on staff qualification)

Incident: any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Intensive Services (IS): A combination of specific services for a targeted population to be used on a frequent basis for a limited period of time. Approval for an IS program and prior authorization for members admitted to an IS program must be obtained by contacting the ASO.

Internal Credentialing: an individual approved to provide Clinic Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Licensed Practical Nurse (LPN): an individual who has completed the licensed practical nurse program from an accredited school and who is licensed by the WV State Board of Examiners for Licensed Practical Nurses.

Licensed Psychologist: a psychologist who has completed the requirements for licensure that have been established by the WV Board of Examiners of Psychologist and is in current good standing with the board.

Office of Health Facility Licensure and Certification (OHFLAC): The office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Physician: As defined in West Virginia Code Annotated §30-3-10, an individual who has been issued a license to practice medicine in the state of WV by the WV Board of Medicine and is in good standing with the board; or an individual licensed by the WV Board of Osteopathy in accordance with West Virginia Code Annotated 30-14-6.

Physician's Assistant: An individual who meets the credentials described in West Virginia Code Annotated §30-3-16, §30-3-13, §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Physician Extender: A medical professional including an advanced practice registered nurse or a physician's assistant functioning within his or her legal scope of practice.

Registered Nurse (RN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse and in good standing with the West Virginia Board of Examiners for Registered Professional Nurses.

Supervised Psychologist: an individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Telehealth: the use of identified technologies to provide behavioral health services for Medicaid Members by qualified providers. When billing a service that has been utilized through Telehealth, providers must bill the service code with a GT Modifier (**See Telehealth Section).**

502.2 MEMBER ELIGIBILITY

Behavioral Health Clinic Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when prior authorization for Behavioral Health Clinic Services is requested of the agency authorized by BMS to perform administrative review. The Prior Authorization process is explained in Section 502.26.2 of this manual.

502.3 MEDICAL NECESSITY

All Behavioral Health Clinic Services covered in this chapter are subject to a determination of medical necessity. In the managed care position paper published in 1999 by the State of WV, medical necessity was defined as:

"Services and Supplies that are:

1. appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
2. provided for the diagnosis or direct care of an illness;
3. within the standards of good practice;
4. not primarily for the convenience of the plan member or provider; and
5. the most appropriate level of care that can be safely provided."

Medical Necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

- Service is the appropriate level of care
- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. As stated in section 502.15.1, the provider may perform one assessment per calendar year in order to update medical necessity (See Service Code H0031 for more details). Diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

The Bureau for Medical Services requires that providers register and/or prior authorize with the agency designated by the Bureau to perform administrative review for services that are rendered. Prior Authorization does not guarantee payment for services rendered.

502.4 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers of Behavioral Health Clinic Services must meet all enrollment criteria as described in Chapter 300.

502.4.1 ENROLLMENT REQUIREMENTS: AGENCY ADMINISTRATION

Each participating provider must develop and maintain a Credentialing Committee composed of senior licensed and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring the following activities:

- Development of written criteria for each specific type of service provided. These criteria must identify the required education, licensure, certification, training, and experience necessary for each staff person to perform each type of service. These criteria must be age and disability specific to populations served as well as ensuring that staff has demonstrated competency to provide the services rendered.

- Review all documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the committee. Based on this review, the committee must determine which services staff are qualified to provide.

- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records.

Participating providers must develop standards for staff training, supervision, and compliance monitoring in accordance state policy and federal regulations.

502.4.2 ENROLLMENT REQUIREMENTS: STAFF QUALIFICATIONS

Services may be rendered to Medicaid members by physician's assistants under the supervision of a psychiatrist. Services may also be rendered to Medicaid members by an Advanced Practice Registered Nurse as defined below. An Advanced Practice Registered Nurse without a psychiatric certification must function under the direct supervision of a WV Board of Medicine approved supervising physician. An Advanced Practice Registered Nurse with a psychiatric certification may practice without direct supervision by a psychiatrist.

A Physician's Assistant (PA) and/or Advanced Practice Registered Nurse must have a signed collaborative agreement for prescriptive authority with a psychiatrist. The collaborative

agreement must document the professional relationship between the Advanced RN practitioner and the physician. Regulations set forth in WV Code, Chapter 30 – Professions and Occupations, Title 11 Legislative Rule – West Virginia Board of Medicine, and Title 19 Legislative Rules – Board of Examiners for Registered Professional Nurses must be followed. Physician's Assistants and/or Advanced Practice Registered Nurses will be referred to as physician extenders throughout the manual.

Documentation including required licenses, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, proof of psychiatric certification as applicable, and any other materials substantiating an individual's eligibility to perform as a practitioner must be kept on file at the Behavioral Health Facility.

All further Staff Qualifications will be indicated under the service codes. All documentation for staff including college transcripts, certifications, credentials, background checks, trainings should be kept in the staff's personnel file and may be reviewed at any time by BMS or the Bureau's contractors or state/federal auditors**.**

502.5 CRIMINAL BACKGROUND CHECKS

All Clinic provider staff, having direct contact with members must, at a minimum, have results from a state level Fingerprint Based Background Check. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must request an additional federal background check utilizing fingerprints through the West Virginia State Police also upon hire and every 3 years of employment. Providers may do an on-line preliminary name base check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by an I/DD Waiver provider cannot be considered to provide services nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm; Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;

- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

Fingerprint based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered.

If aware of recent convictions or change in conviction status of an agency staff member providing Clinic services, the Clinic provider will notify the Program Manager for Behavioral Health Services.

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities must be checked by the Clinic provider for every agency staff who provides Medicaid services prior to employment and monthly throughout employment. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

502.6 CLINICAL SUPERVISION

The purpose of clinical supervision is to improve the quality of services for every member while ensuring adherence to WV Medicaid policy, therefore the provider must have a policy for Clinical Supervision including guidelines for the following:

- the responsibilities of the supervisor,
- credentialing requirements of the supervisor, and
- the minimum frequency for which supervision should occur.

Each agency shall have a chart demonstrating clinical chain of command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of their clinical and administrative supervision.

The clinical supervisor should have an equal or higher degree, credential, or clinical experience than those they supervise. If a clinical supervisor is responsible for a Medicaid funded program, the supervisor should be able to demonstrate familiarity with Medicaid requirements and relevant manuals. This applies to all clinic services rendered.

502.7 SERVICE CERTIFICATION REQUIREMENTS

A physician or physician extender must certify the need for Behavioral Health Clinic Coordinated Services by:

- Signing the "Behavior Health Clinic/Rehabilitation Services, Authorization for Services" form within 72 hours of the member's admission to the program for services and prior to the start of treatment. **If an Initial Service Plan is created on day of intake then a 72 hour authorization form is not required. Upon initiation of the Initial Service Plan, the "Behavior Health Clinic/Rehabilitation Services, and Authorization for Services" form is no longer in effect since it is no longer necessary.** This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all Behavioral Health Clinic Services until the development and initiation of the Initial Service Plan. The initial service plan must include all information that is required on the 72-hour authorization form.

For members receiving *Coordinated Care*, the following is required:

- Development of the Initial Service Plan within seven days of the initial admission and intake
- Development of the Master Service Plan within 30 days of the initial admission and intake
- Review and re-evaluation of the service plan at a minimum every 90 days, or sooner if dictated by the member's needs.

If any Behavioral Health Clinic Services occur outside the time frames of these forms which authorize services, the services provided are not billable.

502.8 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 800 (A), General Administration*, of the Provider Manual and are subject to review by state and federal auditors.

502.9 CLINIC PROVIDER REVIEWS

The primary means of monitoring the quality of Clinic services is through provider reviews conducted by OHFLAC and the contracted agent as determined by BMS by a defined cycle. The contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site Clinic provider reviews and/or desk reviews may be conducted by OHFLAC and/or the Contracted Agent in follow up to Incident

Management Reports, complaint data, Plan of Corrections, etc. Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the Clinic provider. If potential disallowances are identified, the Clinic provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the Clinic provider and issue a final report to the Clinic Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Clinic Services. A cover letter to the Clinic provider's Executive Director will outline the following options to effectuate repayment:

(1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

(2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or

(3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments. If the Clinic provider disagrees with the final report, the Clinic provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Common Chapter 800, (A) General Administration* of the West Virginia Medicaid Provider Manual. The Clinic provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the Contracted Agent review, then the Clinic Provider will receive a final letter and a final report from BMS.

Plan of Correction

In addition to the draft exit report sent to the Clinic providers, the Contracted Agent will also send a draft Plan of Correction (POC) electronically. Clinic providers are required to complete the POC and electronically submit a POC to the Contracted Agent for approval within 30 calendar days of receipt of the draft POC from the Contracted Agent. BMS may place a hold on claims if an approved POC is not received by the Contracted Agent within the specified time frame. The POC must include the following:

1.) How the deficient practice for the services cited in the deficiency will be corrected and what system will be put into place to prevent recurrence of the deficient practice;

2.) How the provider will monitor to assure future compliance and who will be responsible for the monitoring;

3.) The date the Plan of Correction will be completed; and

4.) Any provider-specific training requests related to the deficiencies

502.10 TRAINING AND TECHNICAL ASSISTANCE

The Contracted Agent develops and conducts training for Clinic providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

502.11 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning, documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid Members records within one business day of the request.
- Provider must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, Behavioral Health Clinic Service providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 800 (A), General Administration of the Provider Manual.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.

502.12 FOCUSED AND COORDINATED CARE SERVICES

The Bureau of Medical Services expects that each member will receive the type and amount of behavioral health service(s) necessary to ameliorate and stabilize the behavioral health disorder(s) defining medical necessity for services. The BMS has established two levels of behavioral health treatment, with similar but somewhat differing credentialing and documentation requirements. Assessment services are not included within either category but are considered necessary to establish medical necessity for a particular service or level of care.

Focused Care: Members receiving focused services have been determined to have a behavioral health disorder which may be addressed through the provision of low frequency (generally a maximum of once per week, ranging as rarely as once each six months) professional treatment services. Services are provided by a behavioral health professional with at minimum a master's degree in a behavioral health service field, excluding Mental Health Assessment by a Non-Physician. The treatment team consists of the professional and the member and/or member's designated legal representative who together establish a treatment strategy which is documented in the member's record. The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services:

- Medical office services (billed as E/M codes);
- Professional Individual therapy or
- Professional Group therapy
- Assessment and Screening codes

The treatment strategy must relate directly to the behavioral health condition(s) identified as being medically necessary to treat. Documentation of on-going therapeutic and/or medication management contacts must relate directly to the treatment strategy.

Coordinated Care: Members requiring coordinated care are those with severe and/or chronic behavioral health conditions that necessitate a team approach to providing medically necessary care. The treatment is usually provided on a more intensive basis, several times a week if not daily. A full range of individuals may be employed in providing care, ranging from paraprofessionals through psychiatrists. The treatment team consists of the personnel involved in providing the care and includes the member and the member's guardian if any. The member is likely to have a case manager, who is responsible for coordinating and facilitating care.

Documentation consists of a comprehensive service plan. When the member enters the service, an initial plan is developed which dictates care until the interdisciplinary team can meet. An initial plan must be completed within seven days. Those services that are time-limited and of high intensity may require an initial plan immediately upon admission that is then adapted as the member moves through levels of care. Services that are projected to be of unlimited or extended duration are expected to include development of a master service plan within 30 days that describes specific objectives to be achieved during the course of treatment, stated in observable and/or measureable terms. The master service plan must address integration and coordination of various entities and programs providing services to the member. On-going

documentation must reflect the team's ability to communicate issues of concern, member progress and barriers to treatment.

Services falling under Coordinated Care may include but are not limited to the following:

- Assertive Community Treatment
- Professional Individual Therapy
- Professional Group Therapy
- Crisis Stabilization and detoxification services
- Targeted Case Management
- Comprehensive Community Support Services
- Basic Living Skills
- Intensive Service Programs
- Supportive Counseling
- Residential Care for Children and Youth
- Emergency Shelter Care
- Day Treatment

502.13 TELEHEALTH SERVICES

The West Virginia Bureau for Medical Services encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid Members. To utilize Telehealth providers will need to document that the service was rendered under that modality. When filing a claim the Provider will bill the service code with a GT Modifier. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate.

- Minimum equipment standards are transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used as long as the software is HIPAA Compliant and abides by a federal code pertaining to Telehealth.

- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT or HCPCS codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.

- The provider at the distant site is responsible to maintain standards of care within the identified scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- The provider must have an appropriately trained employee of the facility available in the building at all Telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation that involves patient management.
- The health care agency or entity that has the ultimate responsibility for the care of the patient must be licensed in the State of West Virginia and enrolled as a WV Medicaid provider. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within this manual.
- Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider, a contracted employee, or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a participant shall ensure that any written information is provided to the participant in a form and manner which the participant can understand using reasonable accommodations when necessary.
- Participant's consent to receive treatment via telehealth shall be obtained, and may be included in the participant's initial general consent for treatment.
- If the participant (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.

  The health care practitioner who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:

  - The right to withdraw at any time.
  - A description of the risks, benefits and consequences of telemedicine
  - Application of all existing confidentiality protections
  - Right of the patient to documentation regarding all transmitted medical information

- Prohibition of dissemination of any patient images or information to other entities without further written consent.

- BMS Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a Provider and a participant.

502.14 DOCUMENTATION

The WV Bureau for Medical Services recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system. When services require documentation the Bureau will accept both types of documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice.

502.15 ASSESSMENT SERVICES

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff credentialed by the internal credentialing policies and procedures of the agency. Assessment services are designed to make determinations concerning the mental, physical and functional status of the member. Those identified as being in the Foster Care system should receive assessment as rapidly as possible.

502.15.1 MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN

Procedure Code: **H0031**
Service Unit: Event-
Telehealth: Available
Service Limits: Maximum of (four) 4 per year for members with complex behavioral healthcare needs (Coordinated Care) and (two) 2 per year per member with relatively simple behavioral healthcare needs (Focused Care). The provider may request more units if a critical treatment juncture arises, however not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services. Change of payer source does not justify H0031.

Staff Credentials: Staff must have a minimum of a master's degree, bachelor's degree in a field of human services, or a registered nurse. Supervision and oversight by an individual with a minimum of a master's degree is required (See Clinical Supervision). Staff must be properly credentialed by the agency's internal credentialing committee.

Definition: Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

Approved Causes For Utilization:

1. Intake/Initial evaluation;
2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral Health condition to a lesser level of care.
3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment;
   The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services.
5. No one under the age of three (3) will have a H0031 conducted on them. The Medicaid member under the age of the 3 should be referred to the Birth to Three Program.

Documentation:

1. Initial/intake (may include use of standardized screening tools):
   A. Demographic data (name, age, date of birth, etc.);
   B. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
   C. Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
   D. History of behavioral health and health treatment (recent and remote);
   E. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
   F. Medical problems and medications currently prescribed;
   G. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
   H. Analysis of available social support system at present;
   I. Mental status examination;
   J. Recommended treatment (initial);

K. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and
L. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.
M. Efficacy of and compliance with past treatment. (If past treatment is reported)
N. Past treatment history and medication compliance (If past treatment is reported)

2. Re-assessment:
   A. Date of last comprehensive assessment;
   B. Current demographic data;
   C. Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such).
   D. Changes in situation, behavior, functioning since prior evaluation;
   E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
   F. Mental status examination;
   G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
   H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and
   I. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.

Note: H0031, T1023 HE, and **90791 or 90792** are not to be billed at the same initial intake or re-assessment unless the **H0031** is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using **90791 or 90792**.

502.15.2 PSYCHOLOGICAL TESTING WITH INTERPRETATION AND REPORT

Procedure Code: 96101
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology or a Supervised Psychologist under supervision of a Board approved Supervisor.

Definition: Evaluation by a psychologist including psychological testing with interpretation and report. Psychological testing includes, but is not limited to, standard psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. Academic

assessment and assessment required to determine the needs, strengths, functioning level(s), mental status and/or social history of an individual are also included. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations. 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously interpreted, completed and reported technician-and computer-administered tests.

Note: Interpretation and report of technician and computer-based tests may not be completed using this service. It is intended for the integration of previously interpreted and reported technician and computer-based tests.

Documentation: Documentation/Report must contain the following and be completed 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Time Spent (Start/Stop Times)
- Signature with Credentials
- Purpose of Evaluation
- Documentation that Medicaid Member was present for the evaluation
- Report must contain results (score and category) of the administered tests/evaluations
- Report must contain interpretation of the administered tests/evaluations
- Report must contain documentation of mental status exam
- Report must contain a rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology.
- Report must contain recommendations consistent with the findings of administered test/evaluation

Service Exclusions:

- Psychometrician/Technician Work
- Computer - Scoring
- Self-Administered Assessments
- Computer - Interpretation

502.15.3 PSYCHIATRIC DIAGNOSTIC EVALUATION (NO MEDICAL SERVICES)

Procedure Code: 90791
Service Unit: Event (completed evaluation)

Service Limits: Two events per year
Telehealth: Available

Prior Authorization: Refer Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by Board approved Supervisor, a Physician, or a Physician Extender.

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Documentation: Documentation must contain the following and must be completed within 15 calendar days of the date of service.

- Date of Service
- Location of Service
- Psychiatrist's/Psychologist's signature with credentials
- Presenting Problem
- Purpose of the Evaluation
- History of Medicaid Member's presenting illness
- Duration and Frequency of Symptoms
- Current and Past Medication efficacy and compliance
- Psychiatric History up to Present Day
- Medical History related to Behavioral Health Condition
- Mental Status Exam
- Members diagnosis per current DSM or ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis

Appropriate recommendations consistent with the findings of the evaluation.

502.15.4 PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES (this includes prescribing of medications)*

Procedure Code: 90792
Service Unit: Event (completed evaluation)
Service Limits: Two events per year
Telehealth: Yes, as defined in Telehealth section.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be completed by a physician or a physician extender.

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Documentation: Documentation must contain the following and be completed in 15 calendar days of the date of service.

- Date of Service
- Location of Service
- Psychiatrist's signature with credentials
- Documentation that Medicaid Member was present for the evaluation
- Documentation that Medical Evaluation was completed
- Purpose of the Evaluation
- Presenting Problem
- History of the Medicaid Member's presenting illness
- Duration and Frequency of symptoms
- Current and Past Medication including efficacy and compliance
- Psychiatric history up to present day
- Medical History related to behavioral health condition
- Documentation of Mental Status Exam
- Medicaid Member's diagnosis per current DSM and ICD Methodology
- Medicaid Member's prognosis and rationale
- Appropriate recommendations consistent with the findings of the evaluation

502.15.5 SCREENING BY LICENSED PSYCHOLOGIST

Procedure Code: T1023 HE
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One event every six months

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia Licensed psychologist or Supervised Psychologist in good standing with WV Board of Examiners of Psychology.

Definition: This is a screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol. Procedure codes 96101 or 90791 must be used when a more in-depth assessment is indicated.
Documentation: Documentation must contain the following and be completed in 15 calendar days from the date of service

- Date of Service
- Location of Service
- Purpose of Evaluation
- Start/Stop Times
- Practitioner signature and credentials
- Appropriate recommendations based on clinical data gathered in the evaluation

502.15.6 DEVELOPMENTAL TESTING: LIMITED

Procedure Code: 96110
Service Unit: Event (completed interpretation and report)
Telehealth: Not Available
Service Limits: All units must be prior authorized

Payment Limits: This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96101) has been billed in the last six months.

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology, a Psychologist who is under the supervision of a Board approved Supervisor, a physician or physician extender.

Definition: This is limited to developmental testing (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report**.**

Documentation: Documentation must contain the following and be completed in 15 calendar days of the date of service.

- Date of Service
- Location of Service
- Purpose of Evaluation
- Time Spent (start/stop times)

- Signature with credentials
- Documentation that the member was present for the evaluation
- Documentation must contain the results (scores and category) of the administered tests/evaluations
- Documentation must contain the documentation of the mental status exam
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD Methodology
- Recommendations consistent with the findings of the administered tests/evaluations.

502.16 SERVICE PLANNING REQUIREMENTS:

Coordinated Care Services:

Service planning and consultation is available only in the Coordinated Care model of service provision. Service planning codes cannot be billed when the development of a service plan is an integral aspect of the service being provided (for example, Community Psychiatric Supportive Treatment). Service planning is to be conducted when multiple programs and services need to be coordinated by a team representative of the differing agencies and provider groups providing care to the member.

All members receiving coordinated care must have a master service plan. The Agency may choose to create one plan that is modified as the individual moves through a service, or may choose to create an initial service plan followed by a master service plan. Agencies with services with shorter lengths of stay may choose the first option if the length of stay is predicted to be less than thirty days. The initial service plan must be completed within 7 days of admission to a service. The plan must be completed by the primary clinician and the member and/or member's guardian.

The initial service plan must be completed within 7 days of admission to a service. The plan must be completed by the primary clinician and the member and/or member's guardian.

Development of the initial plan without the entire interdisciplinary team is not a billable service (see Service Plan Development for clarification and description of exceptions). The initial plan of service describes the services and/or supports the member is to receive until the assessment process is complete and the master plan of service is developed. This initial plan shall consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed;
- A listing of immediate interventions to be provided along with objectives for the interventions;
- A date for development of a master plan of services. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 days from

the date of the signing of the initial plan. If a program is an intensive service, the master plan must be completed within 7 days; and
- The signature of the member and/or DLR, intake worker, physician and other persons participating in the development of the initial plan.

The Master Service Plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessment(s) during the treatment process.

The Master Plan is developed within 30 days of admission and must include:

- Date of development of the plan;
- Participants in the development of the plan;
- A statement or statements of the goal(s) of services in general terms;
- A listing of specific objectives that the service providers and the member hope to achieve or complete;
- The measures to be used in tracking progress toward achievement of an objective;
- The technique(s) and/or services (intervention) to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives; and
- Discharge Criteria
- A date for review of the plan, timed in consideration of the expected duration of the program or service.
- Start and Stop Times
- Credentials

It is expected that objectives be specific, measureable, realistic and capable of being achieved in the time available in the projected duration of the program or service.

Service plans must be flexible documents that are modified by the team as necessary and clinically appropriate. Service plans must be revisited at critical treatment junctures including changes in level of service to more intensive or less intensive types of care. When an intervention proves to be ineffective the service plan must reflect consideration by the team of changes in the intervention strategy.

502.16.1 MENTAL HEALTH SERVICE PLAN DEVELOPMENT

Procedure Code: H0032
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 16 units per 90 day period If Medicaid Member is in *Focused Care* H0032 cannot be billed.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: An individual service plan is required for all members receiving services through *Coordinated Care.* The treatment team consists of the member and/or guardian, and/or

member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers must be invited to participate in the service planning session. All members of the team must receive adequate notice of the treatment team meeting. If a member of the team does not come, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances. A physician extender may serve on the committee in place of the physician.

An Initial Service Plan is developed based on intake information within seven days of intake; a Master Service Plan is developed within 30 days of intake and must be updated at least every 90 days. It must be updated more frequently, at critical treatment junctures, if necessitated by the member's needs.

All service plans (including updates) must be reviewed, signed, and approved by a physician within 72 hours of the service plan meeting and prior to implementing services.

The physician or designated physician extender must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency
- Have a diagnosis of major psychosis or major affective disorder
- Have an I/D Diagnosis
- Have an Autism Diagnosis
- Have major medical problems in addition to major psychosis and medications
- The presence of the physician or physician extender has been specifically requested by the case manager or the member.

The case manager is responsible for the scheduling and coordination of treatment team meetings, monitoring the implementation of the service plan, and for initiating treatment team meetings as the needs of the member dictate. Justification for the presence of each staff person participating in the meeting is the responsibility of the case manager. Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process. Service planning meetings must be scheduled at times and places that facilitate the inclusion of the member. The agency providing services to the member may bill for participation by any of their staff necessary for the service planning process. Participation by staff from other agencies is not billable by the agency coordinating the service planning session. Participation by family members is not billable. It is important to remember that, although coordination of the service planning process is the responsibility of the case manager, development of the service plan is the responsibility of the treatment team.

Providers must make the proper distinction between service planning and other activities related to case management for the member. The case manager may be involved in the development of individual program plans, such as residential plans, day treatment plans, work training plan educational plans, etc. as called for by the member's Master Service Plan. These types of

activities may constitute billable time for case management services; ***however, when the case manager participates in a treatment team meeting he/she must bill Mental Health Service Plan Development rather than Targeted Case Management.***

Individual program plans for Day Treatment and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services.

Mental Health Service Plan Development reimburses for team member participation. A written service plan is a product of that process and serves as substantiation that the process took place.

Documentation: The following documentation is required for substantiation of Mental Health Service Plan Development:

- A service plan signature page is required. This document is to be placed in the member's clinical record along with the completed service plan or service plan update.
  - There must be signatures of all participating members of the treatment team (including the member, their guardian, or the member's requested representative).
  - All signatures must be original, must include the title and credentials of the individual, must be dated by the treatment team member, and must include the actual time spent providing the service by listing the start-and-stop times of their participation. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process.
- If a staff person from another agency participates in the service planning session, he/she must:
  - Meet the previously listed requirements of the service plan signature page. This includes signing the signature page along with listing the agency they are representing.
  - Write an activity note (which must be included in **their** agency's clinical record) that states their purpose for participating in the meeting, their signature and credentials, the location of the session, date of session, and the actual time spent participating in the session by listing their start-and-stop times.

Documentation must contain the physician's signature or physician extender on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

If the member, their guardian, or the member's requested representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within 7 calendar days by the member or their guardian. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.

502.16.2 PHYSICIAN COORDINATED CARE OVERSIGHT SERVICES

Procedure Code: G9008
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 2 units per 90 days

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by physician or physician extender.
Definition: These are activities performed by a physician or physician extender directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Also, refer to Mental Health Service Plan Development.

Documentation: Documentation must contain the physician or physician extender's signature, date of signature, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

502.16.3 CASE CONSULTATION

Procedure Code: 90887
Service Unit: Event
Telehealth: Available
Service Limits: 1 unit per 90 days

Prior Authorization: Refer to Utilization Management Guidelines

Definition: A Case Consultation Service is an interpretation or explanation of results of psychiatric, and other medical examinations and procedures through the requesting clinician to family or other responsible persons.

These are services provided at the request of a professional requiring the opinion, recommendation, suggestion and/or expertise of another professional for a specific purpose regarding services and/or activities of a member relevant to the particular area of expertise of the consulting professional. The consulting professional must be licensed or certified in the needed area of expertise. Case Consultation may not be used during service planning. The member's case manager cannot be a case consultant. Professional staff persons who participated in the current member's service plan within the current 90 day period, or were directed to provide treatment, cannot bill for case consultation.

Only the consulting professional's time may be billed for this service. Any other professional(s) involved in the case consultation may not bill case consultation for their time. The consulting professional whose services are being billed must currently be an enrolled Medicaid provider if he/she is not an employee (either directly or under contract) of the agency seeking consultation.

Documentation: The consulting professional must document a summary of the consultation that includes: purpose, activities/services discussed, recommendations with desired outcomes, the relationship of the consultation to a specific objective(s) in the service plan, date of service, location, signature and credentials of the consulting professional, and the actual time spent providing the service by listing the start-and-stop times of the consultation.

502.17 SUPPORTIVE SERVICES

502.17.1 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, INDIVIDUAL

Procedure Code: H0004HO
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 60 units per year

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Definition: Behavioral Health Counseling, Professional, Individual, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service.

Often by necessity, Behavioral Health Counseling of children will involve work with parents as the agent of change in maladaptive behavior of children. Structured behavior therapies designed to provide parents with therapeutic tools to control and modify inappropriate behavior and promote adaptive coping behaviors are considered to be appropriate use of this service.

Documentation: Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the

service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal and/or objective on the Plan. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

502.17.2 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, GROUP

Procedure Code: H0004 HO HQ
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 50 units per year

Payment Limits: Behavioral Health Counseling, Professional, Group sessions are limited in size to a maximum of 12 persons per group session.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Professional, Group, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Definition: Behavioral Health Counseling, Professional, Group, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourages personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member in a group setting.

Any therapeutic interventions applied must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting

bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Group, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

Documentation: Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal on the Plan. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

502.17.3 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, INDIVIDUAL

Procedure Code: H0004
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

Definition: Behavioral Health Counseling, Supportive, Individual is a face-to-face intervention provided to a member receiving coordinated care. It must directly support another Behavioral Health service to meet service definition and medical necessity. The supportive intervention is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Individual, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Service Description:

Supportive counseling should:

1) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
2) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Documentation: There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the member's response to the supportive intervention including any improvement or exacerbation of symptoms.

502.17.4 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, GROUP

Procedure Code: H0004HQ
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Payment Limits: Behavioral Health Counseling, Supportive, Group sessions are limited in size to a maximum of 12 persons per group session.

Prior Authorization: Refer Utilization Management Guidelines.

Staff Credentials: All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

Definition: Behavioral Health Counseling, Supportive, Group is a face-to-face coordinated care intervention that is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive,

Group, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Service Description:

Supportive counseling should:

1.) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or

2.) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Documentation: There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the member's response to the supportive intervention including any improvement or exacerbation of symptoms.

502.18 GENERAL MEDICATION SERVICES

General medication services assist a Medicaid member in accessing behavioral medication or medication services. (Methadone administration or case management is not covered.)

502.18.1 COMPREHENSIVE MEDICATION SERVICES: MENTAL HEALTH

Procedure Code: H2010
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Payment Limits: This service includes all physician and nurse oversight; therefore, neither Community Psychiatric Support Treatment (procedure code H0036), Pharmacologic Management (E&M Codes), nor any other physician code can be billed on the same day as Comprehensive Medication Services; Mental Health.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Physician or Physician Extender

Definition: Comprehensive Medication Services; Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy. These services include obtaining the sample for necessary blood work and the laboratory results for a member by a registered nurse and subsequent evaluation of the results by the physician and/or physician extender as necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. This is a physician directed service, a physician or physician extender must be on site and available for direct service as needed. Members may be served individually or by a group/clinic model. Methadone is **not** a covered medication.

Members receiving this service are not precluded from receiving other Behavioral Health Clinic Services on the same day (except for those indicated in this service's definition or "Payment Limits") as long as the actual time frames do not overlap.

Documentation: Documentation must contain a written note of the assessment results as completed by the registered nurse, and other laboratory results, and current psychotropic medication dosage with authorized pharmacy name. The documentation must include: place of service, start/stop time and date of service, and signature of qualified staff providing the service.

502.18.2 NON-METHADONE MEDICATION ASSISTED TREATMENT

Non-Methadone Medication Assisted Treatment Guidelines:

West Virginia Medicaid covers non-Methadone Medication Assisted Treatment Services under the following circumstances:

- Individuals seeking opioid addiction treatment for Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician as specified below, before beginning medication assisted treatment.
- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.
- All physicians agree to adhere to the Coordination of Care Agreement (*See Attachment A in Appendix*) which will be signed by the member, the treating physician and the treating therapist.
- Each member receiving non-methadone medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.

- The agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.

Physician Requirements: The physician responsible for prescribing and monitoring the member's treatment must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider.

Therapy Services: Therapy for Non-Methadone Assisted Treatment Patients is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service **(See Program Guidelines for Professional Therapy Requirements).**

Any therapeutic intervention applied must be performed by a minimum of a Master's Level Therapist using the generally accepted practice of therapies recognized by national accrediting bodies of:

- Psychology plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Psychiatry plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Counseling plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Social work plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions

Physician and Professional Therapy services will be provided for individuals utilizing Buprenorphine®, Suboxone® strips or Vivitrol®. Agencies should be aware that West Virginia law forbids the use of Buprenorphine/Naltrexone in tablet form for the treatment of substance use disorders.

Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic interventions. The plan must also include a schedule detailing the frequency for which therapy services are to be provided.

A member receiving focused care (Physician and Professional Therapy only) will require a treatment strategy in lieu of a Master Service Plan.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the objectives utilizing individual therapeutic interventions. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Program Guidelines:

Note: These are the minimum requirements that are set forth in this manual. Physicians and/or agencies may have more stringent guidelines set forth in their internal policy.

Phase 1: Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of professional therapeutic services per month. The four hours must contain a **minimum** of one (1) hour individual professional therapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

Phase 2: Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of professional therapeutic services per month individual, family, or group. Frequency of therapeutic services may increase based upon medical necessity.

Drug Screens: A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2. A record of the results of these screens must be maintained in the member's record. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

Instructions for non-compliance with treatment:
Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as: two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician's discretion. The physician and/or treatment program has the option to allow the patient to reapply to the program

after 30 days with proven participation in professional therapies. With three violations within six months, the physician will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.

Titration Policy: Titration due to non-compliance is per Physician order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Non-Methadone Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise. The Physician must work with another physician that has a DEA-X. The physician taking responsibility for prescribing and monitoring the member's treatment while the primary physician is unavailable must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed, board certified and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider so that treatment is not interrupted for any reason for Medicaid Members participating in this service. If a physician fails to have a plan in place **a hold will be placed on all Rx authorizations**. At no time is a Nurse Practitioner or a Physician's Assistant to prescribe Suboxone®.

502.19 COMPREHENSIVE PROGRAMS OF SERVICES

Comprehensive services are all-inclusive and may have only a few services which can be billed separately.

502.19.1 DAY TREATMENT

Procedure Code: H2012
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Payment Limits: Day Treatment services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Clinic Service.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Behavioral Health Clinic Day Treatment is a program only for Medicaid members with Intellectually/Developmentally Disabled (I/DD) diagnoses. It is a structured program of skill building instruction and supervision designed to assist members in achieving greater independence (and/or employment**)** in activities of daily living. The programming must be in accordance with each member's needs and interests as reflected in his/her Master Service Plan.

Programs are to include positive behavior support interventions that assist members in reducing challenging behaviors and replacing them with socially valuable, adaptive behaviors and skills. If specific written programs for either skill building or behavior reduction are implemented that require one-to-one staff to member ratio, Therapeutic Behavioral Services – Implementation (procedure code H2019) would be utilized in lieu of Day Treatment.

Day Treatment Services for adults have a maximum staff-to-member ratio of one staff person per five members. They must be available for five days a week for a minimum of four hours each day.

For children under age five, the maximum ratio is one staff per four children. Day Treatment Services for children under the age of five must not be utilized to provide therapeutic activities for more than four hours per day and no more than four days per week.

Day Treatment Services must only be provided at a site listed on the provider's behavioral health clinic provider license. **Activities provided for the purpose of leisure or recreations are not billable services.**

Day Treatment Services include activities occurring in a therapeutic environment designed to increase the members' skills in specific areas. These activities may consist of small group activities using training modules or structured developmental exercises which present the opportunities for members to practice and use developing skills, or participate in member meetings designed to develop social skills. The intensity, frequency, and type of Day Treatment activities must be appropriate to the age and functional level of the member.

Progress on all objectives must be reviewed at 90 day intervals. Any objective that results in no progress after two consecutive 90 day intervals must be discontinued or modified. Areas of intervention may include but are not limited to the following:

- Self-care skills
- Emergency skills
- Mobility skills
- Nutritional skills
- Social skills
- Communication and speech instruction
- Carryover of physical and/or occupational therapy
- Interpersonal skills instruction

- Functional community skills (such as recognizing emergency and other public signs, money management skills, travel training, etc.)
- Volunteering in community service settings
- Citizenship, rights and responsibilities, self-advocacy, etc.
- Other services necessary for a member to participate in the community settings of his/her choice

Program Staff Requirements:

- The Day Treatment program supervisor must meet one of the educational criteria along with the training and experience criteria listed below:
  - Education Criteria (one of the educational criteria must be met):
    - Licensed Psychologist (or Masters level psychologist under supervision for licensure)
    - Licensed Professional Counselor
    - Licensed Certified Social Worker
    - Licensed Social Worker with a minimum of a Bachelor's degree
    - Registered Nurse
    - Masters or Bachelor's level in education with a specialization to a disability group and teaching certification
    - Occupational/recreational or physical therapist with appropriate state certification and licensure
    - Certified Addiction Counselor with minimum of a bachelor degree
    - Master's degree in a human services field with 20 hours verified of training specific to the target population served
    - Bachelor's level degree in a human services field with at least one year of specific experience providing services to individuals with mental retardation and/or developmental disabilities under the supervision of a qualified staff person
  - Training Criteria
    - Each qualified staff person must have verified training, experience, and skills specific to the targeted population served by the Day Treatment Program
  - Experience Criteria
    - All Bachelor level staff are required to obtain 15 hours every two years of continued education relevant to the targeted population served or the provision of Day Treatment Services

- Staff with a Bachelor's degree in a human service field that does not specifically provide training in developmental disabilities services must meet one of the three following criteria:
  - Completion of specific courses relating to developmental disabilities
  - Completion of staff development in-service or classes relating to developmental disabilities

- Completion of 15 hours every two years of continuing education relating to developmental disabilities.

- Paraprofessional staff must have, at a minimum, the following qualifications:
  - Be at least 18 years old
  - A high school diploma or Graduate Equivalent Degree
  - Be currently certified in Standard First Aid and Adult/Child Cardiopulmonary Resuscitation
  - Successfully completed Behavioral Health agency training in all of the following criteria:
    - Various aspects of developmental disabilities
    - Instructional techniques necessary to achieve objectives of individual's program plans
    - Health related issues
    - Recognition of abuse and neglect
    - Individuals' rights and confidentiality
    - Awareness of, and sensitivity to, family and individual's needs
    - Non-aversive behavior intervention techniques for those providers who are implementing behavior support and intervention plans

The Behavioral Health Clinic must maintain documentation of training and qualifications.

Documentation:

- Documentation must contain a daily summary of Day Treatment Services that includes the total time in attendance at the Day Treatment Program by listing the start and stop times of each member's attendance, the place of service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary. This documentation is not required to be stored in the main clinical record, but must be maintained and be available for review.
- Documentation must also include an activity note that describes each separate service/activity provided and the relationship of the service to objectives in the service plan. This includes the signature of staff providing the service along with their credentials, place of service, date of service, and actual time spent providing the service by listing the start and stop times. **Note: All treatment objectives provided in the Day Treatment Program must be included on the member's Master Service Plan (or 90 day update).**
- There must be a daily attendance roster listing those members and staff who participate in each ratio. The roster must be signed (with credential initials) and dated by staff that provided the service. This daily attendance roster must not be stored in the main clinical record, but must be maintained and be available for review.
- There must be monthly notes that summarize progress on the objectives specified in the individual member's service plan or Day Treatment Plan. This documentation must be reviewed at 90 day intervals. The review summaries must be placed in the member's master clinical record. Any objective that results in no progress or desired changes after two consecutive 90 day periods must be discontinued or modified.

Day Treatment Program Certification Process:

Behavioral Health Clinic providers must obtain approval from BMS to provide Day Treatment Services and to bill the West Virginia Medicaid Program for such services. Providers must complete and send the Day Treatment Program Certification form to BMS.

Any changes from an approved original certification must be submitted with corresponding rationale for the changes. A Day Treatment Program must recertify every 2 years. This submission must include a summary of utilization information for the 2 years. Specific content is listed on the Application for Day Treatment Program Certification used by BMS.

502.20 CRISIS SERVICES

Crisis services must be provided at a location licensed to the clinic.

502.20.1 CRISIS INTERVENTION

Procedure Code: H2011
Service Unit: 15 minutes- 16 units per 30 days
Telehealth: Not Available
Service Limits: Refer to Utilization Management Guidelines.

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Specific documented training on crisis intervention

Definition: Crisis Intervention is an unscheduled, direct, face-to-face intervention with a member in need of psychiatric interventions in order to resolve a crisis related to acute or severe psychiatric signs and symptoms. Depending on the specific type of crisis, an array of treatment modalities is available. These include, but are not limited to, individual intervention and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation, stabilize and create a plan as quickly as possible. This service is not intended for use as an emergency response to situations such as members running out of medication or housing problems. Any such activities will be considered inappropriate for billing of this service by the provider.

Documentation: Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

A physician, physician extender, supervised psychologist or licensed psychologist must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow up and whether the treatment plan is to be modified or maintained, the signature and credentials of the physician, physician extender, supervised psychologist or licensed psychologist and the date of service. The signature will serve as the order to perform

the service. If a supervised psychologist is utilized to provide approval for this service, the supervised psychologist must have completed an appropriate training in crisis intervention and systematic de-escalation.

Providers must maintain a permanent clinical record for all members of this service in a manner consistent with applicable licensing regulations.

Exclusions

Listed below are activities that are excluded from being performed through the Crisis Intervention Service Code

- Response to a Domestic Violence Situation
- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting for Transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

502.20.2 COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

Procedure Code: H0036
Service Unit: 15 minutes
Telehealth: Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person
Service Limits: 288 units per six months

Payment Limits: No payment will be made for any other Behavioral Health Clinic Services, except for Targeted Case Management (procedure code T1017). Billing for Community Psychiatric Supportive Treatment cannot exceed 48 units in a 24 hour period (midnight to midnight) and must be utilized on consecutive days.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Community Psychiatric Supportive Treatment is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs and symptoms. (If a Medicaid member experiences more than one crisis, each crisis is considered a separate crisis episode). This physician driven service is intended for persons whose condition can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

Due to the comprehensive nature of this service, no other services (other than Targeted Case Management) may be reimbursed when Community Psychiatric Supportive Treatment is on-

going. These services are not intended for use as an emergency response to situations such as members running out of medication, or loss of housing. Any such activities will be considered as non-reimbursable activities. Since this service is intended to address an episode, it must be rendered on consecutive days of service. Community Psychiatric Supportive Treatment cannot be rendered on alternate days such as Tuesday and Thursday or only on Mondays, Wednesdays, and Fridays; with other days of non-service (such as holidays or weekends) or other intervening services interrupting the episode. Community Psychiatric Supportive Treatment is an acute and short-term service.

Community Psychiatric Supportive Treatment Programs must be available seven days a week to anyone who meets the admission criteria. Availability may include mornings, afternoons, evenings, etc. There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, One staff must have at least high school degree or equivalency, trained in systematic de-escalation, and must have training related to the targeted population being treated (i.e. substance abuse, mental health). The other staff must have an LPN or higher degree in the medical field (See Definitions for further clarifications). Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to assure that each member receives appropriate individual attention, as well as assure the safety and welfare of all members.

The program must have access to a psychiatrist/physician to provide psychiatric evaluations, medication orders at all times.

Much of the structured, staff-directed activity or face-to-face activity which has been documented in an activity note can be considered billable time. Some examples of billable versus non-billable time are as follows:

- Billable activities:

  - Structured, staff-directed activities such as therapies and counseling
  - Time spent by staff in the process of interviewing/assessing members whether for social history, discharge planning, psychological reports, etc.
  - Time spent in treatment team meetings or staff consultation
  - Time spent by staff monitoring one member when specifically ordered by the physician/psychiatrist for reasons of clinical necessity (The physician/psychiatrist's order must state the frequency and duration of the time to be spent monitoring.)
  - Routine observation/monitoring by staff ordered by physician/psychiatrist limited to 10 minutes per hour (can include member's sleep, meal, grooming time). Routine observation time cannot exceed two hours per day. The physician must document the need for the observation as related to the Medicaid Member's qualifying behavioral health condition/crisis episode.

- Non-billable activities:

  - Activity which is recreation or leisure in nature, such as basketball, exercise, reading

newspaper, watching television and or videos

- Social activity such as talking with other members, visiting with family members or significant others, releasing the member from the program on pass
- Time in which the member is sleeping, eating, grooming (except as outlined above).

The following elements are required components of Community Psychiatric Supportive Treatment:

- Comprehensive Psychiatric Evaluation at intake to contain documentation of:
  A. Reason for admission/presenting problems: Purpose of evaluation is to assess symptoms in order to determine need for crisis stabilization services, determine need for changes to medication regimen, and develops an initial plan of care as appropriate.
  B. Presenting problems/reason for the evaluation including list of any collateral interviews conducted
  C. History and description of present illness
  D. Past psychiatric history including description of any past suicidal or homicidal behavior or threats
  E. History of alcohol and other substance use including longest period of sobriety, history of prior treatment attempts, and medical risks associated with detoxification as appropriate
  F. General medical history including list of current medications, current medical providers, and past treatment attempts (may be completed by ancillary staff person)
  G. Developmental, psychosocial and sociocultural history
  H. Occupational and military history (may be completed by ancillary staff person)
  I. Legal history (may be completed by ancillary staff person)
  J. Family history (may be completed by ancillary staff person)
  K. Review of systems (sleep, appetite, pain levels, other systems directly linked to the patient's psychiatric symptoms)
  L. Focused Physical examination including appearance and vital signs, musculoskeletal review of gait and station and description of any specific physical anomalies and allergies
  M. Mental status examination including assessment of insight, judgment, and general cognitive functioning
  N. Assessment of daily functionality and ADLs (may be completed by ancillary staff person)
  O. Diagnostic conclusions and prognosis
  P. Treatment recommendations including clear statement of justification for recommendation for admission to CSU and reasoning for elimination of lesser level of care.
- Daily psychiatric review and examination
- On going psychotropic medication evaluation and administration
- Intensive one-on-one supervision, when ordered by a physician/psychiatrist
- Individual and small group problem solving/support as needed
- Therapeutic activities consistent with the member's readiness, capacities, and the service plan

- Disability-specific interdisciplinary team evaluation and service planning before discharge from Community Psychiatric Supportive Treatment. Discharge service planning must include consideration of the antecedent condition that led to admission to Community Psychiatric Supportive Treatment.
- Psychological/functional evaluations specific to the disability population where appropriate and;
- Family intervention must be made available to the families of members as appropriate Community Psychiatric Supportive Treatment must be provided at a site licensed by WVDHHR for the delivery of Behavioral Health Clinic Services.

ADMISSION AND CONTINUED STAY CRITERIA:

The criteria for prior authorization to for Community Psychiatric Supportive Treatment Services are organized around three primary areas that determine the need for this service:

- Acute Psychiatric signs and symptoms
- Danger to self/others
- Medication management/active drug or alcohol withdrawal

Additionally, criteria for continued stay have been devised so that those members who exceed the service limit but still require Community Psychiatric Supportive Treatment Services can be authorized to continue services.

To receive or continue to receive Community Psychiatric Supportive Treatment Services, the following corresponding criteria must be satisfied.

- **PSYCHIATRIC SIGNS AND SYMPTOMS**

  Admission Criteria (Both criterions must be met)

  – The member is experiencing a crisis due to a mental health condition or impairment in functioning due to acute psychiatric signs and symptoms. The member may be displaying behaviors and/or impairments ranging from impaired abilities in the daily living skills domains to severe disturbances in conduct and emotions. The crisis results in emotional and/or behavioral instability that may be exacerbated by family dysfunction, transient situational disturbance, physical or emotional abuse, failed placement, or other current living situation;

  – The member is in need of a structured, intensive intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the member's needs based on the documented response to prior treatment and/or interventions.

Continued Stay Criteria (One of the three criterions must be met)

- The acute psychiatric signs and symptoms and/or behaviors that necessitated the admission persist at the level documented at admission and the treatments and interventions tried are documented. A modified care plan must be developed which documents treatment methods and projected discharge date based on the change in the care plan.
- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new acute psychiatric symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.
- Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.

- **DANGER TO SELF/OTHERS**

Admission Criteria

- The member is in need of an intensive treatment intervention to prevent hospitalization (e.g. the member engages in self-injurious behavior but not at a level of severity that would require inpatient care, the member is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).

Continued Care Criteria (One of the three criterions must be met)

- Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care
- It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors may be treated safely in the Community Psychiatric Supportive Treatment setting and, a less intensive level of care would not adequately meet the member's needs.

- **MEDICATION MANAGEMENT/ACTIVE DRUG OR ALCOHOL WITHDRAWAL**

Admission Criteria (Either criterion must be met)

- The member is in need of a medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect.
- There is evidence that the member is using drugs that have produced a physical dependency as evidenced by clinically significant withdrawal symptoms which require medical supervision.

Continued Stay Criteria (One of the three criterions must be met)

- Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care
- It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.

- **DOCUMENTATION**

  There must be a permanent clinical record consistent with licensing regulations and agency records/policies for each member-provided Psychiatric Supportive Treatment Service. Items to be included in the clinical record are written orders (for each crisis episode) from the physician/psychiatrist for the Community Psychiatric Supportive Treatment Program, medication orders for each member as indicated, medication administration records when medications are administered, and the member's individualized service plan. See below for Documentation Requirements.

Daily Documentation criteria:

- Number of treatment hours per day
- Summary of the member's status – need for continued CSU
- Member's Service participation
- Symptoms related to the crisis that are being addressed
- If admitted for detox; vitals and use of nationally recognized withdrawal protocol
- Services Provided:

Individual Therapy – notes at a minimum need to contain:

- Addressed specifics of admission criteria to substantiate appropriate level of care
- Substantiation of daily/appropriate treatment services
- Intervention
- Relate back to treatment plan
- Member's response

Group Therapy – notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care
- Substantiation of daily/appropriate treatment services
- Intervention
- Relate back to treatment plan
- Member's response

Family Therapy: notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

Individual Supportive Counseling: notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

Group Supportive Counseling: notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention

- Relate back to treatment plan.
- Member's response.

502.21 BEHAVIOR MANAGEMENT SERVICES

Behavior Management Services are to address the symptoms of the diagnosed behavioral health condition that are negatively impacting the members functioning. These services arise in relation to areas of need identified on the member's service plan. Behavior Management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

502.21.1 THERAPEUTIC BEHAVIORAL SERVICES – DEVELOPMENT

Procedure Code: H2019HO
Service Unit: 15 minutes
Service Limits: All units must be prior authorized
Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: The Behavior Management Specialist must be an individual with a minimum education at the Master's level in psychology, psychiatry, education, social work or counseling This individual's training must have include successful completion of course work or training in the techniques of applied behavior analysis. The Behavior Management Specialist is responsible for all aspects of Behavior Management Services provided by Behavior Management Assistants and must sign all documentation of those services.

The Behavior Management Assistant must be an individual with a minimum education of a bachelor's degree in a human services field **(See definitions for complete listing)** who has been certified by the agency as having training specific to behavior management which is consistent with techniques of applied behavior analysis. Behavior Management Services provided by Behavior Management Assistants are subject to review and approval by the Behavior Management Specialist. A copy of the provider's training program for its Behavioral Health Assistant staff must be retained and filed by the provider. (The Behavior Management Assistant must use the HO modifier when providing Therapeutic Behavioral Services – Development, procedure code H2019HO, since their documentation must be reviewed and signed by the Behavior Management Specialist. Otherwise, the wrong service, Therapeutic Behavioral Services – Implementation, procedure code H2019, would be billed).

Definition: Therapeutic Behavioral Services - Development includes four major components:

- Behavior Assessment
- Plan Development
- Implementation Training
- Data Analysis and Review of the Behavior Management Plan once implementation has begun.

Management services (detailed under procedure code H2019).

Behavior Assessment Component

Behavior Assessment is a process of observation, data collection, behavior and skill assessments, and functional analysis that describes behaviors and the circumstances under which they occur. Prior to the development of the Behavior Management Plan, behavior assessment activities must culminate in the identification of target behavior(s) (those behaviors which the plan proposes to increase, decrease, shape, or eliminate). The target behaviors must be described in specific terms, and they must be stated in terms of an objective, quantifiable measurement. The target behaviors must address symptoms of the diagnosed behavioral health condition that negatively impacts the member's overall functioning. Baseline data (quantified measurements which describe the scope, frequency and duration of the targeted behaviors) must be collected on each target behavior. Baseline data are then reviewed to determine if the data justifies or supports the development of a Behavior Management Plan.

Following implementation of the Behavior Management Plan, behavior assessment must occur to determine objectively whether to continue, modify, or terminate the plan.

Plan Development Component

Plan Development refers to those activities required for the formal development of a Behavior Management Plan. It should be noted that a formal plan is developed only if objective baseline data supports and demonstrates the need for such a plan. A Behavior Management Plan for which there is no documentation of behavior management implementation activity must be considered invalid for billing purposes except for those activities related to assessment where a decision was made based on assessment data that it was not appropriate to proceed.

In those instances when baseline data indicate an occurrence of the target behavior(s) at a frequency or duration not sufficient to warrant the development of a complete Behavior Management Plan and its implementation training and on-going data analysis and review, the Behavior Management Specialist or the Behavior Management Assistant may develop a **Behavior Protocol**. A Behavior Protocol is a document that describes a consistent response(s) upon the occurrence/reoccurrence of the target behavior(s) as a means to maintain the rate of behavior(s) at a low rate. No more than two units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Protocol**.** Following the development of a Behavior Protocol, no further Therapeutic Behavioral Services billing must occur unless a new problem behavior is discovered. If this occurs, behavior assessment on the new behavior must follow, and the process should start anew.

When a Behavior Management Plan has achieved the criteria for success (the objective, quantified amount of behavior change has been maintained for the time period specified in the plan), the Behavior Management Specialist or the Behavior Management Assistant must develop a **Behavior Management Maintenance Plan**. A Behavior Management Maintenance Plan is a document that describes a consistent response(s) to the target behavior(s) as a means Therapeutic Behavioral Services - Implementation is an integral component of Behavior to maintain target level performance. No more than four units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Management

Maintenance Plan. Following the implementation of the Behavior Management Maintenance Plan (which is not to exceed 90 days), the Behavior Management Specialist or the Behavior Management Assistant may conduct data analysis and review on no more than three occasions (a maximum of one unit each occasion) to assure that behavior levels are maintained.

Implementation Training Component

Implementation training is the process by which the Behavior Management Specialist or the Behavior Management Assistant provides the rationale for the plan, defines the behavior(s) that are targeted for change and instructs the individual(s) responsible in the specific steps necessary for implementation of the plan. All individuals who will be involved in providing Therapeutic Behavioral Services – Implementation (procedure code H2019) must receive implementation training prior to implementation of the plan. This includes agency employees and/or significant others (e.g., parents, teachers, foster care providers, etc.).

Data Analysis and Review Component

Data Analysis and Review is the process by which the Behavior Management Specialist or the Behavior Management Assistant evaluates plan effectiveness. Plan effectiveness is determined through a comparison of the baseline data for the target behavior(s) with objective, quantified implementation data to determine whether the plan is leading to achievement of the criteria for success. Any necessary direct observation of member ***behavior*** is included in this category. This analysis and review result in the determination of continuation, modification, or termination of the Behavior Management Plan.

Documentation Requirements:

There are four types of Therapeutic Behavioral Services - Development documentation:

- Activity notes
- Behavior Management Plan
- Behavior Protocol
- Behavior Management Maintenance Plan.

Standard Activity Notes Documentation Requirements

Activity Notes identify the specific component of Therapeutic Behavioral Services - Development (i.e., Behavior Assessment, Plan Development, Implementation Training, Data Analysis and Review) that was performed, place of service, date of service, the amount of time spent by listing the start-and-stop times, and the signature (with credential initials) of the staff person who provided the service.

Behavior Assessment documentation must be present prior to the development of the Behavior Management Plan In addition to the standard activity notes documentation requirements, behavior assessment documentation must reflect that the following activities have occurred in this order.

- Identification of the target behavior(s).

- Specific description of each target behavior in terms capable of objective, quantified measurement.
- Collection of baseline data on each target behavior to obtain an objective, quantifiable determination of its occurrence/nonoccurrence.
- Review and analysis of baseline data to determine objectively if a need for further Behavior Management Services exists.

Following implementation of the Behavior Management Plan, **Behavior Assessment** documentation must include (in addition to the standard activity notes documentation requirements) rationale for such assessment, which may take one of two forms. These are:

- Identification of a new target behavior. Should this occur, behavior assessment must meet the requirements identified in the above listed additional requirements for behavior assessment documentation to provide objective documentation of the need to modify the plan.

Objective determination through data analysis and review that the plan is not effective. If this occurs, behavior assessment must be conducted to determine if the plan is being implemented correctly. If implementation is not occurring correctly, implementation training must reoccur. If the plan is being implemented correctly, further data-based assessment to determine whether to modify the plan will occur. Documentation for the latter must reflect the specific components of the plan addressed and modified to obtain the desired behavior change.

Activity notes documenting **Plan Development** must include the specific components of the plan itself that were developed in addition to the standard activity notes documentation requirements.

Activity notes for **Implementation Training** must document the training of implementation staff (and/or unpaid support staff) as defined by the plan, the definitions of the behavior(s) targeted for change, and the specific steps necessary for implementation of the plan. It must also include the standard activity notes documentation requirements.

Activity notes for **Data Analysis and Review** must document a measured amount of each target behavior, a comparison of that amount to a previously documented amount and, based on that measured amount, a determination of continuation, modification, or termination of the plan. It must also include the standard activity notes documentation requirements.

Behavior Management Plan Documentation Requirements

The second type of documentation is a separate, freestanding document labeled **Behavior Management Plan.** The Behavior Management Plan must contain, at a minimum, the following components within the body of the plan itself, regardless of their presence anywhere else in the member's record.

- The Name and Agency Identification Number of the member for whom the plan has been developed
- Implementation Date - the date the plan is implemented

- Target Behaviors/Specific Descriptions.
- Baseline data including the actual dates the baseline data was collected.
- The criteria for success – (A generic statement such as "The member will obey the rules more frequently" is not acceptable, as it does not state a quantified amount that can be compared to baseline data).
- Methods of Behavioral Intervention includes the following:
  - Method - A description of the behavioral intervention that implementation staff (and/or unpaid support staff) will employ given the occurrence/nonoccurrence of the target behavior(s).
  - Method and Schedule of Reinforcement - The method statement must specify and describe the method of reinforcement, the type of re-enforcers to be used, when the re-enforcers will be provided (i.e., the schedule of reinforcement), by whom, and whether re-enforcers are delivered upon occurrence/reoccurrence of the target behavior(s), or upon the occurrence of behavior(s) incompatible with the target behavior(s).
  - Data Collection - A description of the quantified information that will be collected during the implementation of the Behavior Management Plan. This must include who collects the information and what type of quantified information is recorded, such as frequency or duration of behavior. This information must be of the same type as that collected during baseline so that comparisons can occur.
- Responsible person - a designated Behavior Management Specialist is responsible for the Behavior Management Plan in terms of its appropriateness in clinical practice and for financial reimbursement, and for identifying staff and/or others and their respective responsibility relative to the plan. It should be noted that implementation staff do not have to be named individually, but they must have received the required implementation training prior to implementing the plan. The Behavior Management Specialist must sign and date all plans prior to their implementation (or review and co-sign plans signed and dated by a Behavior Management Assistant). The signature of any individual(s) who participated in the development of the written plan must also be included in the plan (and the date of their participation), along with the degree, and other credentials (license type and number) of each individual.

Behavior Protocol Documentation Requirements

The third type of documentation is the completed Behavior Protocol. The Behavior Protocol consists of:

- A summary of objective, quantified baseline data
- A rationale for the development of the protocol
- Recommendations for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s)
- Date the protocol was developed, the amount of time spent developing the protocol by listing the start and stop times, and the signature (with credential initials) of the staff person who developed the protocol.

Behavior Management Maintenance Plan Documentation Requirements

The fourth type of documentation is the Behavior Management Maintenance Plan. The Behavior Management Maintenance Plan consists of:

- A summary of objectives
- Quantified implementation data (collected during the implementation of the plan)
- A rationale for the development of a maintenance plan (i.e., the criteria for success has been achieved)
- Recommendation for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s).
  Date the maintenance plan was developed, the amount of time spent developing the plan by listing the start and stop times, and the signature (with credential initials) of the staff person who developed the plan.

502.21.2 THERAPEUTIC BEHAVIORAL SERVICES – IMPLEMENTATION

Procedure Code: H2019
Service Unit: 15 minutes
Service Limits: All units must be prior authorized
Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Behavior Management Implementation services means a face-to-face, hands-on encounter where the actual time is spent in the delivery of a behavioral health service to a specific member (i.e., any delivery of the service must be on a strictly one staff to one member basis). Such encounters are interventions, or reinforcements that have been previously described in the Behavior Management Plan and are measured and recorded. Any and all Therapeutic Behavioral Services - Implementation activities under this procedure will be considered non-reimbursable if the activities are not supported by a Behavior Management Plan that meets the documentation requirements detailed under Therapeutic Behavioral Services – Development (procedure code H2019HO).

General observation and/or monitoring are not considered billable implementation activities.

Documentation: Documentation must contain the intervention used (which is individualized to meet the needs of the member), methods, measurements, delivery of service, outcome of the implementation, place of service, date of service, signature of implementing staff (with credential initials), and the actual time spent by listing the start-and-stop times.

Only trained, qualified staff can provide **billable** Therapeutic Behavioral Services - Implementation Services. Activities provided by a non-staff person may be considered as a valid part of the service if there is documentation of the role and specific activities by such individuals in both the description of the methods of intervention in the Behavior Management Plan and in the data which describes the encounters by non-staff persons as they implement the plan. Activity by non-staff persons as described above, however, will not be considered billable under neither Therapeutic Behavioral Services – Development (procedure code H2019HO), nor Therapeutic Behavioral Services – Implementation (procedure code H2019).

502.22 TRANSPORTATION SERVICES

Behavioral Health Transportation Services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service that is designated in the member's service plan.

502.22.1 NON-EMERGENCY TRANSPORTATION BY VEHICLE OTHER THAN AMBULANCE

Procedure Code: A0120HE
Service Unit: Trip
Service Limits: Six trips daily
Prior Authorization: None

Definition: Non-emergency Transportation by minibus is a service in which a one-way transport of a member by a vehicle other than an ambulance is provided. If more than one member is being transported, each member's transport to the Medicaid service is billable. However, if multiple stops must be made for multiple members, the service provider must only bill for each member's transport to his/her Medicaid reimbursable service. (e.g., a vehicle, carrying two members from their group home, transports the first member to a physician's office and the second to a Day Treatment Program. Only two separate transports must be billed; one for each member. The provider cannot unbundle the second member's trip as two trips; one from the group home to the physician's office, since he received no service there, and the second to the Day Treatment Program).

Documentation: Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times.

502.22.2 NON-EMERGENCY TRANSPORTATION: PER MILE

Procedure Code: A0160HE
Service Unit: One mile
Service Limits: 500 miles per month
Prior Authorization: None

Definition: Non-emergency Transportation: Per Mile is a service in which the member's transportation by the provider is documented and subsequently billed by the mile. Mileage cannot be accumulated during the transport of other members to their destinations even if the member remains in the vehicle during the transport of the other members. Mileage can only be calculated using the shortest, most direct route between the member's place of departure and destination. This code cannot be billed by provider staff unless a member is present in the vehicle.

Documentation: Documentation must consist an activity note describing the purpose for the transport, signed by the providing staff (along with their credentials), type of vehicle used for the transport, place of departure and arrival, actual billable mileage, and date of service.

502.23 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Information* of the Provider Manual.

502.24 SERVICE EXCLUSIONS

In addition to the exclusions listed in *Chapter 100, General Information*, BMS will not pay for the following services:

- Services not meeting the definition of Medical Necessity
- Telephone consultations
- Missed appointments
- Time spent in preparation of reports
- A copy of medical report when the agency paid for the original service
- Experimental services or drugs
- Methadone administration or management
- Any activity provided for the purpose of leisure or recreation
- Services rendered outside the scope of a provider's license

502.25 ROUNDING UNITS OF SERVICE

- Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. Units of service based on an episode or event cannot be rounded.
- Many services are described as being "planned", "structured", or "scheduled". If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.
- The following services are eligible for rounding:
  - Mental Health Service Plan Development (H0032)
  - Mental Health Service Plan Development (H0032AH)
  - Physician Coordinated Care Oversight Services (G9008)
  - Case Consultation (90887)
  - Comprehensive Medication Services; Mental Health (H2010)
  - Crisis Intervention (H2011)
  - Therapeutic Behavioral Services – Development (H2019HO)
  - Therapeutic Behavioral Services – Implementation (H2019)

In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months. Only whole units of service may be billed.**

502.26 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of Behavioral Health Clinic Services described in this chapter.

502.26.1 PRIOR AUTHORIZATION PROCEDURES

- The Bureau for Medical Services requires that providers register and/or prior authorize **all** Behavioral Health Clinic Services described in this manual with exception of Transportation Services, procedure codes A0120HE and A0160HE) with BMS' contracted agent.
- Prior authorization must be obtained from BMS' contracted agent.
- General information on, prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' contracted agent.

502.26.2 PRIOR AUTHORIZATION REQUIREMENTS

- Prior authorization requests for Behavioral Health Clinic Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.

502.27 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

- Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements and Chapter 800, General Administration of the Provider Manual.
- Providers of Behavioral Health Clinic Services must comply, at a minimum, with the following documentation requirements:

  - Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.

  - All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.

  - Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.

- Providers of Behavioral Health Clinic Services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

502.28 BILLING PROCEDURES

- Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- The amount billed to BMS must represent the provider's usual and customary charge for the services delivered.
- Claims must be accurately completed with required information.
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.
- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

502.29 PROGRAM OF SERVICE REQUIREMENTS

Program approval from BMS is required for the following Behavioral Health Clinic Services Program:

- Day Treatment

Chapter 502

Behavioral Health Clinic Services

July 1, 2014

Attachment A

West Virginia Bureau for Medical Services
Behavioral Health Clinic and Rehabilitation Services
Authorization for Services

West Virginia Bureau for Medical Services
Behavioral Health Clinic and Rehabilitation Services
Authorization for Services

Client Name: _____ Medicaid Number: _____

Admission Date: _____ Diagnosis(es): _____

The following Medical or Remedial services have been authorized for the above named recipient in order to reduce physical or mental disability and/or to restore functional ability:

Type of Service: (check the services authorized)

	Assessment Services		Service Planning
	Case Consultation		Behavioral Health Counseling
	Skills Training and Development		General Medical Care Services
	Assertive Community Treatment (ACT)		Comprehensive Community Support
	Day Treatment		Crisis Intervention
	Community Psychiatric Supportive Tx.		Residential Children's Services
	Therapeutic Behavioral Services		Transportation Services
	Other:		Other:

I certify that the services for the above-named individual are medically necessary and appropriate. My determination is based upon:

☐ Personal evaluation of the member within the past seven days; or

☐ Review of assessment(s) provided by an individual functioning within his/her scope of practice and approved by the credentialing committee of this agency.

Any change or extension in services indicated above will be authorized in an individualized service plan or written treatment strategy as required by behavioral health licensing regulations and BMS policy.

_____ _____

Signature of Initiating/Admitting Staff (Valid for 72 hours) Date

_____ _____

Signature of Physician/Licensed Psychologist Date

Attachment A

Chapter 502

Behavioral Health Clinic Services

July 1, 2014

Attachment B

Coordination of Care and Release of Information Form

Suboxone/Subutex/Vivitrol Providers

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider

Communication between behavioral providers and your Suboxone/Subutex/Vivitrol Prescribing Physician other Behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You have a right to a copy of this signed authorization.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. **This consent expires in one year (12 months) from the date of my signature below unless otherwise stated herein.**

_____ (*BH Provider*) is authorized to release protected health information related to the evaluation and treatment of _____ (*Member*) to _____ (*Suboxone/Subutex/Vivitrol Prescribing Physician).*

(Member Name) _____

(Medicaid ID#) _____

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider

(Date of Birth – MM/DD/YYYY) _____

Suboxone or Vitriol Prescribing Physician:_____

Physician Phone: _____

Physician Address: _____

BH Provider Name: _____

BH Provider Phone:_____

BH Provider Address: _____

Disclosure may include the following verbal or written information: (check all that apply) ___ Demographic Information	___ History & physical	___ Laboratory/diagnostic testing results	___ Other (specify below)
___ Discharge summary	___ Medication records	___ Behavioral health/psychological consult	___ Psychological Eval/Testing Results
___ ER record report	___ Psychiatric evaluation	___ Psychosocial assessment	___ Service Plan
___ Substance abuse treatment record			___ Summary of treatment records, progress notes & contact dates

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Providers and BH Providers

(Print Provider Name) _____

(Signature)_____

(Date)_____

I want to inform you that _____was seen by me for the treatment of: (Member Name)

DSM-IV and/or medical diagnosis:

_____

Date of appointment:

_____

Summary:

The treatment plan consists of the following modalities:

_____ Individual Psychotherapy _____ Group Psychotherapy _____ Family Psychotherapy

_____ Psychological Testing _____Other (specify) _____ Medication Management (see below)

Current Medication(s) (Dosage, Frequency and Delivery)

The following medication was or will be started (indicate medication and dosage):

Estimated length of treatment:

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients. WV Department of Health and Human Resources Bureau for Medical Services.

Chapter 502

Behavioral Health Clinic Services

July 1, 2014

Attachment C

Application for Day Treatment Certification

APPLICATION FOR
MEDICAID DAY TREATMENT CERTIFICATION

Please complete the following identifying information for your agency.

Name of Provider/Agency operating Day-Treatment at site listed below: _____

_____

Provider/Agency Address: _____

_____

Current Medicaid Provider Number: _____

Name of Day-Treatment Program: _____

Day-Treatment Program Address: _____

_____

Effective Dates of B. H. License: _____ Date of Approved CON: _____

Name & Title of Individual Completing Application: _____

_____

Telephone Number: _____ Extension: _____

Fax Number: _____

PROGRAM DESCRIPTION

A. THIS AGENCY IS APPLYING FOR CERTIFICATION (PLEASE CHECK ALL BOXES THAT APPLY):

☐ Initial or New Certification
☐ Recertification
☐ Clinic Services Day-Treatment Program
☐ Rehabilitation Services Day-Treatment Program

B. TYPES OF POPULATION(S) TO BE SERVED:

An application must be submitted for each day-treatment licensed program site operated by your agency. If your agency is serving more than one population at one site, a separate program activity time grid must be completed for each of the populations checked below.

1. ADULTS WITH:

☐ Alcohol/Substance Abuse ☐ Mental Illness ☐ Intellectually/Developmentally Disabled

2. CHILDREN WITH:

☐ Developmental Delay ☐ Serious Emotional Disturbances

C. SITE OF OPERATIONS

Day-Treatment Program Site:

_____

Address:

_____

D. HOURS OF OPERATIONS

Hours of Operation: ___a.m. ___a.m.
___p.m. ___p.m.

Days of Operations: M T W T F S S
(CIRCLE ALL THAT APPLY)

E. PROGRAM CAPACITY

In the last month, what was:

1. Average number of clients served in program per day? _____
2. Maximum number of clients who can be served on any day? _____

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:

- Difference in programmatic approaches or emphasis on each population served at this site

- Program admission and discharge criteria

- Differences in programmatic approaches to individuals with lower-versus-higher functional impairment

- Any specific programmatic emphasis or focus

MANAGEMENT AND PERSONNEL

1. DAY-TREATMENT PROGRAM DIRECTOR:

   NAME: _____

   QUALIFICATIONS: _____

   EDUCATION: _____

   _____

   _____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year.)

   Date of Experience:

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for day-treatment program director in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

   _____ Yes Date of Review: _____

4. PROGRAM DIRECTOR TIME SCHEDULE:

   A. Please indicate the number of hours per week the program director spends in program management activities, such as staff scheduling, activities planning, service plan review, treatment planning, etc.

      _____ Program management hours per week

   B. Please indicate the number of hours per week the program director spends carrying out or participating directly with clients in activities listed on weekly grid.

      _____ Day-treatment activities hours per week.

   C. List each type of staff member by job title used by your agency for day-treatment services.

JOB TITLE	NUMBER OF STAFF IN DAY-TREATMENT WITH THIS TITLE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

5. Attach a job description for each job title listed in #1 above.

6. Attach a weekly schedule for all staff reflected in #1 above.

CLINIC DAY-TREATMENT

A. Program Activities: Population MR/DD

Please indicate which of the following activities are carried out in your agency's day-treatment program by checking the appropriate boxes and filling in the staff-to-client ratio for each activity:

			Staff-to-Client Ratios
Self-Care Skills	☐ Yes	☐ No	_____ to _____
Emergency Skill	☐ Yes	☐ No	_____ to _____
Mobility Skills	☐ Yes	☐ No	_____ to _____
Nutrition Skills	☐ Yes	☐ No	_____ to _____
Social Skills	☐ Yes	☐ No	_____ to _____
Communications/Speech	☐ Yes	☐ No	_____ to _____
Physical/Occupational Therapy Reinforcement	☐ Yes	☐ No	_____ exercise to _____
Interpersonal Skills	☐ Yes	☐ No	_____ to _____
Functional Community Skills	☐ Yes	☐ No	_____ to _____
Volunteering in Community Skills	☐ Yes	☐ No	_____ to _____
Citizenship, Rights, and Responsibilities	☐ Yes	☐ No	_____ to _____
Self-Advocacy	☐ Yes	☐ No	_____ to _____
Other Services	☐ Yes	☐ No	_____ to _____
(Specify)_____	☐ Yes	☐ No	_____ to _____
_____	☐ Yes	☐ No	_____ to _____
_____	☐ Yes	☐ No	_____ to _____

CHAPTER 503 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH REHABILITATION SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter		July 1, 2014

CHAPTER 503 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH REHABILITATION SERVICES

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CHAPTER 503 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH REHABILITATION SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary behavioral health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal regulations. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the West Virginia Bureau for Medical Services (BMS).

This chapter sets forth BMS's requirements for payment of Behavioral Health Rehabilitation Services provided by Behavioral Health providers to eligible West Virginia (WV) Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Behavioral Health Rehabilitation Services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (WVDHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

The Bureau of Medical Services has a joint goal with Medicaid Enrolled Providers to ensure effective services are provided to Medicaid Members.

Medicaid Enrolled Providers should give priority to children that have been identified as being in the foster care system. To uphold our responsibility to children in foster care, addressing children's needs must begin at entry and by making these foster children a priority especially with the assessment services stated in this manual. Medicaid Enrolled Providers should make a good faith effort to complete assessments in a timely manner as well as work with Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid Members have the right to freedom of choice when choosing a provider for treatment. A Medicaid Member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid Members are in violation of their provider agreement.

All Medicaid Enrolled Providers should coordinate care if a Medicaid Member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is the forefront of the Member's treatment. Appropriate Releases of Information should be signed in order that HIPAA Compliant Coordination of Care takes place.

503.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to *Chapter 200, Definitions of the Provider* Manual. In addition, the following definitions also apply to the requirements for payment of Behavioral Health Rehabilitation Services described in this chapter.

Abuse and Neglect as defined in **West Virginia Code §49-1-3**

Assertive Community Treatment (ACT) is an intensive and highly integrated approach for community mental health service delivery. ACT teams serve outpatients whose symptoms of mental illness result in serious functioning difficulties in several major areas of life.

Advanced Alcohol & Drug Counselor (AADC): professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Advanced Practice Registered Nurse (APRN) : As defined in **West Virginia Code §30-7-1**: A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

Alcohol & Drug Counselor (ADC): professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Alcohol & Drug Clinical Supervisor (ADC-S): certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements

Administrative Service Organization (ASO): the contracted agent of BMS.

Behavioral Health Rehabilitation Services: services that are medical or remedial that recommended by a physician, physician extender, licensed psychologist, or supervised psychologist for the purpose of reducing a physical or mental disability and restoration of a member to his/her best function level. These services are designed for all members with conditions associated with mental illness, substance abuse and/or dependence. Behavioral Health Rehabilitation Services may be provided to members in a variety of settings, including in the home, community, or a residential program, but do not include services provided in an inpatient setting.

Behavioral Health Condition: a mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment.

Coordination of Care: Sharing information between relevant parties to plan, arrange, implement, and monitor provision of services to Medicaid Members.

Critical Juncture: any time there is a significant event or change in the member's life that requires a treatment team meeting. The occurrence constitutes a change in the member's needs that require services, treatment, or interventions to be decreased, increased or changed. The member's needs affected would be related to their behavioral health, physical health, change in setting or crisis.

Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

External Credentialing: a process by which an individual's external credential is verified to provide Medicaid Rehabilitation Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Freedom of Choice: The guaranteed right of a beneficiary to select a participating provider of their choice.

Homeless- An individual meeting the current federal definition of homelessness as defined in **42 USC § 11302.**

Foster Child: The West Virginia Department of Health and Human Resources defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Human Services Degree: A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:

- Psychology
- Criminal Justice
- Nursing
- Sociology
- Social Work
- Counseling/Therapy
- Teacher Education
- Behavioral Health
- Other Degrees approved by the West Virginia Board of Social Work.

(Note: Some services require specific degrees as listed in the manual see specific services for detailed information on staff qualification.)
Incident: any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Incident: any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Intensive Services (IS): A combination of specific services for a targeted population to be used on a frequent basis for a limited period of time. Approval for an IS program and prior authorization for members admitted to an IS program must be obtained by contacting the ASO.

Internal Credentialing: an individual approved to provide Rehabilitation Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Licensed Practical Nurse (LPN): an individual who has completed the licensed practical nurse program from an accredited school and who is licensed by the WV State Board of Examiners for Licensed Practical Nurses.

Licensed Psychologist: a psychologist who has completed the requirements for licensure that have been established by the WV Board of Examiners of Psychologist and is in current good standing with the board.

Office of Health Facility Licensure and Certification (OHFLAC): The office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Physician: As defined in West Virginia Code Annotated §30-3-10, an individual who has been issued a license to practice medicine in the state of WV by the WV Board of Medicine and is in good standing with the board; or an individual licensed by the WV Board of Osteopathy in accordance with West Virginia Code Annotated 30-14-6.

Physician's Assistant: An individual who meets the credentials described in West Virginia Code Annotated §30-3-16, §30-3-13, §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Physician Extender: A medical professional including an advanced practice registered nurse or a physician's assistant functioning within his or her legal scope of practice.

Registered Nurse (RN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse and in good standing with the West Virginia Board of Examiners for Registered Professional Nurses.

Supervised Psychologist: an individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Telehealth: the use of identified technologies to provide behavioral health services for Medicaid Members by qualified providers. When billing a service that has been utilized through Telehealth, providers must bill the service code with a GT Modifier (**See Telehealth Section).**

503.2 MEMBER ELIGIBILITY

Behavioral Health Rehabilitation Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when prior authorization for Behavioral Health Rehabilitation Services is requested of the agency authorized by BMS to perform administrative review. The Prior Authorization process is explained in Section 503.29 of this manual.

503.3 MEDICAL NECESSITY

All Behavioral Health Rehabilitation Services covered in this chapter are subject to a determination of medical necessity. In the managed care position paper published in 1999 by the State of WV, medical necessity was defined as:

"Services and Supplies that are:

1. appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
2. provided for the diagnosis or direct care of an illness;
3. within the standards of good practice;
4. not primarily for the convenience of the plan member or provider; and
5. the most appropriate level of care that can be safely provided."

Medical Necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. As stated in section 503.15.1, the provider may perform one assessment per calendar year in order to update medical necessity (See Service Code H0031 for more details). Diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

The Bureau for Medical Services requires that providers register and/or prior authorize with the agency designated by the Bureau to perform administrative review for services that are rendered. Prior Authorization does not guarantee payment for services rendered.

503.4 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers of Behavioral Health Rehabilitation Services must meet all enrollment criteria as described in Chapter 300.

503.4.1 ENROLLMENT REQUIREMENTS: AGENCY ADMINISTRATION

Each participating provider must develop and maintain a Credentialing Committee composed of senior licensed and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring the following activities:

- Development of written criteria for each specific type of service provided. These criteria must identify the required education, licensure, certification, training, and experience necessary for each staff person to perform each type of service. These criteria must be age and disability specific to populations served as well as ensuring that staff has demonstrated competency to provide the services rendered.
- Review all documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the committee. Based on this review, the committee must determine which services staff are qualified to provide.
- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records.

Participating providers must develop standards for staff training, supervision, and compliance monitoring in accordance with existing state policy and federal regulations.

503.4.2 ENROLLMENT REQUIREMENTS: STAFF QUALIFICATIONS

Services may be rendered to Medicaid members by physician's assistants under the supervision of a psychiatrist. Services may also be rendered to Medicaid members by an Advanced Practice Registered Nurse as defined below. An Advanced Practice Registered Nurse without a psychiatric certification must function under the direct supervision of a WV Board of Medicine approved supervising physician. An Advanced Practice Registered Nurse with a psychiatric certification may practice without direct supervision by a psychiatrist.

A Physician's Assistant (PA) and/or Advanced Practice Registered Nurse must have a signed collaborative agreement for prescriptive authority with a psychiatrist. The collaborative agreement must document the professional relationship between the Advanced RN practitioner and the physician. Regulations set forth in WV Code, Chapter 30 – Professions and Occupations, Title 11 Legislative Rule – West Virginia Board of Medicine, and Title 19 Legislative Rules – Board of Examiners for Registered Professional Nurses must be followed. Physician's Assistants and/or Advanced Practice Registered Nurses will be referred to as physician extenders throughout the manual.

Documentation including required licenses, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, proof of psychiatric certification as applicable, and any other materials substantiating an individual's eligibility to perform as a practitioner must be kept on file at the Behavioral Health Facility.

All further Staff Qualifications will be indicated under the service codes. All documentation for staff including college transcripts, certifications, credentials, background checks, trainings should be kept in the staff's personnel file and may be reviewed at any time by BMS or the Bureau's contractors or state and federal auditors.

503.5 CRIMINAL BACKGROUND CHECKS

All Rehabilitation provider staff, having direct contact with members must, at a minimum, have results from a state level Fingerprint Based Background check. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must request an additional federal background check through the West Virginia State Police also upon hire and every 3 years of employment. Providers may do an on-line preliminary name based check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm; Felony drug related offenses within the last 10 years;

- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

Fingerprint based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered.

If aware of recent convictions or change in conviction status of an agency staff member providing Rehabilitation services, the Rehabilitation provider will notify the Program Manager for Behavioral Health Services.

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities must be checked by the Rehabilitation provider for every agency staff who provides Medicaid services prior to employment and monthly throughout employment. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

503.6 CLINICAL SUPERVISION

The purpose of clinical supervision is to improve the quality of services for every member while ensuring adherence to WV Medicaid policy, therefore the provider must have a policy for Clinical Supervision including guidelines for the following:

- the responsibilities of the supervisor,
- credentialing requirements of the supervisor, and
- the minimum frequency for which supervision should occur.

Each agency shall have a chart demonstrating clinical chain of command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of their clinical and administrative supervision.

The clinical supervisor should have an equal or higher degree, credential, or clinical experience than those they supervise. If a clinical supervisor is responsible for a Medicaid funded program, the supervisor should be able to demonstrate familiarity with Medicaid requirements and relevant manuals. This applies to all rehabilitation services rendered.

503.7 SERVICE CERTIFICATION REQUIREMENTS

A physician, physician extender, or psychologist must certify the need for Behavioral Health Rehabilitation Coordinated Services by:

- Signing the "Behavior Health Clinic/Rehabilitation Services, Authorization for Services" form within 72 hours of the member's admission to the program for services and prior to the start of treatment. **If an Initial Service Plan is created on day of intake then a 72-hour authorization form is not required. Upon initiation of the Initial Service Plan, the "Behavior Health Clinic/Rehabilitation Services, and Authorization for Services" form is no longer in effect since it is no longer necessary.** This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all Behavioral Health Rehabilitation Services until the development and initiation of the Initial Service Plan. The initial service plan must include all information that is required on the 72-hour authorization form.

- If a Medicaid Member is considered to be in *Focused Care* then a provider cannot bill for a Service Plan and/or Treatment Plan. No 72 hour Authorization is required for individuals receiving only Focused Treatment Services.

For members receiving *Coordinated Care*, the following is required:

- Development of the Initial Service Plan within seven days of the initial admission and intake
- Development of the Master Service Plan within 30 days of the initial admission and intake
- Review and re-evaluation of the service plan at a minimum every 90 days, or sooner if dictated by the member's needs

If any Behavioral Health Rehabilitation Services occur outside the time frames of these forms which authorize services, the services provided are not billable.

503.8 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as

policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 800 (A), General Administration*, of the Provider Manual and are subject to review by state and federal auditors.

503.9 REHABILITATION PROVIDER REVIEWS

The primary means of monitoring the quality of Rehabilitation services is through provider reviews conducted by OHFLAC and the Contracted Agent as determined by BMS by a defined cycle. The Contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site Rehabilitation provider reviews and/or desk reviews may be conducted by OHFLAC and/or the Contracted Agent in follow up to Incident Management Reports, complaint data, Plan of Corrections, etc. Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the Rehabilitation provider. If potential disallowances are identified, the Rehabilitation provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the Rehabilitation provider and issue a final report to the Rehabilitation Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Rehabilitation Services. A cover letter to the Rehabilitation provider's Executive Director will outline the following options to effectuate repayment:

(1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

(2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or

(3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

If the Rehabilitation provider disagrees with the final report, the Rehabilitation provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Common Chapter 800 (A), General Administration* of the West Virginia Medicaid Provider Manual. The Rehabilitation provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the Contracted Agent review, then the Rehabilitation Provider will receive a final letter and a final report from BMS.

Plan of Correction

In addition to the draft exit report sent to the Rehabilitation providers, the Contracted Agent will also send a draft Plan of Correction (POC) electronically. Rehabilitation providers are required to complete the POC and electronically submit a POC to the Contracted Agent for approval within 30 calendar days of receipt of the draft POC from the Contracted Agent. BMS may place a hold on claims if an approved POC is not received by the Contracted Agent within the specified time frame. The POC must include the following:

1.) How the deficient practice for the services cited in the deficiency will be corrected and what system will be put into place to prevent recurrence of the deficient practice;

2.) How the provider will monitor to assure future compliance and who will be responsible for the monitoring;

3.) The date the Plan of Correction will be completed; and

4.) Any provider-specific training requests related to the deficiencies

503.10 TRAINING AND TECHNICAL ASSISTANCE

The Contracted Agent develops and conducts training for Rehabilitation providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

503.11 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning, documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid Members records within one business day of the request.

- Provider must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, Behavioral Health Rehabilitation Service providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 800 (A) General Administration of the Provider Manual.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.

503.12 FOCUSED AND COORDINATED CARE SERVICES

The Bureau of Medical Services expects that each member will receive the type and amount of behavioral health service(s) necessary to ameliorate and stabilize the behavioral health disorder(s) defining medical necessity for services. The BMS has established two levels of behavioral health treatment, with similar but somewhat differing credentialing and documentation requirements. Assessment services are not included within either category but are considered necessary to establish medical necessity for a particular service or level of care.

Focused Care: Members receiving focused services have been determined to have a behavioral health disorder which may be addressed through the provision of low frequency (generally a maximum of once per week, ranging as rarely as once each six months) professional treatment services. Services are provided by a behavioral health professional with at minimum a master's degree in a behavioral health service field, excluding Mental Health Assessment by a Non-Physician. The treatment team consists of the professional and the member and/or member's designated legal representative who together establish a treatment strategy which is documented in the member's record. The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services:

- Medical office services (billed as E/M codes);
- Professional Individual therapy
- Professional Group therapy
- Assessment and Screening codes

The treatment strategy must relate directly to the behavioral health condition(s) identified as being medically necessary to treat. Documentation of on-going therapeutic and/or medication management contacts must relate directly to the treatment strategy.

Coordinated Care: Members requiring coordinated care are those with severe and/or chronic behavioral health conditions that necessitate a team approach to providing medically necessary care. The treatment is usually provided on a more intensive basis, several times a week if not daily. A full range of individuals may be employed in providing care, ranging from paraprofessionals through psychiatrists. The treatment team consists of the personnel involved

in providing the care and includes the member and the member's guardian if any. The member is likely to have a case manager, who is responsible for coordinating and facilitating care.

Documentation consists of a comprehensive service plan. When the member enters the service, an initial plan is developed which dictates care until the interdisciplinary team can meet. An initial plan must be completed within seven days. Those services that are time-limited and of high intensity may require an initial plan immediately upon admission that is then adapted as the member moves through levels of care. Services that are projected to be of unlimited or extended duration are expected to include development of a master service plan within 30 days that describes specific objectives to be achieved during the course of treatment, stated in observable and/or measureable terms. The master service plan must address integration and coordination of various entities and programs providing services to the member. On-going documentation must reflect the team's ability to communicate issues of concern, member progress and barriers to treatment.

Services falling under Coordinated Care may include but are not limited to the following:

- Assertive Community Treatment
- Professional Individual Therapy
- Professional Group Therapy
- Crisis Stabilization and detoxification services
- Targeted Case Management
- Comprehensive Community Support Services
- Basic Living Skills
- Intensive Service Programs
- Supportive Counseling
- Professional therapy and medication management provided in the context of the Coordinated Care services
- Residential Care for Children and Youth
- Emergency Shelter Care
- Day Treatment

503.13 TELEHEALTH SERVICES

The West Virginia Bureau for Medical Services encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid Members. To utilize Telehealth providers will need to document that the service was rendered under that modality. When filing a claim the Provider will bill the service code with a GT Modifier. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate.

- Minimum equipment standards are transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used as long as the software is HIPAA Compliant and abides by a federal code pertaining to Telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT or HCPCS codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.
- The provider at the distant site is responsible to maintain standards of care within the identified scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- The provider must have an appropriately trained employee of the facility available in the building at all Telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation that involves patient management.
- The health care agency or entity that has the ultimate responsibility for the care of the patient must be licensed in the State of West Virginia and enrolled as a WV Medicaid provider. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within this manual.
- Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider, a contracted employee, or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a participant shall ensure that any written information is provided to the participant in a form and manner which the participant can understand using reasonable accommodations when necessary.
- Participant's consent to receive treatment via telehealth shall be obtained, and may be included in the participant's initial general consent for treatment.

- If the participant (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.

  The health care practitioner who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:
  - The right to withdraw at any time.
  - A description of the risks, benefits and consequences of telemedicine
  - Application of all existing confidentiality protections
  - Right of the patient to documentation regarding all transmitted medical information
  - Prohibition of dissemination of any patient images or information to other entities without further written consent.

- BMS Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a Provider and a participant.

503.14 DOCUMENTATION

The WV Bureau for Medical Services recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system. When services require documentation the Bureau will accept both types of documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice.

503.15 ASSESSMENT SERVICES

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff credentialed by the internal credentialing policies and procedures of the agency. Assessment services are designed to make determinations concerning the mental, physical and functional status of the member. Those identified as being in the Foster Care system should receive assessment as rapidly as possible.

503.15.1 MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN

Procedure Code: **H0031**
Service Unit: Event-
Telehealth: Available-

Service Limits: Maximum of (four) 4 per year for members with complex behavioral healthcare needs (Coordinated Care) and (two) 2 per year per member with relatively simple behavioral healthcare needs (Focused Care). The

provider may request more units if a critical treatment juncture arises, however not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services. Change of payer source does not justify H0031.

Staff Credentials: Staff must have a minimum of a master's degree, bachelor's degree in a field of human services, or a registered nurse. Supervision and oversight by an individual with a minimum of a master's degree is required (See Clinical Supervision). Staff must be properly credentialed by the agency's internal credentialing committee.

Definition: Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

Approved Causes For Utilization:

1. Intake/Initial evaluation;
2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral Health condition to a lesser level of care.
3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment;
   The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services.
5. No one under the age of three (3) will have a H0031 conducted on them. The Medicaid member under the age of the 3 should be referred to the Birth to Three Program.

Documentation:

1. Initial/intake (may include use of standardized screening tools):
   A. Demographic data (name, age, date of birth, etc.);
   B. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
   C. Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living,

social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
D. History of behavioral health and health treatment (recent and remote);
E. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
F. Medical problems and medications currently prescribed;
G. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
H. Analysis of available social support system at present;
I. Mental status examination;
J. Recommended treatment (initial);
K. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and
L. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.
M. Efficacy of and compliance with past treatment. (If past treatment is reported)
N. Past treatment history and medication compliance (If past treatment is reported)

2. Re-assessment:
   A. Date of last comprehensive assessment;
   B. Current demographic data;
   C. Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such).
   D. Changes in situation, behavior, functioning since prior evaluation;
   E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
   F. Mental status examination;
   G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
   H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and
   I. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.

Note: H0031, T1023HE and **90791 or 90792** are not to be billed at the same initial intake or re-assessment unless the **H0031** is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using **90791 or 90792**.

503.15.2 PSYCHOLOGICAL TESTING WITH INTERPRETATION AND REPORT

Procedure Code: 96101

Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology or a Supervised Psychologist under supervision of a Board approved Supervisor.

Definition: Evaluation by a psychologist including psychological testing with interpretation and report. Psychological testing includes, but is not limited to standard psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. Academic assessment and assessment required to determine the needs, strengths, functioning level(s), mental status and/or social history of an individual are also included. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations. 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously interpreted, completed and reported technician-and computer-administered tests.

Note: Interpretation and report of technician and computer-based tests may not be completed using this service. It is intended for the integration of previously interpreted and reported technician and computer-based tests.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:

- Date of Service
- Location of Service
- Time Spent (Start/Stop Times)
- Signature with Credentials
- Purpose of the Evaluation
- Documentation that Medicaid Member was present for the evaluation
- Report must contain results (score and category) of the administered tests/evaluations
- Report must contain interpretation of the administered tests/evaluations
- Report must contain documentation of mental status exam
- Report must contain a rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology.
- Report must contain recommendations consistent with the findings of administered test/evaluation

Service Exclusions:

- Psychometrician/Technician Work
- Computer - Scoring
- Self-Administered Assessments
- Computer - Interpretation

503.15.3 PSYCHIATRIC DIAGNOSTIC EVALUATION (NO MEDICAL SERVICES)

Procedure Code:	90791
Service Unit:	Event (completed evaluation)
Service Limits:	Two events per year
Telehealth:	Available
Prior Authorization:	Refer to Utilization Management Guidelines.
Staff Credentials:	Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by Board approved Supervisor, a Physician, or a Physician Extender.

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Documentation: Documentation must contain the following and be completed in 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Purpose of Evaluation
- Psychiatrist's/Psychologist's signature with credentials
- Presenting Problem
- History of Medicaid Member's presenting illness
- Duration and Frequency of Symptoms
- Current and Past Medication efficacy and compliance
- Psychiatric History up to Present Day
- Medical History related to Behavioral Health Condition
- Mental Status Exam

- Members diagnosis per current DSM or ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

503.15.4 PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES *(this includes prescribing of medications)

Procedure Code: 90792
Service Unit: Event (completed evaluation)
Service Limits: Two events per year
Telehealth: Yes, as defined in Telehealth section.

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be completed by a physician or a physician extender

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Documentation: Documentation must contain the following and be completed 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Psychiatrist's signature with credentials
- Purpose of the evaluation
- Documentation that Medicaid Member was present for the evaluation
- Documentation that Medical Evaluation was completed
- Presenting Problem
- History of the Medicaid Member's presenting illness
- Duration and Frequency of symptoms
- Current and Past Medication including efficacy and compliance
- Psychiatric history up to present day
- Medical History related to behavioral health condition
- Documentation of Mental Status Exam

- Medicaid Member's diagnosis per current DSM and ICD Methodology
- Medicaid Member's prognosis and rationale
- Appropriate recommendations consistent with the findings of the evaluation

503.15.5 SCREENING BY LICENSED PSYCHOLOGIST

Procedure Code: T1023 HE
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One event every six months

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia Licensed psychologist or Supervised Psychologist in good standing with WV Board of Examiners of Psychology

Definition: This is a screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol. Procedure codes 96101 or 90791 must be used when a more in-depth assessment is indicated.

Documentation: Documentation must contain the following:

- Date of Service
- Location of Service
- Purpose of Evaluation
- Start/Stop Times
- Practitioner signature and credentials
- Appropriate recommendations based on clinical data gathered in the evaluation

503.15.6 DEVELOPMENTAL TESTING: LIMITED

Procedure Code: 96110
Service Unit: Event (completed interpretation and report)
Telehealth: Not Available
Service Limits: All units must be prior authorized

Payment Limits: This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96101) has been billed in the last six months.

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology, a Psychologist who is under the supervision of a Board approved Supervisor, a physician or physician extender.

Definition: This is limited to developmental testing (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report**.**

Documentation:

Documentation must contain the following:

- Date of Service
- Location of Service
- Purpose of Evaluation
- Time Spent (start/stop times)
- Signature with credentials
- Documentation that the member was present for the evaluation
- Documentation must contain the results (scores and category) of the administered tests/evaluations
- Documentation must contain the documentation of the mental status exam
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD Methodology

Recommendations consistent with the findings of the administered tests/evaluations.

503.16 SERVICE PLANNING REQUIREMENTS:

Coordinated Care Services:

Service planning and consultation is available only in the Coordinated Care model of service provision. Service planning codes cannot be billed when the development of a service plan is an integral aspect of the service being provided (for example, Community Psychiatric Supportive Treatment). Service planning is to be conducted when multiple programs and services need to be coordinated by a team representative of the differing agencies and provider groups providing care to the member.

All members receiving coordinated care must have a master service plan. The Agency may choose to create one plan that is modified as the individual moves through a service, or may choose to create an initial service plan followed by a master service plan. Agencies with services with shorter lengths of stay may choose the first option if the length of stay is predicted to be less than thirty days. The initial service plan must be completed within 7 days of admission to a service. The plan must be completed by the primary clinician and the member and/or member's guardian.

Development of the initial plan without the entire interdisciplinary team is not a billable service (see Service Plan Development for clarification and description of exceptions). The initial plan of service describes the services and/or supports the member is to receive until the assessment process is complete and the master plan of service is developed. This initial plan shall consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed;
- A listing of immediate interventions to be provided along with objectives for the interventions;
- A date for development of a master plan of services. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 days from the date of the signing of the initial plan. If a program is an intensive service the master plan must be completed within 7 days; and
- The signature of the member and/or DLR, intake worker, physician and other persons participating in the development of the initial plan.

The Master Service Plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessment(s) during the treatment process.

The Master Plan is developed within 30 days of admission and must include:

- Date of development of the plan;
- Participants in the development of the plan;
- A statement or statements of the goal(s) of services in general terms;
- A listing of specific objectives that the service providers and the member hope to achieve or complete;
- The measures to be used in tracking progress toward achievement of an objective;
- The technique(s) and/or services (intervention) to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives; and
- Discharge Criteria
- A date for review of the plan, timed in consideration of the expected duration of the program or service.
- Start and Stop Times
- Credentials

It is expected that objectives be specific, measureable, realistic and capable of being achieved in the time available in the projected duration of the program or service.

Service plans must be flexible documents that are modified by the team as necessary and clinically appropriate. Service plans must be revisited at critical treatment junctures including changes in level of service to more intensive or less intensive types of care. When an intervention proves to be ineffective the service plan must reflect consideration by the team of changes in the intervention strategy.

503.16.1 MENTAL HEALTH SERVICE PLAN DEVELOPMENT

Procedure Code: H0032
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 16 units per 90 day period. If Medicaid Member is in *Focused Care* H0032 cannot be billed.

Prior Authorization: Refer Utilization Management Guidelines.

Definition: An individual service plan is required for all members receiving services through *Coordinated Care.* The treatment team consists of the member and/or guardian, and/or member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers must be invited to participate in the service planning session. All members of the team must receive adequate notice of the treatment team meeting. If a member of the team does not come, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances. A physician extender may serve on the committee in place of the physician.

An Initial Service Plan is developed based on intake information within seven days of intake; a Master Service Plan is developed within 30 days of intake and must be updated at least every 90 days. It must be updated more frequently, at critical treatment junctures, if necessitated by the member's needs.

All service plans (including updates) must be reviewed, signed, and approved by a physician within 72 hours of the service plan meeting and prior to implementing services.

The physician, designated physician extender, or licensed or supervised psychologist must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency
- Have a diagnosis of major psychosis or major affective disorder
- Have an I/D Diagnosis
- Have an Autism Diagnosis
- Have major medical problems in addition to major psychosis and medications
- The presence of the physician or physician extender has been specifically requested by the case manager or the member.

The case manager is responsible for the scheduling and coordination of treatment team meetings, monitoring the implementation of the service plan, and for initiating treatment team meetings as the needs of the member dictate. Justification for the presence of each staff person participating in the meeting is the responsibility of the case manager. Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process. Service planning meetings must be scheduled at times and places that facilitate the

inclusion of the member. The agency providing services to the member may bill for participation by any of their staff necessary for the service planning process. Participation by staff from other agencies is not billable by the agency coordinating the service planning session. Participation by family members is not billable. It is important to remember that, although coordination of the service planning process is the responsibility of the case manager, development of the service plan is the responsibility of the treatment team.

Providers must make the proper distinction between service planning and other activities related to case management for the member. The case manager may be involved in the development of individual program plans, such as residential plans, day treatment plans, work training plans, educational plans, etc. as called for by the member's Master Service Plan. These types of activities may constitute billable time for case management services; ***however, when the case manager participates in a treatment team meeting he/she must bill Mental Health Service Plan Development rather than Targeted Case Management.***

Individual program plans for Day Treatment, Children's Residential Services, and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services.

Mental Health Service Plan Development reimburses for team member participation. A written service plan is a product of that process and serves as substantiation that the process took place.

Documentation: The following documentation is required for substantiation of Mental Health Service Plan Development:

- A service plan signature page is required. This document is to be placed in the member's clinical record along with the completed service plan or service plan update.
  - There must be signatures of all participating members of the treatment team (including the member, their guardian, or the member's requested representative).
  - All signatures must be original, must include the title and credentials of the individual, must be dated by the treatment team member, and must include the actual time spent providing the service by listing the start-and-stop times of their participation. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process.
- If a staff person from another agency participates in the service planning session, he/she must:
  - Meet the previously listed requirements of the service plan signature page. This includes signing the signature page along with listing the agency they are representing.
  - Write an activity note (which must be included in **their** agency's clinical record) that states their purpose for participating in the meeting, their signature and credentials, the location of the session, date of session, and the actual time spent participating in the session by listing their start-and-stop times.

Documentation must contain the physician's signature or that of the psychologist or physician extender on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

If the member, their guardian, or the member's requested representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within 7 calendar days by the member or their guardian. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.

503.16.2 MENTAL HEALTH SERVICE PLAN DEVELOPMENT BY PSYCHOLOGIST

PROCEDURE CODE: H0032 AH
SERVICE UNIT: 15 minutes
TELEHEALTH: Available
SERVICE LIMITS: One unit per month
PRIOR AUTHORIZATION: Refer to Utilization Management Guidelines.

DEFINITION:
These are activities performed by a licensed psychologist directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Mental Health Service Plan Development.

DOCUMENTATION:
Documentation must contain the licensed psychologist's signature, **in ink or in an electronic documentation system**, on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and stop times of his/her participation. A psychologist under supervision of a Licensed Psychologist may perform this service with oversight of their Supervising Licensed Psychologist. The Supervising Licensed Psychologist must indicate their oversight by their signature and the date.

503.16.3 PHYSICIAN COORDINATED CARE OVERSIGHT SERVICES

Procedure Code: G9008
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 2 units per 90 days

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by physician or physician extender.

Definition: These are activities performed by a physician or physician extender directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Also, refer to Mental Health Service Plan Development.

Documentation: Documentation must contain the physician or physician extender's signature, date of signature, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

503.16.4 CASE CONSULTATION

Procedure Code: 90887
Service Unit: Event
Telehealth: Available

Service Limits: 1 unit per 90 days

Prior Authorization: Refer to Utilization Management Guidelines

Definition: A Case Consultation Service is an interpretation or explanation of results of psychiatric, and other medical examinations and procedures through the requesting clinician to family or other responsible persons.

These are services provided at the request of a professional requiring the opinion, recommendation, suggestion and/or expertise of another professional for a specific purpose regarding services and/or activities of a member relevant to the particular area of expertise of the consulting professional. The consulting professional must be licensed or certified in the needed area of expertise.

Case Consultation may not be used during service planning. The member's case manager cannot be a case consultant. Professional staff persons who participated in the current member's service plan within the current 90 day period, or were directed to provide treatment, cannot bill for case consultation.

Only the consulting professional's time may be billed for this service. Any other professional(s) involved in the case consultation may not bill case consultation for their time. The consulting professional whose services are being billed must currently be an enrolled Medicaid provider if he/she is not an employee (either directly or under contract) of the agency seeking consultation.

Documentation: The consulting professional must document a summary of the consultation that includes: purpose, activities/services discussed, recommendations with desired outcomes, the relationship of the consultation to a specific objective(s) in the service plan, date of service, location, signature and credentials of the consulting professional, and the actual time spent providing the service by listing the start-and-stop times of the consultation.

503.17 SUPPORTIVE SERVICES

503.17.1 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, INDIVIDUAL

Procedure Code: H0004HO
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 60 units per year

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Definition: Behavioral Health Counseling, Professional, Individual, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service.

Often by necessity, Behavioral Health Counseling of children will involve work with parents as the agent of change in maladaptive behavior of children. Structured behavior therapies designed to provide parents with therapeutic tools to control and modify inappropriate behavior and promote adaptive coping behaviors are considered to be appropriate use of this service.

Documentation: Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal and/or objective on the Plan. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

503.17.2 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, GROUP

Procedure Code: H0004 HO HQ
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 50 units per year

Payment Limits: Behavioral Health Counseling, Professional, Group sessions are limited in size to a maximum of 12 persons per group session.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Professional, Group, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Definition: Behavioral Health Counseling, Professional, Group, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourages personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member in a group setting.

Any therapeutic interventions applied must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Group so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

Documentation: Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response

to the service. If there is a Master Service Plan, the intervention should be reflective of a goal on the Plan. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

503.17.3 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, INDIVIDUAL

Procedure Code: H0004
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

Definition: Behavioral Health Counseling, Supportive, Individual is a face-to-face intervention provided to a member receiving coordinated care. It must directly support another Behavioral Health service to meet service definition and medical necessity The supportive intervention is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Individual, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Service Description:

Supportive counseling should:

1) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional

control as it impacts daily functioning as related to their behavioral health condition; and/or

2) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Documentation: There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the member's response to the supportive intervention including any improvement or exacerbation of symptoms.

503.17.4 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, GROUP

Procedure Code: H0004HQ
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Payment Limits: Behavioral Health Counseling, Supportive, Group sessions are limited in size to a maximum of 12 persons per group session.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

Definition: Behavioral Health Counseling, Supportive, Group is a face-to-face coordinated care intervention that is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Group, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Service Description:

Supportive counseling should:

1.) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or

2.) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Documentation: There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the member's response to the supportive intervention including any improvement or exacerbation of symptoms.

503.18 SKILLS TRAINING AND DEVELOPMENT

Procedure Code: H2014U4 Skills Training 1:1 by Paraprofessional
H2014U1 Skills Training 1:2-4 by Paraprofessional
H2014HNU4 Skills Training 1:1 by Professional
H2014HNU1 Skills Training 1:2-4 by Professional
Service Unit: 15 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Skills Training and Development is a combination of structured individual and group activities offered to members who have basic skill deficits. These skill deficits may be due to several factors such as history of abuse or neglect, or years spent in institutional settings or supervised living arrangements that did not allow normal development in the areas of daily living skills.

The purpose of this service is to provide therapeutic activities focused on Skills Training and Development Services which are elementary, basic, and fundamental to higher-level skills and are designed to improve or preserve a member's level of functioning. Therapeutic activities may be provided to a member in his/her natural environment through a structured program as identified in the goals and objectives described in the service plan. Therapeutic activities include, but are not limited to:

- Learning and demonstrating personal hygiene skills
- Managing living space
- Manners
- Sexuality
- Social appropriateness
- Daily living skills

Where these services are provided in a group context, the group must be limited to four members to each staff person. In any setting, these services target members who require direct prompting or direct intervention by a provider.

Recreational trips, visits to the mall, recreational/leisure time activities, activities which are reinforcements for behavioral management programs, and social events are not therapeutic services and cannot be billed as Skills Training and Development Services.

The following guidelines apply to Skills Training and Development Services provided to young children:

- The service must be age and functionally appropriate and be delivered at the intensity and duration that best meets the needs of individual children.
- The service must not be utilized to provide therapeutic activities for children under the age of five in a group setting for more than four hours per day or more than four days per week.
- Therapeutic activities for young children must promote skill acquisition, include necessary adaptations and modifications, and be based upon developmentally appropriate practice. These services must also be provided in a way that supports the daily activities and interactions within the family's routine.

Skill acquisitions for Skills Training and Development Services for young children include, but are not limited to:

- Adaptive, self-help, safety, and nutritional skills
- Parent-child interactions, peer interactions, coping mechanisms, social competence, and adult-child interactions
- Interpersonal and communication skills
- Mobility, problem solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills.

Documentation: Documentation must contain an activity note describing the service/activity provided and the relationship of the service/activity to objectives in the member's service plan. Documentation must include: the signature and credentials of the staff providing the service,

place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

Additionally, if the service is provided in a ratio of 1:2-4, there must be an attendance roster listing those members and staff who participate in each ratio. The roster must be signed (with credential initials) and dated by staff that provided the service. It must not be stored in the main clinical record, but must be maintained and be available for review.

503.19 GENERAL MEDICATION SERVICES

General medication services assist a Medicaid member in accessing behavioral medication or medication services. (Methadone administration or case management is not covered.)

503.19.1 COMPREHENSIVE MEDICATION SERVICES: MENTAL HEALTH

Procedure Code: H2010
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Payment Limits: This service includes all physician and nurse oversight; therefore, neither Community Psychiatric Support Treatment (procedure code H0036), Pharmacologic Management (E&M Codes), nor any other physician code can be billed on the same day as Comprehensive Medication Services; Mental Health.

Prior Authorization: Refer Utilization Management Guidelines.

Staff Credentials: Physician or Physician Extender

Definition: Comprehensive Medication Services; Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy. These services include obtaining the sample for necessary blood work and the laboratory results for a member by a registered nurse and subsequent evaluation of the results by the physician and/or physician extender as necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. This is a physician directed service, a physician or physician extender must be on site and available for direct service as needed. Members may be served individually or by a group/clinic model. Methadone is **not** a covered medication.

Members receiving this service are not precluded from receiving other Behavioral Health Rehabilitation Services on the same day (except for those indicated in this service's definition or "Payment Limits") as long as the actual time frames do not overlap.

Documentation: Documentation must contain a written note of the assessment results as completed by the registered nurse, and other laboratory results, and current psychotropic medication dosage with authorized pharmacy name. The documentation must include: place of service, start/stop time and date of service, and signature of qualified staff providing the service.

503.19.2 NON-METHADONE MEDICATION ASSISTED TREATMENT

Non-Methadone Medication Assisted Treatment Guidelines:

West Virginia Medicaid covers non-Methadone Medication Assisted Treatment Services under the following circumstances:

- Individuals seeking opioid addiction treatment for Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician as specified below, before beginning medication assisted treatment.
- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.
- All physicians agree to adhere to the Coordination of Care Agreement (See Attachment A) which will be signed by the member, the treating physician and the treating therapist.
- Each member receiving non-methadone medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.
- The agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.

Physician Requirements: The physician responsible for prescribing and monitoring the member's treatment must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider.

Therapy Services: Therapy for Non-Methadone Assisted Treatment Patients is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service **(See Program Guidelines for Professional Therapy Requirements).**

Any therapeutic intervention applied must be performed by a minimum of a Master's Level Therapist using the generally accepted practice of therapies recognized by national accrediting bodies of:

- Psychology plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Psychiatry plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Counseling plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Social work plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions

Physician and Professional Therapy services will be provided for individuals utilizing Buprenorphine, Suboxone strips or Vivitrol®. Agencies should be aware that West Virginia law forbids the use of Buprenorphine/Naltrexone in tablet form for the treatment of substance use disorders.

Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic interventions. The plan must also include a schedule detailing the frequency for which therapy services are to be provided.
A member receiving focused care (Physician and Professional Therapy only) will require a treatment strategy in lieu of a Master Service Plan.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the objectives utilizing individual therapeutic interventions. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Program Guidelines:

Note: These are the minimum requirements that are set forth in this manual. Physicians and/or agencies may have more stringent guidelines set forth in their internal policy.

Phase 1: Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of professional therapeutic services per month. The four hours must contain a **minimum** of one (1) hour individual professional therapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

Phase 2: Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of professional therapeutic services per month individual, family, or group. Frequency of therapeutic services may increase based upon medical necessity.

Drug Screens: A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2. A record of the results of these screens must be maintained in the member's record. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

Instructions for non-compliance with treatment:
Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as: two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician's discretion. The physician and/or treatment program has the option to allow the patient to reapply to the program after 30 days with proven participation in professional therapies. With three violations within six months, the physician will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.

Titration Policy: Titration due to non-compliance is per Physician order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Non-Methadone Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise. The Physician must work with another physician that has a DEA-X. The physician taking responsibility for prescribing and monitoring the member's treatment while the primary physician is unavailable must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed, board certified and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act

of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider so that treatment is not interrupted for any reason for Medicaid Members participating in this service. If a physician fails to have a plan in place **a hold will be placed on all Rx authorizations**. At no time is a Nurse Practitioner or a Physician's Assistant to prescribe Suboxone.

503.20 COMPREHENSIVE PROGRAMS OF SERVICES

Comprehensive services are all-inclusive and may have only a few services which can be billed separately.

503.20.1 DAY TREATMENT

Procedure Code: H2012
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Payment Limits: Day Treatment services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Rehabilitation Service.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Day Treatment is a structured program of on-going, regularly scheduled therapeutic activities to increase a member's skill level, produce behavioral change which improves adaptive functioning, and/or which facilitates progress toward more independent living in accordance with member's potential and interest as reflected in the Service Plan Day Treatment Services for adults have a maximum staff-to-member ratio of one staff person per five members. They must be available for five days a week for a minimum of four hours each day.

For children under age five, the maximum ratio is one staff per four children. Day Treatment Services for children under the age of five must not be utilized to provide therapeutic activities for more than four hours per day and no more than four days per week.

Day Treatment Services must only be provided at a site listed on the provider's behavioral health provider license. **Activities provided for the purpose of leisure or recreations are not billable services.**

Day Treatment Services include activities occurring in a therapeutic environment designed to increase the members' skills in specific areas. These activities may consist of small group activities using training modules or structured developmental exercises which present the opportunities for members to practice and use developing skills, or participate in member meetings designed to develop social skills. The intensity, frequency, and type of Day Treatment activities must be appropriate to the age and functional level of the member.

Progress on all objectives must be reviewed at 90 day intervals. Any objective that results in no progress after two consecutive 90 day intervals must be discontinued or modified. Areas of intervention may include but are not limited to the following:

- Self-care skills
- Emergency skills
- Mobility skills
- Nutritional skills
- Social skills
- Communication and speech instruction
- Carryover of physical and/or occupational therapy
- Interpersonal skills instruction
- Functional community skills (such as recognizing emergency and other public signs, money management skills, travel training, etc.)
- Volunteering in community service settings
- Citizenship, rights and responsibilities, self-advocacy, etc.
- Other services necessary for a member to participate in the community settings of his/her choice

Program Staff Requirements:

- The Day Treatment program supervisor must meet one of the educational criteria along with the training and experience criteria listed below:
  - Education Criteria (one of the educational criteria must be met):
    - Licensed Psychologist (or Masters level psychologist under supervision for licensure)
    - Licensed Professional Counselor
    - Licensed Certified Social Worker
    - Licensed Social Worker with a minimum of a Bachelor's degree
    - Registered Nurse
    - Masters or Bachelor's level in education with a specialization to a disability group and teaching certification
    - Occupational/recreational or physical therapist with appropriate state certification and licensure
    - Certified Addiction Counselor with minimum of a bachelor degree
    - Masters degree in a human services field with 20 hours verified of training specific to the target population served
  - Bachelor's level degree in a human services field with at least one year of specific experience providing services to the target population served.
  - Training Criteria
    - Each qualified staff person must have verified training, experience, and skills specific to the targeted population served by the Day Treatment Program

  - Experience Criteria
    - All Bachelor level staff are required to obtain 15 hours every two years of continued education relevant to the targeted population served or the provision of Day Treatment Services

- Staff with a Bachelor's degree in a human service field that does not specifically provide training in developmental disabilities services must meet one of the three following criteria:
  - Completion of specific courses relating to developmental disabilities
  - Completion of staff development in-service or classes relating to developmental disabilities
  - Completion of 15 hours every two years of continuing education relating to developmental disabilities.

- Paraprofessional staff must have, at a minimum, the following qualifications:
  - Be at least 18 years old
  - A high school diploma or Graduate Equivalent Degree
  - Be currently certified in Standard First Aid and Adult/Child Cardiopulmonary Resuscitation
  - Successfully completed Behavioral Health agency training in all of the following criteria:
    - Various aspects of developmental disabilities
    - Instructional techniques necessary to achieve objectives of individual's program plans
    - Health related issues
    - Recognition of abuse and neglect
    - Individuals' rights and confidentiality
    - Awareness of, and sensitivity to, family and individual's needs
    - Non-aversive behavior intervention techniques for those providers who are implementing behavior support and intervention plans

The Behavioral Health Rehabilitation Provider must maintain documentation of training and qualifications.

Documentation:

- Documentation must contain a daily summary of Day Treatment Services that includes the total time in attendance at the Day Treatment Program by listing the start and stop times of each member's attendance, the place of service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary. This documentation is not required to be stored in the main clinical record, but must be maintained and be available for review.
- Documentation must also include an activity note that describes each separate service/activity provided and the relationship of the service to objectives in the service plan. This includes the signature of staff providing the service along with their credentials, place

of service, date of service, and actual time spent providing the service by listing the start and stop times. **Note: All treatment objectives provided in the Day Treatment Program must be included on the member's Master Service Plan (or 90 day update).**

- There must be a daily attendance roster listing those members and staff who participate in each ratio. The roster must be signed (with credential initials) and dated by staff that provided the service. This daily attendance roster must not be stored in the main clinical record, but must be maintained and be available for review.
- There must be monthly notes that summarize progress on the objectives specified in the individual member's service plan or Day Treatment Plan. This documentation must be reviewed at 90 day intervals. The review summaries must be placed in the member's master clinical record. Any objective that results in no progress or desired changes after two consecutive 90 day periods must be discontinued or modified.

Day Treatment Program Certification Process:

Behavioral Health Rehabilitation providers must obtain approval from BMS to provide Day Treatment Services and to bill the West Virginia Medicaid Program for such services. Providers must complete and send the Day Treatment Program Certification form to BMS.

Any changes from an approved original certification must be submitted with corresponding rationale for the changes. A Day Treatment Program must recertify every 2 years. This submission must include a summary of utilization information for the 2 years. Specific content is listed on the Application for Day Treatment Program Certification used by BMS.

503.20.2 COMPREHENSIVE COMMUNITY SUPPORT SERVICES

PROCEDURE CODE: H2015
TELEHEALTH: Unavailable
SERVICE UNIT: 15 minutes
SERVICE LIMITS: All units must be prior authorized

PAYMENT LIMITS: Comprehensive Community Support services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Rehabilitation Service.

PRIOR AUTHORIZATION: Refer to Utilization Management Guidelines.

DEFINITION: Comprehensive Community Support is a long-term, preventive, and rehabilitative service designed to serve members with severe and persistent mental illness whose quality of life and level of functioning would be negatively impacted without structured, ongoing skill maintenance and/or enhancement activities. This is a structured program of ongoing, regularly scheduled activities designed to maintain a member's level of functioning, prevent deterioration which could result in the need for institutionalization, and/or facilitate a member's return to their previously demonstrated level of functioning. This may be accomplished through skill maintenance and/or development and behavioral programming designed to maintain or improve adaptive functioning. This service emphasizes community-based activities.

Comprehensive Community Support Services are to be provided in accordance with the member's potential and interests as reflected in the Master Service Plan. The intensity, frequency and type of Comprehensive Community Support activities must be appropriate to the age and functional level of the member, and individualized to meet their own specific needs and future plans. Critical skills identified as essential to maintain placement in the community and preventing hospitalization will also be targeted for skill maintenance/enhancement.
Examples of skill areas (if the member has the specific need) include:

- Health Education - first aid, pedestrian and passenger safety, home safety
- Meal Preparation - nutrition, menu planning, cooking
- Personal Hygiene - grooming, oral and general body care
- Utilization of Community Resources - church groups, clubs, volunteer work, getting and keeping entitlements, learning to access recreational opportunities, Internet and computer skills, etc. [Note: Recreational activities themselves (including trips to a mall, activities which may be reinforcement for a behavioral program, and social events) are not billable under this code.]
- Interpersonal Skills
- Problem Solving
- Communications - assertiveness, correspondence, initiating conversation, giving and taking compliments and criticism, body language, active listening, etc.
- Stress Reduction - relaxation techniques, biofeedback, etc.
- Interpersonal relationships with peers, caregivers, family, etc.
- Interaction with strangers
- Social Skill Development and Coping Skills
- Social Competence - social skill training, presenting opportunities for social interaction
- Understanding Mental Illness - medication usage, course of the illness, symptom management, coping mechanisms, normalization, etc.

This service has a maximum staff-to-member ratio of one staff person per 12 members when provided at a licensed site; and a maximum staff-to-member ratio of one staff person to eight members when provided in a community setting. The amount of Comprehensive Community Support provided is individually determined and should not automatically reflect the program's operating hours. Members eligible for Comprehensive Community Support do not meet medical necessity for Day Treatment services. Comprehensive Community Support services must be based at a site listed on the agency's behavioral health license. Training may occur onsite or in community settings.

DOCUMENTATION:

- All treatment objectives addressed in a Comprehensive Community Support Program must be included on the member's Individual Master Service Plan.
- A daily attendance roster reflecting all participants (with start-and-stop times of participation specific to each member) must be maintained and available for review at the community treatment site. The roster must be signed and dated by all staff that have been providing Comprehensive Community Support Services, and must list staff start-and-stop times. The

daily attendance roster must note the location of the services/activities and actual staff/member ratios. It is not required to be maintained in the master clinical record, but must be maintained in accordance with Medicaid records retention policy. After one year, daily attendance rosters may be stored at the provider's record retention facility.

- Documentation for each daily episode of Comprehensive Community Support must include a description of the service/activity provided and the relationship of the service/activity to objectives in the service plan. Progress on each objective in the service plan being addressed must be noted. Documentation must include the date of service, start-and-stop time spent for each specified activity, and the location of the service/activity. Daily documentation must become part of the master clinical file.
- When services are reviewed by the treatment team as part of the service planning process, each objective being implemented in the Comprehensive Community Support Program must be addressed. Documentation must include progress toward objectives, problems that impeded progress, and provide a decision to continue the same plan, or adjust the plan to meet the changing needs of the member. Additionally, all documentation requirements for Mental Health Service Plan Development (procedure code H0032) must be satisfied.

STAFF QUALIFICATIONS:

- The Comprehensive Community Support program site must be supervised by a Qualified Mental Health Professional (QMHP) with a minimum of a Bachelor's degree and experience working with individuals with serious and persistent mental illness. The full-time-equivalent hours in the agency's job description for the supervisor must reflect the number of hours expected supervising the program If the supervisor is included as part of the direct care ratio, the hours spent supervising must be outside of the direct care hours provided by the supervisor.
- Paraprofessional staff must possess at a minimum a high school diploma and have verified training, experience and skills specific to working with individuals with serious and persistent mental illness.

COMPREHENSIVE COMMUNITY SUPPORT PROGRAM CERTIFICATION PROCESS:

- All Comprehensive Community Support programs require approval through the completion of the Comprehensive Community Support Certification Form. The application is reviewed and subject to approval by the Bureau for Medical Services.
- New Comprehensive Community Support Programs must submit the Comprehensive Community Support Certification Form to BMS for approval. All programs must be based at a site listed on the provider Behavioral Health License. Billing may commence after receiving initial Bureau approval.
- After initial approval, a desk review and/or an onsite review will be conducted to validate the approval. BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per policy contained in Chapter 800 (A), Medicaid regulations.
- Any changes from an original certification must be submitted with corresponding rationale for the changes. See Attachment C.

503.21 CRISIS SERVICES

503.21.1 CRISIS INTERVENTION

Procedure Code: H2011
Service Unit: 15 minutes- 16 units per 30 days
Telehealth: Not Available
Service Limits: Refer to Utilization Management Guidelines.

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Bachelor's degree in Human Services with specific documented training on crisis intervention

Definition: Crisis Intervention is an unscheduled, direct, face-to-face intervention with a member in need of psychiatric interventions in order to resolve a crisis related to acute or severe psychiatric signs and symptoms. Depending on the specific type of crisis, an array of treatment modalities is available. These include, but are not limited to, individual intervention and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation, stabilize and create a plan as quickly as possible. This service is not intended for use as an emergency response to situations such as members running out of medication or housing problems. Any such activities will be considered inappropriate for billing of this service by the provider.

Documentation: Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

A physician, physician extender, supervised psychologist or licensed psychologist must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow up and whether the treatment plan is to be modified or maintained, the signature and credentials of the physician, physician extender, supervised psychologist or licensed psychologist and the date of service. The signature will serve as the order to perform the service. If a supervised psychologist is utilized to provide approval for this service, the supervised psychologist must have completed an appropriate training in crisis intervention and systematic de-escalation.

Providers must maintain a permanent clinical record for all members of this service in a manner consistent with applicable licensing regulations.

Exclusions

Listed below are activities that are excluded from being performed through the Crisis Intervention Service Code

- Response to a Domestic Violence Situation
- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting for Transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

503.21.2 COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

Procedure Code: H0036
Service Unit: 15 minutes
Telehealth: Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person
Service Limits: 288 units per six months

Payment Limits: No payment will be made for any other Behavioral Health Rehabilitation Services, except for Targeted Case Management (procedure code T1017). Billing for Community Psychiatric Supportive Treatment cannot exceed 48 units in a 24 hour period (midnight to midnight) and must be utilized on consecutive days.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Community Psychiatric Supportive Treatment is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs and symptoms. (If a Medicaid member experiences more than one crisis, each crisis is considered a separate crisis episode). This physician driven service is intended for persons whose condition can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

Due to the comprehensive nature of this service, no other services (other than Targeted Case Management) may be reimbursed when Community Psychiatric Supportive Treatment is on-going. These services are not intended for use as an emergency response to situations such as members running out of medication, or loss of housing. Any such activities will be considered as non-reimbursable activities. Since this service is intended to address an episode, it must be rendered on consecutive days of service. Community Psychiatric Supportive Treatment cannot be rendered on alternate days such as Tuesday and Thursday or only on Mondays, Wednesdays, and Fridays; with other days of non-service (such as holidays or weekends) or other intervening services interrupting the episode. Community Psychiatric Supportive Treatment is an acute and short-term service.

Community Psychiatric Supportive Treatment Programs must be available seven days a week to anyone who meets the admission criteria. Availability may include mornings, afternoons, evenings, etc. There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must have at least high school degree or equivalency, trained in systematic de-escalation, and must have training related to the targeted population being treated (i.e. substance abuse, mental health). The other staff must have an LPN or higher degree in the medical field (See Definitions for further clarifications). Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to assure that each member receives appropriate individual attention, as well as assure the safety and welfare of all members.

The program must have access to a psychiatrist/physician/physician extender to provide psychiatric evaluations and medication orders at all times.

Much of the structured, staff-directed activity or face-to-face activity which has been documented in an activity note can be considered billable time. Some examples of billable versus non-billable time are as follows:

- Billable activities:
  - Structured, staff-directed activities such as therapies and counseling
  - Time spent by staff in the process of interviewing/assessing members whether for social history, discharge planning, psychological reports, etc.
  - Time spent in treatment team meetings or staff consultation
  - Time spent by staff monitoring one member when specifically ordered by the physician/psychiatrist for reasons of clinical necessity (The physician/psychiatrist's order must state the frequency and duration of the time to be spent monitoring.)
  - Routine observation/monitoring by staff ordered by physician/psychiatrist limited to 10 minutes per hour (can include member's sleep, meal, grooming time). Routine observation time cannot exceed two hours per day. The physician must document the need for the observation as related to the Medicaid Member's qualifying behavioral health condition/crisis episode.
- Non-billable activities:
  - Activity which is recreation or leisure in nature, such as basketball, exercise, reading a newspaper, watching television and or videos
  - Social activity such as talking with other members, visiting with family members or significant others, releasing the member from the program on pass
  - Time in which the member is sleeping, eating, grooming (except as outlined above).

The following elements are required components of Community Psychiatric Supportive Treatment:

- Comprehensive Psychiatric Evaluation at intake to contain documentation of:

A. Reason for admission/presenting problems: Purpose of evaluation is to assess symptoms in order to determine need for crisis stabilization services, determine need for changes to medication regimen, and develops an initial plan of care as appropriate.
B. Presenting problems/reason for the evaluation including list of any collateral interviews conducted
C. History and description of present illness
D. Past psychiatric history including description of any past suicidal or homicidal behavior or threats
E. History of alcohol and other substance use including longest period of sobriety, history of prior treatment attempts, and medical risks associated with detoxification as appropriate
F. General medical history including list of current medications, current medical providers, and past treatment attempts (may be completed by ancillary staff person)
G. Developmental, psychosocial and sociocultural history (may be completed by ancillary staff person)
H. Occupational and military history (may be completed by ancillary staff person)
I. Legal history (may be completed by ancillary staff person)
J. Family history (may be completed by ancillary staff person)
K. Review of systems (sleep, appetite, pain levels, other systems directly linked to the patient's psychiatric symptoms)
L. Focused Physical examination including appearance and vital signs, musculoskeletal review of gait and station and description of any specific physical anomalies and allergies
M. Mental status examination including assessment of insight, judgment, and general cognitive functioning
N. Assessment of daily functionality and ADLs (may be completed by ancillary staff person)
O. Diagnostic conclusions and prognosis
P. Treatment recommendations including clear statement of justification for recommendation for admission to CSU and reasoning for elimination of lesser level of care.

- Daily psychiatric review and examination
- On going psychotropic medication evaluation and administration
- Intensive one-on-one supervision, when ordered by a physician/psychiatrist
- Individual and small group problem solving/support as needed
- Therapeutic activities consistent with the member's readiness, capacities, and the service plan
- Disability-specific interdisciplinary team evaluation and service planning before discharge from Community Psychiatric Supportive Treatment. Discharge service planning must include consideration of the antecedent condition that led to admission to Community Psychiatric Supportive Treatment.
- Psychological/functional evaluations specific to the disability population where appropriate and;

- Family intervention must be made available to the families of members as appropriate Community Psychiatric Supportive Treatment must be provided at a site licensed by WVDHHR for the delivery of Behavioral Health Rehabilitation Services.

ADMISSION AND CONTINUED STAY CRITERIA:

The criteria for prior authorization to exceed service limits for Community Psychiatric Supportive Treatment Services are organized around three primary areas that determine the need for this service:

- Acute Psychiatric signs and symptoms
- Danger to self/others
- Medication management/active drug or alcohol withdrawal

Additionally, criteria for continued stay have been devised so that those members who still require Community Psychiatric Supportive Treatment Services can be authorized to continue services.

To receive or continue to receive Community Psychiatric Supportive Treatment Services, the following corresponding criteria must be satisfied.

- **PSYCHIATRIC SIGNS AND SYMPTOMS**

  Admission Criteria (Both criteria must be met)

  - The member is experiencing a crisis due to a mental health condition or impairment in functioning due to acute psychiatric signs and symptoms. The member may be displaying behaviors and/or impairments ranging from impaired abilities in the daily living skills domains to severe disturbances in conduct and emotions. The crisis results in emotional and/or behavioral instability that may be exacerbated by family dysfunction, transient situational disturbance, physical or emotional abuse, failed placement, or other current living situation;

  - The member is in need of a structured, intensive intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the member's needs based on the documented response to prior treatment and/or interventions.

  Continued Stay Criteria (One of the three criteria must be met)

  - The acute psychiatric signs and symptoms and/or behaviors that necessitated the admission persist at the level documented at admission and the treatments and interventions tried are documented. A modified care plan must be developed which documents treatment methods and projected discharge date based on the change in the care plan.

- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new acute psychiatric symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.

- Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.

- **DANGER TO SELF/OTHERS**

  Admission Criteria

  - The member is in need of an intensive treatment intervention to prevent hospitalization (e.g. the member engages in self-injurious behavior but not at a level of severity that would require inpatient care, the member is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).

  Continued Care Criteria (One of the three criteria must be met)

  - Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.
  - It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
  - New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting and, a less intensive level of care would not adequately meet the member's needs.

- **MEDICATION MANAGEMENT/ACTIVE DRUG OR ALCOHOL WITHDRAWAL**

  Admission Criteria (Either criteria must be met)

  - The member is in need of a medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect.
  - There is evidence that the member is using drugs that have produced a physical dependency as evidenced by clinically significant withdrawal symptoms which require medical supervision.

Continued Stay Criteria (One of the three criteria must be met)

- Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but treatment goals have not been reached.
- It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.

- **DOCUMENTATION**

  There must be a permanent clinical record consistent with licensing regulations and agency records/policies for each member-provided Psychiatric Supportive Treatment Service. Items to be included in the clinical record are written orders (for each crisis episode) from the physician/psychiatrist for the Community Psychiatric Supportive Treatment Program, medication orders for each member as indicated, medication administration records when medications are administered, and the member's individualized service plan. See below for Documentation Requirement.

  Daily Documentation criteria:

- Number of treatment hours per day
- Summary of the member's status – need for continued CSU
- Member's Service participation
- Symptoms related to the crisis that are being addressed
- If admitted for detox; vitals and use of nationally recognized withdrawal protocol
- Services Provided:

Individual Therapy – notes at a minimum need to contain:

- Addressed specifics of admission criteria to substantiate appropriate level of care
- Substantiation of daily/appropriate treatment services
- Intervention

- Relate back to treatment plan
- Member's response

Group Therapy – notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care
- Substantiation of daily/appropriate treatment services
- Intervention
- Relate back to treatment plan
- Member's response

Family Therapy – notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

Individual Supportive Counseling: notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

Group Supportive Counseling: notes at a minimum need to contain:

- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

503.22 ASSERTIVE COMMUNITY TREATMENT (ACT)

Procedure Code: H0040
Service Unit: 24 hours

Telehealth: Available for the following services Behavioral Health, Supportive, Individual and Group; Behavioral Health Counseling, Professional, Individual and Group; Mental Health Assessment by Non-Physician; Psychiatric Diagnostic Evaluation (No Medical Services); Psychiatric Diagnostic Evaluation with Medical Services; medication management via E/M codes; and Screening by a Licensed Psychologist.

Service Limits: One per day - All units must be prior authorized

Payment Limits: Payment for ACT services is all-inclusive. GT Modifier does not need to billed when Telehealth is utilized. Documentation should reflect that Telehealth was utilized.

No payment will be made for ACT services when the member is hospitalized for a psychiatric condition, or receiving Community Psychiatric Supportive Services (except for 84 hours per year). However, the ACT Team must maintain contact and be part of the hospital discharge efforts. No Psychiatric services other than 90887, Personal Care Services (procedure codes T1001, T1002, or T1019) or H0036 Community Psychiatric Supportive Services up to 84 hours per year may be billed for members receiving ACT services; however ACT cannot be billed concurrently with Community Psychiatric Supportive Services.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: ACT is an inclusive array of community-based rehabilitative mental health services for members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization and therefore, require a well-coordinated and integrated package of services, provided over an extended duration, in order to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have co-occurring conditions including mental health and substance use or mental health and mild intellectual disability. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT team members in the member's community environment.

ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a more supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

Only qualified teams, certified by the Bureau of Behavioral Health and Health Facilities and the Bureau for Medical Services, may provide ACT services. Certification of the team must be renewed, following initial approval, at Bureau-designated intervals, or with any changes in personnel. All currently certified ACT Teams must submit for recertification by January 1, 2015.

Purpose: ACT is a service designed to achieve the following treatment goals:

- To reduce psychiatric hospitalization for members with serious and persistent mental illnesses;
- To provide an established clinical relationship with the member and his or her natural support system in order to promote continuity of care;
- To compose and implement a mutually agreed service plan promoting success and satisfaction in the community;
- To increase the cognizance of the member to the need for medication compliance, the nature of his or her disease, and early warning signs of psychiatric difficulty so as to maximize his or her functioning and independence in the community;
- To improve successful integration into the larger community through non-traditional approaches to broadening a member's social support base;
- To ensure that the member's basic needs for sustaining community living are addressed, promoting acquisition of independent levels of adult living skills whenever possible; and
- To maintain member engagement in treatment by providing supportive behavioral health and skill development services in a community environment so as to maximize generalization of learning.

Member Participation Criteria: Members eligible to become a recipient of ACT services must meet one of the following criteria:

- Three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months;
- Five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months; or
- 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months.

The Bureau for Medical Services may authorize ACT services for members within other specific target populations who exhibit medical necessity for the service (e.g., persons who are homeless and who have a severe and persistent mental illness, members with a mental illness who have frequent contact with law enforcement or the criminal justice system, or members with co-occurring mental illness and chemical addiction who require consistent monitoring).

A member must have an eligible diagnosis as determined by BMS' contracted authorization agent and be in an eligible disability group of Serious and Persistent Mental Health Disorders or co-occurring Mental Health and Substance Abuse Disorders or co-occurring Mental Health Disorders and Mild Intellectual Disability.

An ACT Team may serve members on an on-going basis following authorization/re-authorization of eligibility based upon continuing need and clinical appropriateness of ACT services.

ACT Team Composition And Staff Qualifications: The ACT Team must include a multidisciplinary staff mix, including mental health professionals and substance abuse treatment professionals. The team is composed at a minimum of a psychiatrist or board certified physician

with behavioral health experience and five other staff persons. The additional five (minimum) staff composing the ACT Team must include:

1. One full time Team Leader/Supervisor with three (3) years' experience in behavioral health services, two (2) of which must be in a supervisory capacity, and a master's degree and valid West Virginia license in Counseling, Social Work, Psychology, a Supervised Psychologist. A registered nurse may serve as a team leader if the team has an additional full time registered nurse.

2. One full time Registered nurse with one year of psychiatric experience;

3. Two (2) full time staff at the Master's level in Counseling, Social Work, or Psychology and two (2) years' experience in behavioral health services. At least one of these individuals must have experience in substance abuse assessment/treatment and/or vocational rehabilitation; and

4. One full time staff with a Bachelor's degree in Social Work or an alternative Behavioral Science, with one year of behavioral health experience.

ACT Weekend and Holiday Requirements: Staff working as weekend and holiday coverage may be on a rotating basis. Staff must be sufficient to meet ACT Members' needs including, but not limited to, medication delivery, crisis response – via phone or face to face, therapeutic services to promote stability. The ACT staff individual on call must review each member with the ACT Team Leader or the team leader's designee, which must be a master's level staff or RN on the certified ACT Team each weekend day and holiday. The physician or physician extender must be accessible for medication adjustments or any issues that arise that would indicate the need for a physician or physician extender to be involved.

Role Of The Physician: The physician must be actively involved with members and the team. He/she must participate in the daily ACT Team meetings, though he or she may do so by means of tele-video conferencing when unable to be physically present. A suitably trained and experienced physician extender (Advanced Practice Registered Nurse or Physician's Assistant) under the direct supervision of the team physician may participate on the team in lieu of the physician; however the substitution on team meetings must be documented. The physician and/or physician extender must physically attend at least one team meeting per week.

The physician must physically participate in the annual service planning session, and must demonstrate direct and on-going involvement with the ACT team and ACT members.
The physician or physician extender must be actively involved with the team and the members for a minimum of 16 hours per week.

Caseload Mix And Ratios: The certified ACT Team must always have the required minimum staffing unless temporary approval is obtained from the Bureau for Medical Services to operate the team in the absence of a member.

The maximum number of members served by an approved ACT Team is 120.

The team must preserve a staff/member ratio of at least 1:10 (i.e., one staff person to ten members, not counting the Physician or physician extender) when the number of ACT members served by the team exceeds 50.

With the exception of the team physician and physician extender, if any, the ACT Team cannot serve non-ACT members.

ACT Service Elements: ACT is a Recovery oriented program**. "**"Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential " (SAMHSA, 2012).

The ACT Team is required to directly provide the following combination of case management and rehabilitation services:

- Assertive outreach designed to identify and engage individuals that meet clinical guidelines and could benefit from the program;
- Sustained effort to engage the member in treatment, medication education and prompting, and skill development activities in order to facilitate more integrated and successful community living;
- Comprehensive and appropriate assessment of medical, environmental and social needs;
- Maintenance of on-going involvement with the member during stays in environments such as inpatient care, convalescent care facilities, community care hospitals, or rehabilitation centers in order to assist in transition back to a community placement;
- Member-specific advocacy;
- Assistance with securing basic necessities (e.g., food, income, safe and stable housing, medical and dental care, other social, educational, vocational, and recreational services);
- Facilitation of maintenance of living arrangements during periods of institutional care. The member and his/her support system remains responsible for these expenses;
- Counseling, problem solving, and personal support;
- Psychiatric services and medication management;
- Assistance in obtaining necessary primary care services;
- Facilitation and improvement of daily living/community living skills;
- Behavior management as necessary and appropriate;
- 24-hour crisis response for ACT members;
- Transportation or facilitation of transportation to necessary community and Medicaid services as specified on the treatment plan;
- Representative payee-ship or facilitation of representative payeeship when needed;
- Collaboration with family/personal support network; and
- Assistance with preparation of advanced psychiatric directives.

Because ACT is a community focused treatment modality, a minimum of 75 percent of service must be delivered outside of program offices.

ACT Fidelity Indicators:

- The team works with a small caseload (10 to one preferred when caseloads exceed 50);
- The team is cooperative and collaborative. Team members are familiar with and work with all clients;
- Program meeting occurs daily other than federally recognized holidays;
- The team leader is a practicing clinician providing services at least 50% of the time;
- Program staff remain consistent over time; turnover is low;
- The program operates at 95% or more of full staffing on average over a 12 month period;
- The physician/physician extender works at least 16 hours per week on teams with 50 clients, proportionally more on larger teams;
- Each team has one full time registered nurse in a program of 50 clients;
- At least one staff member has training or certification in working with members with substance abuse issues;
- The program is of sufficient size to provide consistently the necessary staffing, diversity, and coverage (minimum 6 members);
- The program has explicitly defined admission criteria that address a clearly defined population;
- No more than 6 new members are admitted per month on average;
- The program is required to have available the following five services: medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services;
- The program provides 24 hour services for crisis intervention;
- The team is actively involved in admission in 95% or more of hospital admissions. Admission involvement must become active as soon as the team becomes aware that the member is at risk of being admitted or has been admitted without the team's prior knowledge to an institutional environment, including Crisis Stabilization Units. Active involvement is demonstrated by regular contact with the institutional treatment team, exchange of information as necessary, contact with the member as possible and appropriate, and interaction with family members as necessary and desired by the member;
- The team participates in discharge planning for 95% of members, providing assistance to the institutional team with housing, benefits, medication appointments, etc.;
- All members are served on a time-unlimited basis with fewer than 5% of the population expected to graduate annually;
- 75% of member contacts occur outside the clinic setting;
- The team actively pursues engagement of treatment resistant members as described in the policy described below under "Discharge Criteria";
- The program is aggressive in assuring engagement and uses outreach and contacts with corrections and homeless programs to engage members;

- Each member receives an average of two face to face contacts with a team member per week;
- Each member receives at least four contacts per week of any type;
- With or without the member present, the team provides support and skills for the member's support network: family, landlords, employers, etc.;
- One or more team members provides direct treatment and substance abuse treatment for members with substance use disorders;
- The program uses group modalities as a treatment strategy for people with substance use disorders;
- The program uses a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations of abstinence; and
- Stable recovering members may be involved as members of the team providing direct services.

Medication Delivery And Monitoring: If a provider delivers medications to a member on a regular basis, the provider must have a policy that ensures that:

Delivery date, time, person receiving and name of medication delivered is documented, including amount delivered (the list of medications and dosages may be contained in the member record however each delivery must be logged either in the member record or in a central location);

If there are children or other incapacitated adults in the home, medications are at least initially stored properly in a secure location;

If medications are delivered to a member at a location other than the home, the medications must be delivered in a manner that ensures the confidentiality of the member and shields the nature of the items delivered; and

A system of monitoring the member's compliance with consumption of medications is created with the agreement and participation of the member. The nature of the monitoring system will be individualized and designed by the clinical team in conjunction with the member. This system may consist of the member logging consumption of his or her own medications. The member has the right to refuse participation in a monitoring system however the provider may then refuse to deliver medications to the member's residence and/or make alternative arrangements for the provision of medications if clinically appropriate.

Documentation: The program must have a valid authorization for service from the Bureau for Medical Services to bill for ACT services.

At entry into the program, there must be documentation of a comprehensive assessment and a recommendation by a qualified professional that ACT services are necessary and appropriate. The team must develop an initial service plan for the ACT member within seven days of admission into the program. The initial plan must authorize the services to be provided to the member until the comprehensive plan for the member is complete.

The ACT Team, including the member, must amend or develop a comprehensive service plan for the member within 30 days. The plan must describe goals and specific objectives the member hopes to achieve with the assistance of ACT. The comprehensive plan must identify the services to be provided under ACT and must be approved by the member, as signified by his or her signature.

The team may elect to create a comprehensive plan upon admission into the program without completing an initial and subsequent comprehensive plan, however the on-going plan must reflect amendments made in services, goals and/or objectives as the team moves forward. The service plan is a fluid document which must be amended as the needs of the member change or are newly recognized.

The record must sufficiently document assessments, service plans, and the nature and extent of services provided, such that a person unfamiliar with the ACT Team can identify the member's treatment needs and services rendered.

The comprehensive plan must identify the Qualified Team that is providing ACT to the member. The certification of the team and a roster of members assigned to an ACT Team must be available for review.

All staff contacts with members of the ACT team must be documented. Each entry needs to include date and place of the contact, the purpose, content and outcome of the contact, the start and stop times of the contact, and the signature, credentials, and title of the individual providing the service.

At minimum the documentation must include the following:

1. A log documenting the discussion of each member in the daily team meeting (except weekends and federal holidays);
2. A weekly summary of member status;
3. 90 day reviews of the comprehensive plan and/or documentation of team meetings and revisions of comprehensive plans at the time of critical treatment junctures; and
4. Documentation of each member contact as described above.

Each member enrolled in ACT must receive a minimum of two face-to-face contacts with one or more ACT team members per week. Documentation must provide evidence of the delivery of at least four separate ACT services per week (e.g., four days of medication delivery is inappropriate and insufficient to meet this standard), but so long as the two contacts required for face to face is met, the service may be indirect, telephonic, collateral, etc. It is permissible for a member to receive more than one service during one member contact, however the documentation must clearly describe the two or more services provided.

The 90 day review required for each ACT participant must summarize progress towards achieving the service objectives and describe problems that impeded progress towards meeting objectives. If a member is clearly not making progress toward achieving an objective after 90

days, the team must either amend the objective or describe why the objective was not amended. An objective on an ACT plan may include activities designed to preserve stability in the community, rather than requiring active progress towards meeting an objective.

A team may maintain an "inactive roster" as described below. The roster must include a list of each ACT recipient who has not received services in the past 30 to 60 days and describe why the member is included on the roster. Members must be discharged from ACT if they have been on the "inactive roster" more than 60 days.

Discharge Criteria:

A provider may discharge an ACT recipient of services for the following reasons:

1. The member no longer meets eligibility criteria;
2. The member has met all program goals and is at maximum level of functioning;
3. The member has moved outside of the ACT team's geographic area;
4. The member is no longer participating or refuses services regardless of the ACT team's efforts at engagement; and/or
5. By virtue of diagnosis or intensity of service needs, the member would be better served by an alternative program of care.

The team must document at least weekly attempts to locate the member for 30 days before a discharge should be considered. Attempts should not consist solely of telephone calls but should include at least weekly visits to the location the member was last known to live and telephone calls or visits to significant others for the member.

If a member consistently refuses to participate or cannot be located, the provider has the option to place the member on an "inactive roster" after 30 days of no contact, preserving the authorization for service. Providers must not bill ACT services for members on an inactive roster. This option should be utilized primarily when the member is familiar to the team and has a history of being unavailable or noncompliant for periods of time, but returning to service regularly. At 30 days of lack of contact or refusal to participate, the provider must make a decision as to whether to place the individual on the inactive roster, or discharge him or her. If the member is on the inactive roster for 60 days with no contact and/or continued refusal of services, the agency must discharge the member from ACT.

The provider is required to notify the Contracted Agent within 72 hours of discharge of an ACT participant in order to terminate the authorization for services.

Billing for ACT services is permissible only when active treatment is occurring based on a current service plan. No billing may be submitted for a member enrolled in ACT who has not received services from ACT Team staff for a period of seven days or more. When services resume, billing may resume.

ACT Team Certification Process:

- All ACT Teams require initial approval through the completion of the ACT Team Certification form. The certification form is reviewed and subject to approval by the Bureau for Medical Services (BMS) and the Bureau of Behavioral Health and Health Facilities (BHHF). Certification is specific to the individuals in a team, the team composition, and qualifications submitted. Specific certification elements are described in the BMS application form for the ACT Certification.
- Certification packet may be requested from BMS and will be sent electronically or through postal service at the request of the provider **(See Attachment D**)
- Certification is valid for 2 years from the approval date stated on the certification letter issued by BMS.
- BMS will issue a denial or acceptance of a certification team within 30 days of receipt of completed certification packet
- A provider must apply for certification of each ACT Team.
- No ACT services may be billed for a member without written certification of the ACT Team by BMS.
- Re-certification shall occur each two years through a process developed by BMS in conjunction with BHHF.
- All teams must be based at a site listed on the provider's Behavioral Health License. Administrative support must be provided by the parent agency sufficient to meet scheduling and support needs of the ACT Team.
- Billing may commence after receiving approval from BMS. After initial approval, a site review will be conducted to validate the approval.
- BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per the policy contained in Chapter 800, Medicaid regulations.
- Variations from the original certification must be submitted with corresponding rationale for changes.
- When a team member resigns or is no longer associated with the Certified ACT Team, the ACT Team must replace the team member within 30 days of the team member's last day. The provider is responsible for notification of the BMS in writing within two working days of the resignation of the team member. A team is considered then to be provisionally certified until the team member is replaced. The provisional is in place until the team member is replaced. The provider may apply for extended provisional certification if an appropriately credentialed individual cannot be found within the original 30 day period. The BMS will notify the provider in writing of the acceptability of the proposed replacement team member after review of the individual's credentials as submitted by the provider. If more than one team member resigns or is terminated, the 30 day provisional status will be reinitiated at the loss of the subsequent team member.

503.23 RESIDENTIAL CHILDREN'S SERVICES

Residential Children's Services are comprehensive programs for those children who, when professionally evaluated, reflect a combination of diagnostic, functional, behavioral, or social support conditions which indicate they must be served in residential settings outside their families, and in some instances outside a regular school setting. Services must include a comprehensive array of

treatment/intervention modalities in accordance with the service description for which the provider is certified, and must be clinically appropriate for the type of child population served. EPSDT services for children in child residential programs should be requested and authorized by the ASO.

503.23.1 RESIDENTIAL CHILDREN'S SERVICES LEVEL I

PROCEDURE CODE: H0019U1
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

PAYMENT LIMITS: Residential Children's Services are limited in age to members under the age of 21. Many Behavioral Health Services are included in the provision of this service and; therefore, cannot be billed while a child is reflected in the census of a Residential Children's Service setting. The Behavioral Health Services not included in this service which may be billed separately are: Psychological Testing with Interpretation and Report (procedure code 96101), Psychiatric Diagnostic Interview Examination (procedure code 90791 & 90792), Screening by Licensed Psychologist (procedure code T1023), Mental Health Service Plan Development by Psychologist (procedure code H0032AH), Physician Coordinated Care Oversight Services (procedure code G9008), Behavioral Health Counseling, Professional (procedure codes H0004HO and H0004HOHQ), Crisis Intervention (procedure code H2011), Therapeutic Behavioral Services - Developmental (procedure code H2019HO), and the Transportation Services (procedure codes A0120HE and A0160HE).

PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:
Residential Children's Services, Level I is a structured 24-hour therapeutic group care setting that targets youth with a confirmed current DSM or ICD diagnosis that manifests itself through adjustment difficulties in school, home, and/or community. This level of service is designed for children or youth whose needs can best be met in a community-based setting where the child can remain involved in community-based school and recreational activities. These youths usually can function in public school and in a group residential setting with a minimal amount of supportive services and behavioral interventions. The goal of supportive residential programs is to enable children to overcome their problems to the degree that they may move to a less restrictive community placement or independent living situation. This service level is appropriate for members:

- Whose relationship with their families or whose family situations, level of development, and social or emotional problems are such that they cannot accept family ties or establish and maintain relationships in a less restrictive environment, or
- Who are in transition from a more intensive form of care.

Members in need of this level of service display impaired abilities in the social, communication, or daily living skills domains. Life threatening symptoms are generally absent. They generally are able to interact appropriately in social settings with a minimal amount of adjustment problems. Although they may display emotional problems such as anxiety, depression, avoidance, etc., these are not part of a persistent, long term pattern nor do they preclude normal social functioning in most school or community settings. Where aggressive acting out behaviors are present, they are not of a degree or at a frequency to require ongoing measures of control (restraint, hospitalization, and chemical

interventions) and generally respond to logical/natural consequences and supportive counseling interventions.

PROGRAM REQUIREMENT:
Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling, Supportive
- Skills Training and Development

These services must be provided in accordance with the minimum standards established by the Bureau for Medical Services in this chapter of the Provider Manual, and with the certification standards established by the WVDHHR for children's group residential services. This service can only be reimbursed to agencies dually licensed as behavioral health services and as childcare group residential facilities, and only for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 a.m. (midnight), the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

DOCUMENTATION:
There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.23.2 RESIDENTIAL CHILDREN'S SERVICES LEVEL II

PROCEDURE CODE: H0019U2
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

PAYMENT LIMITS: Residential Children's Services are limited in age to members under the age of 21. Many Behavioral Health Services are included in the provision of this service and; therefore, cannot be billed while a child is reflected in the census of a Residential Children's Service setting. The Behavioral Health Services not included in this service which may be billed separately are: Psychological Testing with Interpretation and Report (procedure code 96101), Psychiatric Diagnostic Interview Examination (procedure code 90791 &90792), Mental Health Service Plan Development by Psychologist (procedure code H0032AH), Physician Coordinated Care Oversight Services (procedure code G9008), and the Transportation Services (procedure codes A0120HE and A0160HE).

PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:
Residential Children's Services, Level II is a structured group-care setting targeting youth with a confirmed current DSM or ICD Diagnosis that manifests itself in the form of moderate to severe adjustment difficulties in school, home, and/or community. These youths cannot function in a public school setting without significant psychosocial and psycho-educational support. In the residential care setting they require substantial professional level treatment services and behavioral interventions that normally require a multidisciplinary team. The goals of intermediate residential treatment programs are to develop interpersonal skills and remediate social skill deficits and disruptive behavior patterns that preclude living in a less restrictive environment.

Children served at this level are characterized by persistent patterns of disruptive behavior and exhibit disturbances in age-appropriate adaptive functioning and social problem solving. Disturbance in psychological functioning is common and may present some risk of causing harm to themselves or others. This population generally displays emotional problems and/or persistent behavior patterns challenging enough to preclude socially appropriate functioning in family, school, and community contacts without behavior management and additional structure and support.

Most often the children display multi-agency needs that require interagency planning and interventions including behavioral health, education, child welfare, juvenile justice, and others. In this target population, children display a persistent pattern of challenging behavior that has been present for at least 1 year and is not a reaction to a single precipitating event.

Children in Level II have a current ICD or DSM diagnosis usually in the disruptive behavior disorders, mood disorders, or in the psychoactive substance use disorder categories. Their social functioning limitations are significant to a degree that they require up to 24 hours of supervision, structure and support upon admission. Generally, they respond well to structure and treatment, and the level of supervision required initially can be gradually withdrawn. From time-to-time, they can present a danger to themselves or others, but this is not a routine issue in treatment.

They possess cognitive capacity and can participate in academic and vocational education, but often require specialized instruction and a modified learning environment within a public or alternative secondary or primary school setting.

PROGRAM REQUIREMENTS:
Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment Services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling
- Skills Training and Development
- Crisis Intervention 24-hour availability
- Therapeutic Behavioral Services

These services must be provided in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and with the certifications standards as established by the WVDHHR for children's group residential services.

This service can only be reimbursed to providers who are dually licensed as behavioral health services and childcare facilities and for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 am (midnight), the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

DOCUMENTATION:
There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.

- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.23.3 RESIDENTIAL CHILDREN'S SERVICES LEVEL III

PROCEDURE CODE: H0019U3
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

PAYMENT LIMITS: Residential Children's Services are limited in age to members under the age of 21. No other Behavioral Health Services, other than Transportation Services (procedure codes A0120HE and A0160HE), can be billed while a child is reflected in the census of a Residential Children's Service setting.

PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:
Residential Children's Services, Level III is a highly-structured, intensively-staffed, 24-hour group care setting targeting youth with a confirmed current DSM or ICD diagnosis which manifests itself in severe disturbances in conduct and emotions. As a result, they are unable to function in multiple areas of their lives. Residential treatment facilities provide a highly structured program with formalized behavioral programs and therapeutic interventions designed to create a therapeutic environment where all planned activities and applied interventions are designed with the goal of stabilizing the child's serious mental condition.

The service plan is implemented in all aspects of the child's daily living routine. The focus of intensive residential treatment is on psycho-social rehabilitation aimed at returning the child to an adequate level of functioning. In the case of children and adolescents, this includes rehabilitation in instances where psychiatric or substance abuse disorders have significantly disrupted the achievement of the expected development level.

This service level is comprised of children who display seriously disordered behaviors with sufficient frequency to be considered an established pattern of long duration, or are so intense that they preclude social interaction in school, family, or community environments. Often, they exhibit persistent or unpredictable aggression, serious sexual acting-out behavior, and marked withdrawal and depression.

Symptoms of thought disorder are often present. They routinely present a significant danger to themselves or others.

Children in Level III have a current ICD or DSM diagnoses that include major depression, bipolar disorders, posttraumatic stress disorders, other anxiety disorders, thought disorders, and personality disorders. Where the focus of care has been on antisocial and dangerous behavior patterns, an

initial diagnosis of Conduct Disorder, Severe may be present. However, in many of these cases, underlying significant psychiatric disturbance will reveal itself during the course of treatment.

Substantial social, academic, and vocational functional limitations are characteristics of the population's behavior pattern, and as a result they require substantial environmental structure and controls including 24-hour awake supervision, verbal crisis response, medical management, chemical interventions, physical restraint, and alternative learning environments. The key element is that these children present behaviors so intense, severe, and unpredictable to be seriously detrimental to their growth, development, welfare, or to the safety of others.

PROGRAM REQUIREMENTS:
Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment Services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling
- Skills Training and Development
- Crisis Intervention 24-hour availability
- Therapeutic Behavioral Services
- Any needed Behavioral Health Service including psychiatric and medication management services
- On-campus schooling

These services must be provided in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and with the certification standards established by the DHHR for children's group residential services.

This service can be reimbursed only to providers who are dually licensed to provide behavioral health services and as childcare group residential facilities, and for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 a.m. (midnight), the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

DOCUMENTATION:
There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a

written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site.

The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.23.4 BEHAVIORAL HEALTH: SHORT-TERM RESIDENTIAL (FOR CHILDREN)

PROCEDURE CODE: H0019U4
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

PAYMENT LIMITS: Short-Term Residential Services are limited in age to members under the age of 21. No payment will be made for any other Behavioral Health Services, except for Targeted Case Management (procedure code T1017) or Transportation Services (procedure codes A0120HE and A0160HE).

PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:
Short-Term Residential is a structured crisis service for children up to age 21 and provided in a community-based, small-group, residential setting. It must be provided in a site licensed as a Children's Emergency Shelter by the WVDHHR. The service is delivered in an environment that is safe, supportive, and therapeutic. The purpose of this service is to provide a supportive environment designed to minimize stress and emotional instability which may have resulted from family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of a child from a failed placement or other current living situation. Short-Term Residential involves a comprehensive array of supportive and therapeutic services including, but not limited to, individual and small-group counseling, crisis intervention, behavior management, clinical evaluation, service planning, and enhancement of daily living skills.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 a.m. (midnight), the eight continuous hours must occur between the start and end of the census period. On each day of

the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

ADMISSION CRITERIA FOR SHORT-TERM RESIDENTIAL SERVICES:
In order to be eligible to receive Short-Term Residential Services, a child must meet the following criteria: criteria A and A1, or criteria B, or criteria C.

(A) Child is experiencing a crisis due to a mental condition or impairment in functioning due to a problematic family setting. The child may be displaying behaviors and/or impairments ranging from impaired abilities in the social, communication, or daily living skills domains to severe disturbances in conduct and emotion. The crisis results in emotional instability which may be caused by family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of the child from a failed placement or other current living situation.

AND

(A1) Child is in need of 24-hour treatment intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the child's needs based on the documented response to prior treatment and/or intervention.

OR

(B) Child is in need of 24-hour treatment/intervention to prevent hospitalization (e.g., the child engages in self-injurious behavior, but not at a level of severity that would require psychiatric hospitalization, or the child is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).

OR

(C) The child is in need of step-down from a more restrictive level of care as part of a transitional discharge plan (e.g., behaviors/symptoms remain at a level which requires out of home care, but the placement plan has not been fully implemented).

DISCHARGE CRITERIA FOR SHORT-TERM RESIDENTIAL SERVICES:
It is expected that in most cases, a child's Short-term Residential needs will be met within a 30-day period prior to discharge. In order to be discharged, the child must meet one of the following criteria:

- Appropriate placement has been located which meets the child's treatment and care needs as outlined in the service plan.
- The crisis that necessitated placement has abated, and the child has returned to a level of functioning that allows reintegration into a previous care setting.
- The child exhibits new symptoms or maladaptive behaviors that cannot be treated safely and effectively in the Short-term Residential setting and which necessitate more restrictive care (e.g. inpatient).

CRITERIA FOR APPROVAL OF CONTINUED CARE EXTENSIONS IN A SHORT-TERM RESIDENTIAL PROGRAM:

For those cases in which it is considered necessary to continue a child's participation in the program, a physician's order and appropriate justification with related documentation are required. Short-Term

Residential Services may be extended beyond 30 days in those cases where appropriate clinical criteria for continued service are met, and the extension has prior authorization approval by BMS' contracted agent. The child must meet one of the following criteria to receive approval for a continued care extension:

- Symptoms, behaviors or conditions persist at the level documented upon admission and the projected time frame for accessing longer-term placement has not been reached.
- Relevant member and family progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to this level of care have been observed and documented, but treatment goals have not been reached and/or an appropriate level of care is not available.
- It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement but the treatment/placement plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and placement options.
- New symptoms or maladaptive behaviors have appeared which have been incorporated into the service plan and modified the plan of care for the member.
- These new symptoms and maladaptive behaviors may be treated safely in the Short-term Residential setting and a less intensive level of care would not adequately meet the child's needs.

PROGRAM CERTIFICATION:

Short-Term Residential Programs must be approved by the Bureau for Medical Services and the Bureau of Children and Families (BCF). The Behavioral Health Rehabilitation Services provider proposing to provide the services must submit to BMS and BCF a program description which includes: proposed staffing patterns, staff credentials, service locations, operating hours, service components, and a general schedule of Short-term Residential service component activities.

DOCUMENTATION:

There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Short-Term Residential Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.24 BEHAVIOR MANAGEMENT SERVICES

Behavior Management Services are to address the symptoms of the diagnosed behavioral health condition that are negatively impacting the members functioning. These services arise in relation to areas of need identified on the member's service plan. Behavior Management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

503.24.1 THERAPEUTIC BEHAVIORAL SERVICES – DEVELOPMENT

Procedure Code: H2019HO
Service Unit: 15 minutes
Service Limits: All units must be prior authorized
Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: The Behavior Management Specialist must be an individual with a minimum education at the Master's level in psychology, psychiatry, education, social work or counseling This individual's training must have include successful completion of course work and documented training in behavioral theory. The Behavior Management Specialist is responsible for all aspects of Behavior Management Services provided by Behavior Management Assistants and must sign all documentation of those services.

The Behavior Management Assistant must be an individual with a minimum education of a bachelor's degree in a human services field **(See definitions for complete listing)** who has been certified by the agency as having training specific to behavior management which is consistent with documented training in behavioral theory. Behavior Management Services provided by Behavior Management Assistants are subject to review and approval by the Behavior Management Specialist. A copy of the provider's training program for its Behavioral Health Assistant staff must be retained and filed by the provider. (The Behavior Management Assistant must use the HO modifier when providing Therapeutic Behavioral Services – Development, procedure code H2019HO, since their documentation must be reviewed and signed by the Behavior Management Specialist. Otherwise, the wrong service, Therapeutic Behavioral Services – Implementation, procedure code H2019, would be billed).

Definition: Therapeutic Behavioral Services - Development includes four major components:

- Behavior Assessment
- Plan Development
- Implementation Training
- Data Analysis and Review of the Behavior Management Plan once implementation has begun.

Therapeutic Behavioral Services - Implementation is an integral component of Behavior Management services (detailed under procedure code H2019).

Behavior Assessment Component

Behavior Assessment is a process of data collection, behavior and skill assessments, functional

analysis, and observation that describes behaviors and the circumstances under which they occur. Prior to the development of the Behavior Management Plan, behavior assessment activities must culminate in the identification of target behavior(s) (those behaviors which the plan proposes to increase, decrease, shape, or eliminate). The target behaviors must be described in specific terms beyond the developmental and they must be stated in terms of an objective, quantifiable measurement. The target behaviors must address symptoms of the diagnosed behavioral health condition that negatively impacts the member's overall functioning. The target behavior(s) is causing a functional deficit and is related to the behavioral health condition. Baseline data (quantified measurements which describe the intensity, frequency and duration of the targeted behaviors) must be collected on each target behavior. Baseline data are then reviewed to determine if the data justifies or supports the development of a Behavior Management Plan.

Following implementation of the Behavior Management Plan, behavior assessment must occur to determine objectively whether to continue, modify, or terminate the plan.

Plan Development Component

Plan Development refers to those activities required for the formal development of a Behavior Management Plan. It should be noted that a formal plan is developed only if objective baseline data supports and demonstrates the need for such a plan. A Behavior Management Plan for which there is no documentation of behavior management implementation activity must be considered invalid for billing purposes except for those activities related to assessment where a decision was made based on assessment data that it was not appropriate to proceed.

In those instances when baseline data indicate an occurrence of the target behavior(s) at a frequency or duration not sufficient to warrant the development of a complete Behavior Management Plan and its implementation training and on-going data analysis and review, the Behavior Management Specialist or the Behavior Management Assistant may develop a **Behavior Protocol**. A Behavior Protocol is a document that describes a consistent response(s) upon the occurrence/reoccurrence of the target behavior(s) as a means to maintain the rate of behavior(s) at a low rate. No more than two units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Protocol**.** Following the development of a Behavior Protocol, no further Therapeutic Behavioral Services billing must occur unless a new problem behavior is discovered. If this occurs, behavior assessment on the new behavior must follow, and the process should start anew.

When a Behavior Management Plan has achieved the criteria for success (the objective, quantified amount of behavior change has been maintained for the time period specified in the plan), the Behavior Management Specialist or the Behavior Management Assistant may develop a **Behavior Management Maintenance Plan**. A Behavior Management Maintenance Plan is a document that describes a consistent response(s) to the target behavior(s) as a means to maintain target level performance. No more than four units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Management Maintenance Plan. Following the implementation of the Behavior Management Maintenance Plan (which is not to exceed 90 days), the Behavior Management Specialist or the Behavior Management Assistant may conduct data analysis and review on no more than three occasions (a maximum of one unit each occasion) to assure that behavior levels are maintained.

Implementation Training Component

Implementation training is the process by which the Behavior Management Specialist or the Behavior Management Assistant provides the rationale for the plan, defines the behavior(s) that are targeted for change and instructs the individual(s) responsible in the specific steps necessary for implementation of the plan. All individuals who will be involved in providing Therapeutic Behavioral Services – Implementation (procedure code H2019) must receive implementation training prior to implementation of the plan. This includes agency employees and/or significant others (e.g., parents, teachers, foster care providers, etc.).

Data Analysis and Review Component

Data Analysis and Review is the process by which the Behavior Management Specialist or the Behavior Management Assistant evaluates plan effectiveness. Plan effectiveness is determined through a comparison of the baseline data for the target behavior(s) with objective, quantified implementation data to determine whether the plan is leading to achievement of the criteria for success. Any necessary direct observation of member ***behavior*** is included in this category. This analysis and review result in the determination of continuation, modification, or termination of the Behavior Management Plan.

Documentation Requirements:

There are four types of Therapeutic Behavioral Services - Development documentation:

- Activity notes
- Behavior Management Plan
- Behavior Protocol
- Behavior Management Maintenance Plan.

Standard Activity Notes Documentation Requirements

Activity Notes identify the specific component of Therapeutic Behavioral Services - Development (i.e., Behavior Assessment, Plan Development, Implementation Training, Data Analysis and Review) that was performed, place of service, date of service, the amount of time spent by listing the start-and-stop times, and the signature (with credential initials) of the staff person who provided the service.

Behavior Assessment documentation must be present prior to the development of the Behavior Management Plan In addition to the standard activity notes documentation requirements, behavior assessment documentation must reflect that the following activities have occurred in this order:

- Identification of the target behavior(s).
- Specific description of each target behavior in terms capable of objective, quantified measurement.
- Collection of baseline data on each target behavior to obtain an objective, quantifiable determination of its occurrence/nonoccurrence.
- Review and analysis of baseline data to determine objectively if a need for further Behavior Management Services exists.

Following implementation of the Behavior Management Plan, **Behavior Assessment** documentation must include (in addition to the standard activity notes documentation requirements) rationale for such assessment, which may take one of two forms. These are:

- Identification of a new target behavior. Should this occur, behavior assessment must meet the requirements identified in the above listed additional requirements for behavior assessment documentation to provide objective documentation of the need to modify the plan.

Objective determination through data analysis and review that the plan is not effective. If this occurs, behavior assessment must be conducted to determine if the plan is being implemented correctly. If implementation is not occurring correctly, implementation training must reoccur. If the plan is being implemented correctly, further data-based assessment to determine whether to modify the plan will occur. Documentation for the latter must reflect the specific components of the plan addressed and modified to obtain the desired behavior change.

Activity notes documenting **Plan Development** must include the specific components of the plan itself that were developed in addition to the standard activity notes documentation requirements.

Activity notes for **Implementation Training** must document the training of implementation staff (and/or unpaid support staff) as defined by the plan, the definitions of the behavior(s) targeted for change, and the specific steps necessary for implementation of the plan. It must also include the standard activity notes documentation requirements.

Activity notes for **Data Analysis and Review** must document a measured amount of each target behavior, a comparison of that amount to a previously documented amount and, based on that measured amount, a determination of continuation, modification, or termination of the plan. It must also include the standard activity notes documentation requirements.

Behavior Management Plan Documentation Requirements

The second type of documentation is a separate, freestanding document labeled **Behavior Management Plan.** The Behavior Management Plan must contain, at a minimum, the following components within the body of the plan itself, regardless of their presence anywhere else in the member's record.

- The Name and Agency Identification Number of the member for whom the plan has been developed
- Implementation Date - the date the plan is implemented
- Target Behaviors/Specific Descriptions.

- Baseline data including the actual dates the baseline data was collected.
- The criteria for success – (A generic statement such as "The member will obey the rules more frequently" is not acceptable, as it does not state a quantified amount that can be compared to baseline data).
- Methods of Behavioral Intervention includes the following:

- Method - A description of the behavioral intervention that implementation staff (and/or unpaid support staff) will employ given the occurrence/nonoccurrence of the target behavior(s).
- Method and Schedule of Reinforcement - The method statement must specify and describe the method of reinforcement, the type of reinforcers to be used, when the reinforcers will be provided (i.e., the schedule of reinforcement), by whom, and whether reinforcers are delivered upon occurrence/reoccurrence of the target behavior(s), or upon the occurrence of behavior(s) incompatible with the target behavior(s).
- Data Collection - A description of the quantified information that will be collected during the implementation of the Behavior Management Plan. This must include who collects the information and what type of quantified information is recorded, such as frequency or duration of behavior. This information must be of the same type as that collected during baseline so that comparisons can occur.

- Responsible person - a designated Behavior Management Specialist is responsible for the Behavior Management Plan in terms of its appropriateness in clinical practice and for financial reimbursement, and for identifying staff and/or others and their respective responsibility relative to the plan. It should be noted that implementation staff do not have to be named individually, but they must have received the required implementation training prior to implementing the plan. The Behavior Management Specialist must sign and date all plans prior to their implementation (or review and co-sign plans signed and dated by a Behavior Management Assistant). The signature of any individual(s) who participated in the development of the written plan must also be included in the plan (and the date of their participation), along with the degree, and other credentials (license type and number) of each individual.

Behavior Protocol Documentation Requirements

The third type of documentation is the completed Behavior Protocol. The Behavior Protocol consists of:

- A summary of objective, quantified baseline data
- A rationale for the development of the protocol
- Recommendations for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s)
- Date the protocol was developed, the amount of time spent developing the protocol by listing the start and stop times, and the signature (with credential initials) of the staff person who developed the protocol.

Behavior Management Maintenance Plan Documentation Requirements

The fourth type of documentation is the Behavior Management Maintenance Plan. The Behavior Management Maintenance Plan consists of:

- A summary of objectives
- Quantified implementation data (collected during the implementation of the plan)
- A rationale for the development of a maintenance plan (i.e., the criteria for success has been achieved)
- Recommendation for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s).

Date the maintenance plan was developed, the amount of time spent developing the plan by listing the start and stop times, and the signature (with credential initials) of the staff person who developed the plan.

503.24.2 THERAPEUTIC BEHAVIORAL SERVICES – IMPLEMENTATION

Procedure Code: H2019
Service Unit: 15 minutes
Service Limits: All units must be prior authorized
Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Behavior Management Implementation services means a face-to-face, hands-on encounter where the actual time is spent in the delivery of a behavioral health service to a specific member (i.e., any delivery of the service must be on a strictly one staff to one member basis). Such encounters are interventions, or reinforcements that have been previously described in the Behavior Management Plan and are measured and recorded. Any and all Therapeutic Behavioral Services - Implementation activities under this procedure will be considered non-reimbursable if the activities are not supported by a Behavior Management Plan that meets the documentation requirements detailed under Therapeutic Behavioral Services – Development (procedure code H2019HO).

General observation and/or monitoring are not considered billable implementation activities.

Documentation: Documentation must contain the intervention used (which is individualized to meet the needs of the member), methods, measurements, delivery of service, outcome of the implementation, place of service, date of service, signature of implementing staff (with credential initials), and the actual time spent by listing the start-and-stop times.

Only trained, qualified staff can provide **billable** Therapeutic Behavioral Services - Implementation Services. Activities provided by a non-staff person may be considered as a valid part of the service if there is documentation of the role and specific activities by such individuals in both the description of the methods of intervention in the Behavior Management Plan and in the data which describes the encounters by non-staff persons as they implement the plan. Activity by non-staff persons as described above, however, will not be considered billable under neither Therapeutic Behavioral Services – Development (procedure code H2019HO), nor Therapeutic Behavioral Services – Implementation (procedure code H2019).

503.25 TRANSPORTATION SERVICES

Behavioral Health Transportation Services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service that is designated in the member's service plan.

503.25.1 NON-EMERGENCY TRANSPORTATION BY VEHICLE OTHER THAN AMBULANCE

Procedure Code: A0120HE
Service Unit: Trip

Service Limits: Six trips daily
Prior Authorization: None

Definition: Non-emergency Transportation by minibus is a service in which a one-way transport of a member by a vehicle other than an ambulance is provided. If more than one member is being transported, each member's transport to the Medicaid service is billable. However, if multiple stops must be made for multiple members, the service provider must only bill for each member's transport to his/her Medicaid reimbursable service. (e.g., a vehicle, carrying two members from their group home, transports the first member to a physician's office and the second to a Day Treatment Program. Only two separate transports must be billed; one for each member. The provider cannot unbundle the second member's trip as two trips; one from the group home to the physician's office, since he received no service there, and the second to the Day Treatment Program).

Documentation: Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times.

503.25.2 NON-EMERGENCY TRANSPORTATION: PER MILE

Procedure Code: A0160HE
Service Unit: One mile
Service Limits: 500 miles per month
Prior Authorization: None

Definition: Non-emergency Transportation: Per Mile is a service in which the member's transportation by the provider is documented and subsequently billed by the mile. Mileage cannot be accumulated during the transport of other members to their destinations even if the member remains in the vehicle during the transport of the other members. Mileage can only be calculated using the shortest, most direct route between the member's place of departure and destination. This code cannot be billed by provider staff unless a member is present in the vehicle.

Documentation: Documentation must consist an activity note describing the purpose for the transport, signed by the providing staff (along with their credentials), type of vehicle used for the transport, place of departure and arrival, actual billable mileage, and date of service.

503.26 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Information* of the Provider Manual.

503.27 SERVICE EXCLUSIONS

In addition to the exclusions listed in *Chapter 100, General Information*, BMS will not pay for the following services:

- Services not meeting the definition of Medical Necessity

- Telephone consultations
- Missed appointments
- Time spent in preparation of reports
- A copy of medical report when the agency paid for the original service
- Experimental services or drugs
- Methadone administration or management
- Any activity provided for the purpose of leisure or recreation
- Services rendered outside the scope of a provider's license

503.28 ROUNDING UNITS OF SERVICE

- Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. Units of service based on an episode or event cannot be rounded.
- Many services are described as being "planned", "structured", or "scheduled". If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.

The following services are eligible for rounding:

- Mental Health Service Plan Development (H0032)
- Mental Health Service Plan Development by Psychologist (H0032AH)
- Physician Coordinated Care Oversight Services (G9008)
- Case Consultation (90887)
- Comprehensive Medication Services; Mental Health (H2010)
- Crisis Intervention (H2011)
- Therapeutic Behavioral Services – Development (H2019HO)
- Therapeutic Behavioral Services – Implementation (H2019)

In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months. Only whole units of service may be billed.**

503.29 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of Behavioral Health Rehabilitation Services described in this chapter.

503.30 PRIOR AUTHORIZATION PROCEDURES

- The Bureau for Medical Services requires that providers prior authorize **all** Behavioral Health Rehabilitation Services described in this manual with exception of Transportation Services, (procedure codes A0120HE and A0160HE) with BMS' contracted agent.

- Prior authorization must be obtained from BMS' contracted agent.
- Information on prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' contracted agent.

503.30.1 PRIOR AUTHORIZATION REQUIREMENTS

- Prior authorization requests for Behavioral Health Rehabilitation Services must be submitted within the timelines required by BMS' Contracted agent
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.

503.31 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

- Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements and Chapter 800, General Administration of the Provider Manual.
- Providers of Behavioral Health Rehabilitation Services must comply, at a minimum, with the following documentation requirements:
  - Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
  - All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
  - Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
- Providers of Behavioral Health Rehabilitation Services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

503.32 BILLING PROCEDURES

- Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- The amount billed to BMS must represent the provider's usual and customary charge for the services delivered.
- Claims must be accurately completed with required information.
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.

- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

503.33 PROGRAM OF SERVICE REQUIREMENTS

Program approval from BMS is required for the following Behavioral Health Rehabilitation Services Program:

- Day Treatment
- Assertive Community Treatment
- Comprehensive Community Supportive Services

Chapter 503

Behavioral Health Rehabilitation Services

July 1, 2014

Attachment A

West Virginia Bureau for Medical Services
Behavioral Health Clinic and Rehabilitation Services
Authorization for Services

West Virginia Bureau for Medical Services
Behavioral Health Clinic and Rehabilitation Services
Authorization for Services

Client Name: _____ Medicaid Number: _____

Admission Date: _____ Diagnosis(es): _____

The following Medical or Remedial services have been authorized for the above named recipient in order to reduce physical or mental disability and/or to restore functional ability:

Type of Service: (check the services authorized)

	Assessment Services		Service Planning
	Case Consultation		Behavioral Health Counseling
	Skills Training and Development		General Medical Care Services
	Assertive Community Treatment (ACT)		Comprehensive Community Support
	Day Treatment		Crisis Intervention
	Community Psychiatric Supportive Tx.		Residential Children's Services
	Therapeutic Behavioral Services		Transportation Services
	Other:		Other:

I certify that the services for the above-named individual are medically necessary and appropriate. My determination is based upon:

☐ Personal evaluation of the member within the past seven days; or

☐ Review of assessment(s) provided by an individual functioning within his/her scope of practice and approved by the credentialing committee of this agency.

Any change or extension in services indicated above will be authorized in an individualized service plan or written treatment strategy as required by behavioral health licensing regulations and BMS policy.

_____ _____

Signature of Initiating/Admitting Staff (Valid for 72 hours) Date

_____ _____

Signature of Physician/Licensed Psychologist Date

Chapter 503

Behavioral Health Rehab Services

July 1, 2014

Attachment B

Coordination of Care and Release of Information Form

Suboxone/Subutex/Vivitrol Providers

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider

Communication between behavioral health providers and your Suboxone/Vivitrol Prescribing Physician other Behavioral Health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You have a right to a copy of this signed authorization.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. **This consent expires in one year (12 months) from the date of my signature below unless otherwise stated herein.**

_____ (*BH Provider*) is authorized to release protected health information related to the evaluation and treatment of _____ (*Member*) to _____ (*Suboxone/Vivitrol Prescribing Physician).*

(Member Name) _____

(Medicaid ID#) _____

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider

(Date of Birth – MM/DD/YYYY) _____

Suboxone or Vitriol Prescribing Physician:_____

Physician Phone: _____

Physician Address: _____

BH Provider Name: _____

BH Provider Phone:_____

BH Provider Address: _____

Disclosure may include the following verbal or written information: (check all that apply) ___ Demographic Information	___ History & physical	___ Laboratory/diagnostic testing results	___ Other (specify below)
___ Discharge summary	___ Medication records	___ Behavioral health/psychological consult	___ Psychological Eval/Testing Results
___ ER record report	___ Psychiatric evaluation	___ Psychosocial assessment	___ Service Plan
___ Substance abuse treatment record			___ Summary of treatment records, progress notes & contact dates

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider

(Print Provider Name) _____

(Signature) _____

(Date) _____

I want to inform you that _____was seen by me for the treatment of: (Member Name)

DSM-IV and/or medical diagnosis:

_____

Date of appointment:

_____

Summary:

The treatment plan consists of the following modalities:

_____ Individual Psychotherapy _____ Group Psychotherapy _____ Family Psychotherapy

_____ Psychological Testing _____Other (specify) _____ Medication Management (see next page)

Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider

Current Medication(s) (Dosage, Frequency and Delivery)

The following medication was or will be started (indicate medication and dosage):

_____

Estimated length of treatment:

_____

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients. WV Department of Health and Human Resources Bureau for Medical Services.

Chapter 503

Behavioral Health Rehab Services

July 1, 2014

Attachment C

Application for Day Treatment Certification

APPLICATION FOR
MEDICAID DAY TREATMENT CERTIFICATION

Please complete the following identifying information for your agency:

Name of Provider/Agency operating Day-Treatment at site listed below:
_____

Provider/Agency Address: _____

_____

Current Medicaid Provider Number: _____

Name of Day-Treatment Program: _____

Day-Treatment Program Address: _____

_____

Effective Dates of B. H. License: _____

Date of Approved CON: _____

Name & Title of Individual Completing Application: _____

_____

Telephone Number: _____

Extension: _____

Fax Number: _____

PROGRAM DESCRIPTION

A. THIS AGENCY IS APPLYING FOR CERTIFICATION (PLEASE CHECK ALL BOXES THAT APPLY):

- ☐ Initial or New Certification
- ☐ Recertification
- ☐ Clinic Services Day-Treatment Program
- ☐ Rehabilitation Services Day-Treatment Program

B. TYPES OF POPULATION(S) TO BE SERVED:

An application must be submitted for each day-treatment licensed program site operated by your agency. If your agency is serving more than one population at one site, a separate program activity time grid must be completed for each of the populations checked below.

1. ADULTS WITH:

- ☐ Alcohol/Substance Abuse
- ☐ Mental Illness
- ☐ Intellectually/Developmentally Disabled

2. CHILDREN WITH:

- ☐ Developmental Delay
- ☐ Serious Emotional Disturbances

C. SITE OF OPERATIONS

Day-Treatment Program Site:

_____

Address:

_____

D. HOURS OF OPERATIONS

Hours of Operation: ___a.m. ___a.m.
___p.m. ___p.m.

Days of Operations: M T W T F S S
(CIRCLE ALL THAT APPLY)

E. PROGRAM CAPACITY

In the last month, what was:

1. Average number of clients served in program per day_____
2. Maximum number of clients who can be served on any day? ____

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:

- Difference in programmatic approaches or emphasis on each population served at this site

- Program admission and discharge criteria

- Differences in programmatic approaches to individuals with lower-versus-higher functional impairment

- Any specific programmatic emphasis or focus

MANAGEMENT AND PERSONNEL

1. DAY-TREATMENT PROGRAM DIRECTOR:

   NAME: _____

   QUALIFICATIONS:_____

   EDUCATION:_____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year)

   Date of Experience:

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for day-treatment program director in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

   _____ Yes Date of Review: _____

4. PROGRAM DIRECTOR/SUPERVISOR TIME SCHEDULE:

   A. Please indicate the number of hours per week the program director spends in program management activities, such as staff scheduling, activities planning, service plan review, treatment planning, etc.

      _____ Program management hours per week

   B. Please indicate the number of hours per week the program director spends carrying out or participating directly with clients in activities listed on weekly grid.

      _____ Day-treatment activities hours per week.

C. List each type of staff member by job title used by your agency for day-treatment services.

JOB TITLE	NUMBER OF STAFF IN DAY-TREATMENT WITH THIS TITLE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

5. Attach a job description for each job title listed in #1 above.

6. Attach a weekly schedule for all staff reflected in #1 above.

REHABILITATION DAY-TREATMENT

Program Activities

Please indicate which of the following activities are carried out in your agency's day-treatment program by checking the appropriate boxes and filling in the staff-to-client ratio for each activity.

			Staff-to-Client Ratios
Self-care skills	☐ Yes	☐ No	_____ to _____
Emergency skills	☐ Yes	☐ No	_____ to _____
Mobility skills	☐ Yes	☐ No	_____ to _____
Nutrition skills	☐ Yes	☐ No	_____ to _____
Social skills	☐ Yes	☐ No	_____ to _____
Communications/Speech	☐ Yes	☐ No	_____ to _____
Physical exercise /OT reinforcement	☐ Yes	☐ No	_____ to _____
Interpersonal skills	☐ Yes	☐ No	_____ to _____
Functional community skills	☐ Yes	☐ No	_____ to _____
Volunteering in community skills	☐ Yes	☐ No	_____ to _____
Citizenship, rights, and responsibilities	☐ Yes	☐ No	_____ to _____
Self-advocacy	☐ Yes	☐ No	_____ to _____
Other services	☐ Yes	☐ No	_____ to _____
(Specify)_____	☐ Yes	☐ No	_____ to _____
_____	☐ Yes	☐ No	_____ to _____
_____	☐ Yes	☐ No	_____ to_____

Chapter 503

Behavioral Health Rehabilitation Services

July 1, 2014

Attachment D

Comprehensive Community Support Services Program Certification Form

COMPREHENSIVE COMMUNITY SUPPORT SERVICES PROGRAM
REQUIRED DOCUMENTATION

A. Please indicate that copies of the following documents are attached to this application by placing a check or "X" in each of the blanks below:

_____ A Behavioral Health License that is current and lists the site(s) where the Community Focused Treatment Program will be implemented;
_____ Consumer complaint or grievance policy/procedure related to Community Focused Treatment Program.
_____ Emergency (psychiatric/medical) procedures;
_____ Procedure for responding to inappropriate behaviors/aggressive behavior;
_____ Medication management/monitoring as it relates to Community Focused Treatment Program

B. List each staff member used by your center for Comprehensive Community Support Services. (If additional space needed, make copies of this form (HS = High School - GED) (BA= Bachelors) (MA = Masters +)

Name_____

Job_____

Title_____

Highest Degree Obtained_____

Major Field of Study_____

Professional License and/or Certifications _____

_____

HRS per week in program_____

(First only) job title center utilizes HS, BA, MA for post HS only

For post HS only

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____

2. Attach a job description for *each job title* listed in #1 above.

MANAGEMENT AND PERSONNEL

1. COMPREHENSIVE COMMUNITY SUPPORT SERVICES PROGRAM DIRECTOR/SUPERVISOR

NAME: _____

EDUCATION: _____

_____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year):

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for Comprehensive Community Support Services supervisor in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

Date of Review:_____

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:
 HOURS OF OPERATION

Hours of Operation: _____AM _____PM

Days of Operation: M T W Th F S Sun (CIRCLE ALL THAT APPLY)
 PROGRAM CAPACITY_____

Maximum Number of Members who can be served on any day?_____

 PROGRAM SUMMARY
- **Program Name**
- **Target Population**
- **Program Description**
- **Programmatic Approaches**
- **Differences in programmatic approaches to individuals with lower-versus-higher functional impairment**
- **Address how activities are fashioned to be age appropriate**
- **Any specialty programmatic emphasis or focus**
- **Admission Criteria**
- **Continuing stay criteria**
- **Discharge Criteria**

Send Application to:

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES, POLICY UNIT
350 CAPITOL STREET ROOM 251
CHARLESTON, WEST VIRGINIA 25301
APPLICATION FOR
COMPREHENSIVE COMMUNITY SUPPORT SERVICES
TREATMENT
PROGRAM CERTIFICATION

Please complete the following identifying information for your agency:

PROVIDER IDENTIFYING INFORMATION

Name of Provider/Agency Operating Comprehensive Community Support Services Treatment Program site listed below:

_____

Provider/Agency Address: _____

Provider/Agency Telephone Number: _____

Provider/Agency Executive Director/CEO: _____

Current Medicaid Provider Number:

_____

Effective Dates of Behavioral Health License:

_____

Date of Approved Certificate of Need:

_____

Name & Title of Individual Completing Application:

_____

Telephone Number: _____

Extension: _____

Fax Number: _____

E-Mail: _____

Chapter 503

Behavioral Health Rehabilitation Services

July 1, 2014

Attachment E

Application for Assertive Community Treatment (ACT) Team Form & ACT Team Modification Form

ACT PROGRAM CERTIFICATION:

Provisional Certification will be granted by BMS, or its designee, when the provider's initial application for ACT certification meets all required elements with the exception of the hiring of staff. During the provisional period of 60 days the provider shall recruit and hire staff in order to achieve ACT compliance. Full certification is required prior to delivering ACT services.

Certification is granted when an ACT team is compliant with all service requirements , including fidelity factors. Once certified, the ACT team can provide services eligible for reimbursement under ACT to qualified members. Certification includes a site visit by BMS or their designee to ensure all required components are in place. Certification is granted for a period of one year.

Recertification *review* is *conducted* one year following the certification by BMS or their designee to ensure compliance with requirements. This review will consist of a site visit to score the ACT team on adherence to the fidelity scale, organizational and policy requirements. Following the recertification, the ACT team recertification date will then occur every two years. Failure to obtain a satisfactory fidelity rating during any recertification (initial or subsequent) will result in the following:

- Mandatory training for the ACT Team on service requirements and fidelity factors. This training will occur within 30 days from the recertification decision and be administered by BMS or its designee.
- A repeat recertification review will occur 6 months following the negative recertification attempt. If compliance is achieved, then recertification will be granted for a two year period.
- If compliance is not achieved within 6 months then the ACT program will be decertified and the behavioral health providers will transition members served to other appropriate programs or services
- A de-certified ACT program may reapply for certification upon receipt and approval of a remedial plan that addresses prior deficiencies.

If BMS or its designee receives information that an ACT team is not in full compliance with policy, use of licensed personnel, and all requirements then BMS or its designee will complete a recertification review prior to the two year expiration BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program.

Please complete the following identifying information for your agency/company for each team.

Name of Provider/Agency Operating the Assertive Community Treatment Team	
Provider/Agency Telephone number	
Address of Provider/Agency	
Assertive Community Treatment Team Telephone Number/Extension	
Date of Approved Certificate of Need (if applicable)	
Name & Title of Individual Completing Application	
Telephone Number	
Fax Number	
E-Mail of Individual completing application	
Provider/Agency Executive Director/CEO	

Provider Agency Executive Director/CEO Telephone	
Provider Agency Executive Director/CEO Email	
Current Medicaid Provider Number for Rehabilitation Services	
Address from which the Assertive Community Treatment Team is operated from	
Number of ACT Teams Agency has Currently in Place	

ASSESSMENT - TREATMENT PLANNING - DOCUMENTATION

1. Procedure for conducting Assessments

2. Procedures for Treatment Planning - Treatment Place Reviews.

JOB DESCRIPTION/STAFF ROLES:

- Attach a job description for each job title associated with the Assertive Community Treatment Team.

PROGRAM ORGANIZATION AND OPERATION

1. Program Hours - Coverage (Address the following)
   - Description of weekday and weekend hours
   - Description of how after hours on-call will be addressed by the team to cover 24 hours/7 days week
   - Description of how Psychiatrist will be a after hours

2. Service, Intensity and Location (Address the following)

- Location of Site Assertive Community Treatment Team will base operations
- Capacity to provide assertive outreach (multiple contacts per week)
- Capacity to rapidly increase service intensity for an individual when his or her status requires
- Capacity to provide 75 % of contacts in a non-office or non-facility based setting
- Maintaining ongoing involvement with the client during days in environments such as inpatient care, convalescent care facilities, community care hospitals or rehabilitation centers.

3. Program Size (Address the following)

- Anticipated number of clients to be served by the Assertive Community Treatment Team.
- Description of Geographical Area to being served by the team
- Staff/Client Ratio for the following:
  - Psychiatrist (Certified Physician Assistant, Certified Nurse Practitioner, Clinical Nurse Specialist)
  - Nurse
  - Other Staff

4. Staff Communication (Address the following)

- Client Roster of Active Team Members
- Description of how the Daily Staff Assignment will be assigned
- Schedule of Treatment Plan meetings and Treatment Plan Reviews.
- Description of how the Daily Meeting will be conducted
- Procedure for ensuring an intensive review of each active client takes place on a weekly basis

5. Service Scope (Description of the following)

- Case Management
- Crisis Assessment and Intervention;
- Symptom Assessment, Management & Supportive Therapy;
- Provision of Substance Abuse Services
- Work Related Services
- Activities of Daily Living
- Assistance with securing basic necessities
- Social, Interpersonal Relationships and Leisure Time Skill Training
- Support Services
- Education, Support and Consultation to Clients= Families and Other Major Supports

6. Description of how medication will be handled by the team

- Medication Prescription
- Administration
- Monitoring
- Documentation

7. Staff Supervision

ADMISSION - CONTINUING STAY- DISCHARGE CRITERIA

1. ELIGIBILITY CRITERIA:
2. ADMISSION CRITERIA:
3. CONTINUING STAY CRITERIA:
4. DISCHARGE CRITERIA:
5. STAFF CREDENTIALS:

ACT TEAM STAFF COMPOSITION

- Name of Psychiatrist(s):

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Certified Physician Assistant, Certified Nurse Practitioner, Clinical Nurse Specialist (if utilizing):

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Registered Nurse(s)

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Team Leader/Coordinator:

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Substance Abuse Specialist:

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Other Staff

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

OTHER DOCUMENTS

Please indicate that copies of the following documents are attached to this application by placing an X in the box in each of the blanks below:

	A Behavioral Health License that is current and list the site where the Assertive Community Treatment Team will be implemented:
	Emergency (psychiatric/medical) procedures
	Medication management/monitoring as it relates to the Assertive Community Treatment Team
	Consumer complaint or grievance policy/procedure related to Assertive Community Treatment Team.
	Procedure for responding to inappropriate behavior/aggressive behavior as it relates to the Assertive Community Treatment Team.
	Attached Plan of Patient Care in case of Decertification of ACT Team

For BMS Staff Only

BMS Received Date	
BMS Review Meeting Date	
BMS Certification Approval Date	
BMS ACT Team Non-Approval Decision Letter Sent Date	

Please mail the application and all required attachment to:

BUREAU FOR MEDICAL SERVICES, ACT CERTIFICATION
350 CAPITOL STREET, ROOM 251
CHARLESTON, WEST VIRGINIA 25301

ACT TEAM EMPLOYEE MODIFICATION FORM

Completion of this form is required when a change in the ACT Team personnel occurs. The change must be reported to BMS within 30 calendar days of the modification. It is the providers' responsibility to ensure all team member requirements are met and the staff to member ratio is maintained. The ACT provider will be notified by BMS or its designee if any concerns are noted related to the team modification.

Name of ACT Provider: _____

ACT Team Leader Completing Form: _____

Date of Form Completion: _____

Name of new ACT Team Staff: _____

Designated Role on ACT Team: _____

Initial date performing ACT Team functions: _____

Name of previous ACT Team Staff: _____

Designated Role on ACT Team: _____

Last date of performing ACT Team functions: _____

The completed form may be submitted to BMS via fax, mail or email per the addresses below:

WV DHHR—BMS ACT
350 Capital St. Room 251
Charleston, WV 25301
Fax # (304) 558-4739

Attn: Program Manager BH Services

Email: Cynthia.A.Parsons@wv.gov

BMS Portion:
Date of Review: _____

BMS Staff Reviewing Form: _____

Notes:
_____

_____

_____

CHAPTER 504 – COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 504.4.2	Prior Authorization Requirements for Outpatient Services	9/27/05	10/01/05

CHAPTER 504 – COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

SEPTEMBER 27, 2005

SECTION 504.4.2

Introduction: Implementing changes in policy for imaging procedures effective 10/01/05.

Change: Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Directions: Replace pages.

CHAPTER 504—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

TABLE OF CONTENTS

TOPIC

CHAPTER 504–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR CHIROPRACTIC SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

West Virginia Medicaid coverage of chiropractic services is limited to manual manipulation for subluxation of the spine and certain diagnostic radiological examinations related to chiropractic services.

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

This chapter sets forth the Bureau for Medical Services requirements for reimbursement of services provided by independently practicing and licensed chiropractors to eligible West Virginia Medicaid members.

504.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200, Definitions of the Provider Manual. In addition, the following definition also applies to the requirements for reimbursement of chiropractic services described in this chapter.

Manual manipulation – Coverage of chiropractic services specifically limited to treatment by means of manual manipulation, i.e. by use of hands. Additionally, manual devices may be used by chiropractors in performing manual manipulation of the spine, however, no additional payment is available for use of a device nor does Medicaid recognize an extra charge for devices.

Subluxation - For Medicaid coverage, subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically.

504.2 MEDICAL NECESSITY

All services must be medically necessary and appropriate to the member's needs in order to be eligible for reimbursement. The medical records of all members receiving chiropractic services must contain documentation that establishes the medical necessity of the service. Manipulation is deemed ineffective and not medically necessary when it is rendered for conditions other than subluxation of the spine.

IMPORTANT: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.

504.3 PROVIDER PARTICIPATION

To participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau for Medical Services, Chiropractors must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located.
- Meet and maintain all BMS provider enrollment requirements (Outlined in Chapter 300).
- Have a valid signed provider enrollment application/agreement on file.

For provider enrollment application forms or additional information regarding provider participation requirements, please contact the Provider Enrollment Unit at 1-888-483-0793 or (304) 348-3360.

504.4 MEDICAID PROGRAM COVERAGE OF CHIROPRACTIC SERVICES

West Virginia Medicaid limits its coverage of chiropractic services to treatment by means of manual manipulation to correct a subluxation of the spine which is demonstrated by an x-ray. The x-ray requirement is waived for the initially covered services for pregnant women and children, but will be required for children if services above the initial twelve visits are requested.

The x-ray must be taken no more than three months prior to the date a course of treatment was initiated. In certain cases of an acute exacerbation of a chronic subluxation, an x-ray no older than a year may be accepted.

The manual manipulation must be directed to the spine to correct the subluxation. The precise level of the subluxation must be specified in the proposed treatment plan and the symptoms pertinent to the diagnosis must be described. The patient's symptoms must be related to the documented level of subluxation. For example, if pain is the symptom, the pain's location must be stated and an indication given as to whether the listed vertebrae can cause the pain in the identified area.

Attachment 1 lists the types of spinal manipulations (CPT 98940-CPT 98942) that West Virginia Medicaid covers and summarizes the services covered by these codes.

504.4.1 DIAGNOSTIC RADIOLOGY SERVICES

Medicaid reimburses chiropractors for the professional and technical components of covered diagnostic radiology services (CPT 72010-CPT 72120) if the chiropractor performs both parts of the procedure. Attachment 1 summarizes the radiological services reimbursed to Chiropractors.

To be reimbursable, x-rays must be taken on certified radiology equipment that complies with all applicable State and Federal requirements. It is the chiropractor's responsibility to furnish a copy of that certification and to keep that certification current with Medicaid's Provider Enrollment Unit.

Medicaid will provide reimbursement for only one interpretation of an x-ray and will not pay for a second confirmatory x-ray.

504.4.2 IMAGING PROCEDURE

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic

Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

504.5 LIMITATIONS AND CONDITIONS

Coverage of chiropractic services for subluxation of the spine is limited to one treatment per day for a Medicaid member and no more than twelve (12) treatments without prior authorization. A member may receive an additional twelve (12) treatments per calendar year if medically necessary and prior authorized. The maximum number of treatments that a member can have in any given year is 24 treatments.

Adjunctive therapies that a chiropractor may perform, such as diathermy, ultrasound, traction, laboratory tests, or other diagnostic procedures (excluding covered x-rays) are not covered services and will not be reimbursed. The chiropractic manipulative treatment codes include the pre-manipulation patient assessment and post-service work associated with the procedure.

Reimbursement is not available to chiropractors for any of the following radiology services:

- Mobile radiology services
- X-rays for soft tissue diagnosis
- Ultrasound or electrical stimulations.

504.6 PRIOR AUTHORIZATION

All chiropractic services beyond the initial twelve will require prior authorization. The provider is responsible for obtaining any required approvals. Any service rendered prior to obtaining authorization will not be reimbursed to providers, nor may the Medicaid member be held responsible for such charges unless the member did not inform the provider of the Medicaid coverage or signed an agreement to be treated as a private pay patient.

Attachment 2 contains the Chiropractic Information Form that must be completed in order to request prior authorization for chiropractic services. The completed form along with an x-ray report that is timely to the prior authorization request must be sent to:

West Virginia Medical Institute
3100 Chesterfield Ave SE
Charleston, West Virginia 25304

The West Virginia Medical Institute (WVMI) can be reached at 1-800-982-6334 or (304) 346-9167. The fax number is 304-346-8185.

Prior authorization for members who have Medicare and Medicaid benefits is unnecessary for services covered by the Medicare Program. Likewise, if a Medicaid member has private

health insurance, prior authorization is not required from Medicaid and the private insurance must be used before Medicaid.

Prior authorization does not guarantee payment for the approved services. Both providers and members must meet all applicable eligibility requirements, and services must be rendered within the Medicaid Program benefit limitations in effect as of the date of service.

All approved services must be performed within the authorized time frame. Medicaid payments will not be made for services provided outside the time frame.

504.7 GENERAL DOCUMENTATION REQUIREMENTS

Providers must maintain a specific record for all services provided for each West Virginia Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, documentation of services provided, the dates, and times, plus the services which were provided, and the signature of the chiropractor who provided the service along with his/her credentials. Documentation must substantiate medical necessity of the service provided.

In addition to the documentation requirements in this Chapter 504, chiropractors must also comply with the documentation and maintenance of records requirements described in Chapter 100 – General Information, Chapter 300 – Provider Participation, and Chapter 800 – General Administration of the Provider Manual.

504.8 BILLING AND REIMBURSEMENT

Reimbursement for covered spinal manipulations and diagnostic radiological examinations is based on the Resource Based Relative Value Scale (RBRVS) fee schedule, subject to West Virginia Medicaid's coverage policies within the scope of services a chiropractor is legally authorized to perform by the State in which he or she practices. Payment equals the lower of the fee schedule amount or the amount the practitioner charges for the service.

Chapter 600 explains the RBRVS fee schedule.

504.9 MANAGED CARE

If the member belongs to the PAAS Program, the member's PCP must authorize and provide a referral for chiropractic services prior to services being rendered. Unless noted otherwise, services detailed in this manual are the responsibility of the HMO if the Medicaid member is a member of an HMO. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met for those members.

CHAPTER 504

CHIROPRACTIC SERVICES

OCTOBER 1, 2005

ATTACHMENT 1

COVERED PROCEDURES CODES FOR SPINAL MANIPULATIONS AND CHIROPRACTIC DIAGNOSTIC RADIOLOGY SERVICES

Covered Procedures Codes
For Spinal Manipulations and
Chiropractic Diagnostic Radiology Services

Spinal Manipulation Procedure Codes:

CPT Code	Description
98940	Chiropractor manipulation treatment: spinal, one to two regions
98941	Chiropractor manipulation treatment: spinal, three to four regions
98942	Chiropractor manipulation treatment: spinal, five regions

Diagnostic Radiology Services:

CPT Code	Description
72010	Radiological examination, spine, entire, survey study, anteroposterior and lateral
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical, two or three views
72050	Radiologic examination, spine, cervical, minimum of four views
72052	Radiologic examination, spine, cervical, complete, including oblique and flexion and/or extension studies
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070	Radiologic examination, spine, thoracic, two views
72072	Radiologic examination, spine, thoracic, three views
72074	Radiologic examination, spine, thoracic, minimum of four views
72080	Radiologic examination, spine, thoracolumbar, two views
72090	Radiologic examination, spine, scoliosis study, including supine and erect studies
72100	Radiologic examination, spine, lumbrosacral; two or three views
72110	Radiologic examination, spine, lumbrosacral; minimum of four views
72114	Radiologic examination, spine, lumbrosacral, complete, including bending views
72120	Radiologic examination, spine, lumbrosacral; bending views only, minimum of four views

CHAPTER 504
CHIROPRACTIC SERVICES
OCTOBER 1, 2005

ATTACHMENT 2
THE CHIROPRACTIC INFORMATION FORM
(THESE PAGES MAY BE DUPLICATED)

PAGE 1 OF 3

Chiropractic Information Form

This form must be completed by the treating chiropractor and submitted for authorization prior to services being rendered.

Patient Name: _____ Medicaid ID# _____

A. Diagnosis:
   1. _____
   2. _____

B. Specific Spine Subluxation:
   1. Cervical _____ 3. Lumbar _____
   2. Thoracic _____ 4. Other _____

C. Date and history of onset/date and history of exacerbation for this diagnosis:
   _____
   _____
   _____

D. Dates of service for the current calendar year:
   List all dates patient was seen in provider's office for current calendar year only.
_____
_____
_____

E. Subjective complaints:
   1. _____2. _____
   3. _____4._____:

F. Objective Complaints
   1. _____
   2. _____

G. Description of spinal manipulation:
_____
_____

H. Short-term goals of treatment:
_____

I. Long-term goals of treatment:
_____

J. Co-Morbidities that could affect length of treatment:

_____

_____

_____

K. Frequency of requested visits and schedule of declining frequency:

1. Date of first treatment for this authorization request: _____

2. Total number of treatments requested: _____

3. The request is for ____ additional treatments for the month of _____

4. This request is for ___ treatments over 30 60 90 days (circle the appropriate number)

Frequency of requested visits is:

_____ times per week for _____ weeks; and

_____ times per week for _____ weeks.

L. Emergency Request - Please give a brief explanation:

_____

_____

Provider name: _____ Provider ID#_____

Signature: _____ Date: _____

CHAPTER 505–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DENTAL, ORTHODONTIC, AND ORAL HEALTH SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Added Fluoride Varnish Policy	Appendix C	January 16, 2012	January 16, 2012
Corrected verbiage in Appendix A Special Instructions	Appendix A	May 25, 2011	November 1, 2010
Added verbiage to Retrospective Review	505.8 Prior Authorization	May 25, 2011	November 1, 2010
Added verbiage for Orthodontics	505.4 Covered Services	May 25, 2011	November 1, 2010
Entire Chapter	Entire Chapter	September 1, 2010	November 1, 2010

CHAPTER 505– COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DENTAL, ORTHODONTIC, AND ORAL HEALTH SERVICES
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CHAPTER 505– COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DENTAL, ORTHODONTIC, AND ORAL HEALTH SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in this chapter must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical, dental, and mental services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

General dentists and specialty dentists may provide a variety of covered dental services in accordance with his/her licensure and in accordance with the West Virginia State Code Chapter 30, Article 4 and 4A. Coverage decisions are based upon the member's age, medical necessity, and the member's need and may be provided in a practitioner's office, ambulatory surgical center, and outpatient or inpatient hospital. If a Current Dental Terminology (CDT) code requires prior authorization, the service requires prior authorization regardless of place of service. All inpatient hospitalizations require prior authorization (PA) by BMS' Utilization Management Contractor (UMC). Inpatient hospitalization shall not be reimbursed when the service could be provided in an outpatient setting. Requests for prior authorization do not guarantee approval or payment.

Medical doctors who possess a medical or osteopathic license in addition to a dental license will be assigned both a medical and dental provider number for billing services. Current Procedural Terminology (CPT) codes must be billed on a CMS 1500 claim or an 837P electronic claim format with the medical provider number. Current Dental Terminology (CDT) codes must be billed on an ADA claim or an 837D electronic format with the dental provider number. If both CPT and CDT codes exist for the services, CPT codes must be utilized for the service.

Enrolled children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Covered dental services for enrolled adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. Refer to Appendix C for Infant and Child Oral Health Fluoride Varnish Policy.

The fact that a practitioner prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is

eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are provided.

This chapter describes West Virginia Medicaid's coverage policies for general dentistry, orthodontia, and oral surgery.

505.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Definitions and Acronyms.* In addition, the following definitions for general dentistry, specialty dentistry and other oral health services as described in this chapter, include but are not limited to the following:

Abscess – An acute or chronic localized inflammation, probably with a collection of pus, associated with tissue destruction and frequently, swelling; usually secondary to infection.

Benefit Package or Plan – The group of services which make up a plan or set of benefits covered by Medicaid.

Bicuspid – A premolar tooth; a tooth with two cusps.

Bitewing radiograph – An interproximal radiographic view of the coronal portion of the tooth/teeth.

Complete series – An entire set of intra-oral radiographs usually consisting of 14 to 22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

Comprehensive Orthodontic Treatment – A phrase indicating multiple phases of treatment provided at different stages of dentofacial development.

Crown –

- An abutment (artificial crown serving for the retention or support of a dental prosthesis);
- Anatomical (that portion of tooth normally covered by, and including, enamel);
- Artificial (restoration covering or replacing the major part, or the whole of the clinical crown of a tooth); and,
- Clinical (that portion of a tooth not covered by tissues).

Current Dental Terminology (CDT) – A listing of procedure codes and descriptive terms published by the American Dental Association (ADA) for reporting dental services and procedures.

Current Procedural Terminology (CPT) – A listing of descriptive terms and identifying codes developed by the American Medical Association (AMA) for reporting practitioner services and procedures to medical plans and Medicare.

Cuspid – A single cusped tooth located between the incisors and bicuspids.

Dentition – The teeth in the dental arch:

- Adolescent (refers to the stage of permanent dentition prior to cessation of growth)
- Deciduous (refers to the deciduous or primary teeth in the dental arch)
- Permanent (adult, refers to the permanent teeth in the dental arch)
- Transitional (refers to a mixed dentition; begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous teeth).

Dental Assistant – An individual qualified by education, training, and experience who aids or assists a dentist in the delivery of patient care in accordance with delegated procedures or who may perform intra-oral tasks in the dental office. No occupational title other than dental assistant shall be used to describe this individual.

Dental Auxiliary Personnel – Dental hygienists and dental assistants who assist the dentist in the provision of oral health care services to patients.

Dental Hygienist – A person licensed by the West Virginia Board of Dental Examiners who provides preventive oral health care services to patients in the dental office and in a public health setting. No occupational title other than dental hygienist may be used to describe this individual. State dental regulations determine the dental hygienist duties.

Dentures – An artificial substitute for some or all of the natural teeth and adjacent tissues.

- Complete – a prosthetic for the edentulous maxillary or mandibular arch, replacing the full dentition.
- Fixed partial – a prosthetic replacement of one or more missing teeth cemented or otherwise attached to the abutment teeth.
- Removable partial – a removable prosthetic device that replaces missing teeth.

Direct Supervision – Supervision of dental auxiliary personnel provided by a licensed dentist who is physically present in the dental office or treatment facility when procedures are being performed.

Emergent Oral Health Procedures – Covered services provided as quickly as the situation warrants necessary to relieve pain, eliminate infection, or reduce fractures.

Endodontist – A dental specialist who limits his/her practice to treating disease and injuries of the pulp and associated periradicular conditions.

Extraction – The process or act of removing a tooth or tooth parts.

Fracture – The breaking of a part, especially of a bony structure; breaking of a tooth.

General Dentist – A dentist who is not considered a specialist and can perform examinations, evaluations, diagnosing of diseases, disorder and conditions of the oral cavity, maxillofacial area and adjacent and associated structures. They can treat diseases, disorders and conditions of the oral cavity, maxillofacial area and the adjacent and associated structures, fabricate, repair

and alter dental prosthesis, administer anesthesia in accordance with West Virginia Code Chapter 30, Article 4a, and prescribing drugs necessary for dentistry.

General Supervision – A dentist is not required to be in the office or treatment facility when procedures are being performed by the auxiliary dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures and will evaluate the treatment provided by the dental auxiliary personnel.

Impacted tooth – An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

Malocclusion – improper alignment of biting or chewing surfaces of upper and lower teeth.

- **Class I malocclusion** – The relationship of the first molars is normal and the upper and lower jaws are in a normal relationship to each other, but the other teeth are crowded, irregularly spaced, or overlapped.
- **Class II malocclusion** – The lower first molar is distally positioned relative to the upper first molar.
- **Class III malocclusion** – The lower molar mesially positioned relative to the upper molar.

Molar – Teeth posterior to the premolars (bicuspids) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.

Mountain Health Trust – The name of West Virginia Medicaid's Managed Care Program that consists of the Physician Assured Access System (PAAS) and the Medicaid Managed Care Organizations (MCOs).

Occlusion – Any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

Oral and Maxillofacial Surgeon – A dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

Orthodontist – A dental specialist whose practice is limited to the interception and treatment of malocclusion and other neuromuscular and skeletal abnormalities of the teeth and their surrounding structures.

Orthognathic – The functional relationship of maxilla and mandible.

Pediatric Dentist (Pedodontist—old terminology) – A dental specialist whose practice is limited to treatment of children from birth through adolescence (including those with special health care needs, at any age), providing primary and comprehensive preventive and therapeutic oral healthcare.

Periapical – The area surrounding the end of the tooth root.

Peridontist – A dental specialist whose practice is limited to the treatment of diseases of the supporting and surrounding tissues of the teeth.

Preventive dentistry – The aspects of dentistry concerned with promoting good dental and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Primary – A current term used to describe the older verbiage of deciduous or baby teeth.

Primary Care Provider (PCP) – A practitioner associated with the medical home that is the primary contact for provision and coordination of a member's health care services or needs.

Primary Dentition- The teeth that erupt first and are usually replaced by the permanent teeth (baby teeth).

Prosthodontist – A dental specialist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Quadrant – One of the four equal sections into which the dental arches can be divided, begins at the midline of the arch and extends distally to the last tooth.

Radiograph – An image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

Root canal – The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

Sealant – A resinous material designed to be applied to the occlusal surfaces of posterior teeth to prevent occlusal caries.

Space maintainer – A passive appliance, usually cemented in place that holds teeth in position.

Specialty – The practice of a certain branch of dentistry.

Supernumerary teeth – extra erupted or unerupted teeth that resemble teeth of normal shape.

Symptomatic impacted tooth – Pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Transitional Dentition- Begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous (baby) teeth.

505.2 PRACTITIONER PARTICIPATION

West Virginia Medicaid recognizes Doctor of Dental Surgery (DDS) and Doctor of Dental Medicine (DDM) as eligible practitioners to provide general dental, orthodontic and oral and maxillofacial surgery services to enrolled Medicaid members. To be eligible for participation and reimbursement of services provided to Medicaid members, all providers shall:

- Meet all applicable licensing, accreditation and certification requirements;
- Have a valid signed provider enrollment application/agreement on file; and,
- Meet and maintain all BMS provider enrollment requirements.

Refer to *Common Chapter 300, Provider Participation Requirement* for additional information.

505.3 DENTAL HYGIENIST/DENTAL ASSISTANT

Licensed practitioners may assign intra-oral tasks to employed dental hygienists or dental assistants. Refer to West Virginia State Code *§30-4-17 and §30-4-18* for dental hygienists and dental assistants scope of practice. Dental hygienists and dental assistants are not eligible to enroll individually as a Medicaid provider or receive direct reimbursement for services rendered. Services are to be billed over the dentist's NPI.

505.4 COVERED SERVICES

West Virginia Medicaid reimburses for general dentistry, orthodontics, oral and maxillofacial surgery services. Children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, prosthodontics, maxillofacial prosthetics, oral and maxillofacial services, and orthodontics. When covered services are required and initiated before the member's 21st birthday, the service shall be completed within the timeframe established by the treatment plan. Prior authorization may apply.

Covered dental services for adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. Prior authorization and service limits may apply.

Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. (See Prior Authorization Form located at www.wvmi.org for orthodontia criteria). BMS reimburses one treatment of comprehensive orthodontia (CDT Codes D8070, D8080 and D8090) per lifetime per member. If any of the comprehensive orthodontia codes are billed then none of the remaining can be billed; they are a one per lifetime limit for any of the three and are not looked at as per code lifetime limit.

Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age AND the needed surgery is documented in the original orthodontic request.

Current Dental Terminology Procedure Codes for covered dental services for children up to 21 years of age and adults 21 years of age and older is available in *Appendices A and B*.

505.5 LIMITATIONS OF COVERAGE—ADULTS

Dental services for adults, 21 years of age and older, are limited to Emergent services necessary to treat fractures, reduce pain, or eliminate infection. An Oral evaluation for limited

fractures, pain or infection is covered. Prior authorization and service limits may apply. Refer to *Appendix B*.

505.6 ANESTHESIA

Anesthesia in the form of general anesthesia, conscious sedation, and anxiolysis is covered when basic behavior guidance techniques have not been successful or for members who cannot cooperate due to lack of psychological or emotional maturity and/or mental, physical or medical disability. In addition it may be required for members where the use of sedation may protect the developing psyche and/or reduce medical risk.

No dentist may induce central nervous system anesthesia without first having obtained an anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners or from the State Board of Dental Examiners in the state in which they practice for the level of anesthesia being induced.

Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately.

505.7 NON-COVERED SERVICES

Dental services not covered by West Virginia Medicaid include, but are not limited to, the following. Non-covered services are not eligible for a DHHR fair hearing or a desk/document review.

- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Dental services for which PA has been denied or not obtained
- Dental services for the convenience of the member, the member's caretaker, or the provider of service
- Procedures for cosmetic purposes
- Temporomandibular Joint (TMJ) for adults
- Anesthesia services when solely for the convenience of the member, the member's caretaker or the provider of service
- Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately
- Dental services for residents of Intermediate Care and Nursing Facilities i.e., Nursing Home, ICF/MR, and PRTF
- Dental services for participants enrolled in the Division of Rehabilitation Services or when services are covered under a Workers Compensation plan
- Dental services provided by providers not enrolled with West Virginia Medicaid
- Use of an unlisted code when a national CDT code is available
- Unbundled CDT codes

505.8 PRIOR AUTHORIZATION

Effective with this manual, medical necessity review criteria may be based on adaptations of dental standards developed by the Periodicity and Anticipatory Guidance Recommendations by the American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and research-based, nationally accredited medical appropriateness criteria, such as InterQual, OR other appropriate criteria approved by BMS. Prior authorization request forms are available at the BMS' Utilization Management Contractor (UMC) website www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx Prior authorization does not guarantee approval or payment.

The UMC reviews all requests for services requiring prior authorization. It is the responsibility of the treating/prescribing practitioner to submit the appropriate Prior Authorization Request Form with medical documentation to the UMC. The treating practitioner is responsible to assure the assigned prior authorization number is documented on the appropriate claim form when submitting the claim for payment consideration. Refer to *Common Chapter 800*, *General Administration*, for additional information.

When a request for service is denied based on medical necessity, the denial is communicated with the reason(s) of denial to the provider of service and the member or their legal guardian by the UMC. Information related to the member's right to a fair hearing and the provider's right to a reconsideration of the denial is included in the communication.

The use of an unlisted code is prohibited when an appropriate code is available. Therefore, unlisted codes for procedures/services require prior authorization by the UMC. The practitioner shall provide medical documentation and the reason(s) why an unlisted code shall be utilized for the specific procedure/service requested. The aforementioned prior authorization process shall be followed. When an assigned code is identified, the request for the unlisted code shall be denied.
Refer to *Appendices A* and *B* for specific procedure codes requiring prior authorization and service limits for covered services.

Retrospective authorization is available in the following circumstances:

- A procedure/service denied by the member's primary payer providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive Medicaid eligibility; or
- Retrospective review is available for Medicaid members in instances where it is in the dental practitioner's opinion that a procedure that requires prior authorization is medically necessary and per recommended dental practices delaying the procedure may subject the member to unnecessary or duplicative service if delivery of the service is delayed until prior authorization is granted. In these instances, a request for prior authorization must be made by the provider within 10 business days of the date the service is performed. If the procedure(s) does not meet medical necessity criteria upon review by the Utilization Management Contractor (UMC) the prior authorization request will be denied and the provider will not be reimbursed for the service by Medicaid or the member. Prior authorization is also available for medical necessity review before the service is provided.

- A request for retrospective authorization is submitted the next business day following an Emergent procedure/service occurring on weekends, holidays, or at times when the UMC is unavailable.

A request for consideration of retrospective authorization does not guarantee approval or payment.

505.9 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in *Common Chapter 300, Provider Participation Requirements, Section 320.5, Document and Retain Records*, practitioners submitting claims for Medicaid reimbursement shall maintain complete, individual, accurate, and legible medical records. Records shall include documentation of medical necessity procedures/services provided and must be available to BMS or its designee upon request. When documentation is not available, BMS will request repayment.

Documentation requirements include, but are not limited to:

- A referral for treatment
- The primary diagnosis and appropriate CDT code for service to be provided
- A treatment plan (Orthodontics)
- Radiographs
- Photos, when appropriate
- Dental molds, when appropriate
- Documentation to justify medical necessity
- Copy of Prior Authorization Request Form, when applicable
- Copy of ADA claim form submitted for payment consideration, when appropriate.

Supporting documentation for prior authorization review cannot be older than 6 months.

505.10 EARLY PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services. Based on medical necessity, prior authorization is required when service limits are exceeded.

Dental screenings are covered to any child under the age of 21 years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Refer to www.aap.org for the American Academy of Pediatrics Dental (AAPD) periodicity schedule.

505.11 RESIDENTIAL FACILITIES

A. Nursing Facility

Dental services are not eligible for reimbursement as a direct billing to Medicaid if the Medicaid member is a resident of the nursing facility at the time the dental service is provided.

B. Intermediate Care Facility for Mental Retardation (ICF/MR)

Any service required by the member is reimbursed as an all inclusive rate. However, if the ICF/MR does not provide the required service on-site, such as dental, a mutual dental agreement between the ICF/MR and an outside source shall be developed and implemented. Services provided by outside sources are included in the ICF/MR rate and shall not be billed separately.

C. Psychiatric Residential Treatment Facility (PRTF)

Any service required by the member is reimbursed an all inclusive rate. However, if the PRTF does not provide the required service on-site, such as dental, a mutual dental agreement between the PRTF and an outside source shall be developed and implemented. Services provided by outside sources are included in the PRTF rate and shall not be billed separately.

505.12 TOBACCO CESSATION

West Virginia Medicaid in partnership with the Bureau for Public Health (BPH) operates a tobacco cessation program to assist members to discontinue use of tobacco products. In order for members to have access to drugs and other tobacco cessation services, they are required to see their primary care provider and enroll in the program. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are also available through the program. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per calendar year. Pregnant females are eligible for additional course(s) of treatment, when appropriate. Refer to *Chapter 518, Pharmacy Services,* for covered tobacco cessation drug products.

Additional information regarding the tobacco cessation program can be accessed through www.wvdtp.com or www.wvquitline.com. The Bureau for Public Health may also assist in providing services for those who are uninsured or under-insured.

505.13 BILLING and REIMBURSEMENT

505.13.1 Billing

West Virginia Medicaid utilizes Current Dental Terminology (CDT) procedure codes for billing of dental services provided to Medicaid members. Only enrolled providers shall be eligible for reimbursement of services provided. Billing prior to providing services is prohibited. Providers shall not directly bill a Medicaid member for any service without first informing the member that the service is not covered by Medicaid AND a written signed agreement by the member signifying that he/she accepts responsibility for payment.

Medical doctors who possess a medical or osteopathic license in addition to a dental licensed will be assigned both a medical and dental provider number for billing services. Current Procedural Terminology (CPT) codes must be billed on a CMS 1500 claim or an 837P electronic claim format with the medical provider number. Current Dental Terminology (CDT) codes must be billed on an ADA claim or an 837D electronic format with the dental provider number. If both CPT and CDT codes exist for the services, CPT codes must be utilized for the service. Refer to Appendix C for Infant and Child Oral Health Fluoride Varnish Policy.

At the initiation of the approved orthodontic treatment plan, BMS reimburses a one-time total payment to the orthodontist. In the event the initial orthodontist is unable to complete the approved treatment plan, he/she must refund the monies for uncompleted portions of the treatment plan through the reversal/replacement process. Through this process, reimbursement is available to the orthodontist who ultimately completes the treatment plan.

BMS does not require a prior authorization for most services when the member has a primary insurance and that insurance approved and reimbursed for the service. Orthodontic services shall require a Medicaid prior authorization from the UMC regardless of primary insurance.

In instances where procedure/service codes are bundled, unbundling of individual codes is prohibited.

The ADA claim form or electronic form 837D is required for billing general dentistry and specialty dental services.

Refer to *Common Chapter 600, Reimbursement Methodology*, for additional information

505.13.2 Reimbursement Methodology

Medicaid is the payer of last resort. Third-Party Liability, (TPL) is a method of ensuring that BMS is the last payer to reimburse for covered services. Refer to *Common Chapter 600, Reimbursement Methodology,* for additional information.

Reimbursement for general and specialty dental services is based on:

- American Dental Association Survey of Dental Fees for Southern Atlantic Regional Norms

- American Society of Anesthesiology guidelines
- Lesser of the established fees or the provider's usual customary charge to the general public
- Unaltered cost invoice.

Refer to *Common Chapter 600, Reimbursement Methodologies,* for additional information.

505.14 MANAGED CARE

If the Medicaid member is enrolled in a Managed Care Organization (MCO), the MCO is responsible for covered emergent dental services to treat fractures, reduce pain, or eliminate infection for adults 21 years of age and older. These dental services are covered under Mountain Health Trust and reimbursed by the MCO.

505.15 PAAS PROGRAM

If a Medicaid member is enrolled in the PAAS Program, no referral by the PAAS provider is necessary for the member to receive dental services; however, all applicable prior authorization requirements remain and age restrictions apply. Based on medical necessity, prior authorization is required when service limits are exceeded.

505.16 MOUNTAIN HEALTH CHOICES

Mountain Health Choices program is offered by West Virginia Medicaid for certain eligibility categories. It includes a choice of benefit package and primary care provider (PCP), encourages personal responsibility, and provides care coordination for its members through the member's medical home.

Providers can view the member's benefit plan designation on the member's Medicaid card, call the provider eligibility telephone line or utilize the Medicaid Management Information System (MMIS) vendor web portal to determine member eligibility and benefit package. The following will be noted on the member's card to identify the benefit plan in which the member is enrolled:

- ~~T~~R" Traditional Medicaid Benefit Package
- ~~B~~A" Basic Adult Benefit Package
- ~~E~~A" Enhanced Adult Benefit Package
- ~~B~~C Basic Child Benefit Package
- ~~E~~C" Enhanced Child Benefit Package.

See *Chapter 527, Mountain Health Choices*, for information on the Basic and Enhanced Benefit Packages.

CHAPTER 505
DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
NOVEMBER 1, 2010

APPENDIX A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
CHILDREN UP TO AGE 21 YEARS

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
DIAGNOSTIC			
CLINICAL ORAL EVALUATION			
D0120	Periodic oral examination - established patient	2 per calendar year	Not billable with D0140, D0145, D0150 or D9310
D0140	Limited oral evaluation - problem focused	Emergent	Not billable with D0120, D0145, D0150 or D9310
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	1 per 6 months	Age restriction up to 36 months. Not billable with D0120, D0140, D0150 or D9310
D0150	Comprehensive oral evaluation - new or established patient	1 per calendar year	Not billable with D0120, D0140, D0145, D9310
RADIOGRAPH/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)			
D0210	Intraoral-complete series (including bitewings)	1 per 2 years	Not billable with D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273, D0274
D0220	Intraoral-periapical, first film	1 per day	Not billable with D0210 and D0240
D0230	Intraoral-periapical, each additional film	8 per 3 months	Not billable with D0210 and D0240. Must be billed with D0220
D0240	Intraoral- occlusal film	2 per calendar year	Not billable with D0210 and D0220, D0230
D0250	Extraoral- first film	1 per 3 years	
D0260	Extraoral- each additional film	3 per 3 years	Must be billed with D0250
D0270	Bitewing-single film	4 per calendar year	Not billable with D0210, D0272, D0273, D0274
D0272	Bitewings -two films	1 per calendar year	Not billable with D0210, D0273, D0274
D0273	Bitewings – three films	1 per calendar year	Not billable with D0210, D0272, D0274
D0274	Bitewings- four films	1 per calendar year	Not billable with D0210, D0272, D0273
D0290	Posterior - anterior or lateral skull and facial bone survey films	2 per calendar year	

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D0310	Sialography		
D0320	Temporomandibular joint arthrogram, including injection		
D0321	Other temporomandibular joint films, by report		Requires PA with documentation to identify type of radiograph requested.
D0322	Tomographic survey		
D0330	Panoramic film	1 per 3 years	
D0340	Cephalometric film	1 per calendar year	
D0350	Oral/facial photographic images		This code excludes conventional radiographs - For orthodontics only.
TESTS AND EXAMINATIONS			
D0470	Diagnostic casts	2 per calendar year	
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.		
ORAL PATHOLOGY LABORATORY			
GENERALLY PERFORMED IN A PATHOLOGY LABORATORY AND DOES NOT INCLUDE THE REMOVAL OF THE TISSUE SAMPLE FROM THE PATIENT.			
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report		To be used in pathology laboratory reporting transepithelial, disaggregated cell samples by brush biopsy technique.
PREVENTIVE			
DENTAL PROPHYLAXIS			

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D1110	Prophylaxis-adult	1 per 6 months	13 to 21 years of age; Not reimbursable with D1120
D1120	Prophylaxis-child	1 per 6 months	up to 13 years of age; Not reimbursable with D1110
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)			
D1203	Topical application of fluoride - child	2 per calendar year	3 to 13 years of age; Not reimbursable with D1204 or D1206
D1204	Topical application of fluoride-adult	2 per calendar year	13 to 21 years of age; Not reimbursable with D1203 or D1206
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries	2 per calendar year	Not reimbursable with D1203 or D1204. Age restriction of 6 months to 3 years.
OTHER PREVENTIVE SERVICES			
D1320	Tobacco counseling for the control and prevention of oral disease	2 per calendar year	12 to 21 years of age
D1351	Sealant	1 sealant per tooth per 3 years	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration Requires dental areas configuration.
SPACE MAINTENANCE (PASSIVE APPLIANCES)			
D1510	Space maintainer-fixed-unilateral	4 per calendar year	Per quadrant –UR, UL, LL, LR must be included on claim form for payment consideration.
D1515	Space maintainer-fixed-bilateral	2 per calendar year	Upper arch or lower arch must be included on claim form for payment consideration.
D1520	Space maintainer-removable- unilateral	4 per calendar year	See D1510
D1525	Space maintainer-removable- bilateral	2 per calendar year	See D1515
D1550	Recementation of space maintainer	1 per calendar year	
RESTORATIVE			

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
AMALGAM RESTORATIONS (INCLUDING POLISHING)			
D2140	Amalgam- one surface, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, & local anesthesia are included the fee & may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2150	Amalgam- two surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2160	Amalgam-three surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2161	Amalgam-four or more surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
RESIN-BASED COMPOSITE RESTORATIONS – DIRECT			
D2330	Resin-based composite-one surface, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2331	Resin-based composite- two surfaces, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D2332	Resin-based composite-three surfaces, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2390	Resin-based composite crown, anterior	1 tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2391	Resin-based composite, one surface posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2392	Resin-based composite, two surfaces posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2393	Resin-based composite, three surfaces posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
			Radiographs with documentation must be documented in the medical record for date of service
D2394	Resin-based composite, four or more surfaces	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service
CROWNS - SINGLE RESTORATIONS ONLY			
D2751	Crown- porcelain fused to predominately base metal	1 tooth number per 5 years	Requires PA with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S & T. Tooth numbers must also be documented on the claim form for payment consideration.
D2791	Crown- full cast predominately base metal	1 tooth number per 5 years	Requires PA with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S, & T. Tooth numbers must also be documented on the claim form for payment consideration.
OTHER RESTORATIVE SERVICES			
D2920	Recement crown	1 per tooth number per 1 calendar year	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration.
D2930	Prefabricated stainless steel crown-primary tooth	1 per tooth number per 1 calendar year	Requires PA with radiographs. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service.
D2931	Prefabricated stainless steel crown-permanent tooth	1 per tooth number per 1 calendar year	Requires PA with radiographs. Tooth number 1-32 must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service.
D2932	Prefabricated resin crown	1 per tooth number per 1 calendar year	Requires PA with radiographs. Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.
D2933	Prefabricated stainless steel crown with resin window		Requires PA with radiographs. Tooth numbers1-32 must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D2940	Protective restoration	2 per calendar year per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy or on the same date of services as a restoration.
D2950	Core buildup, including any pins	1 per calendar year per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.
D2951	Pin retention- per tooth, in addition to restoration	1 per 3 years per tooth number	Tooth numbers 1-32 must be documented on claim form for payment consideration.
D2952	Cast and core in addition to crown (indirectly fabricated)	1 per 3 years per tooth number	Tooth numbers 1-32 must be documented on claim form for payment consideration.
D2954	Prefabricated post & core in addition to crown	1 per 3 years per tooth number	Tooth numbers 1-32 or A-T must be documented on claim form for payment consideration.
ENDODONTICS - INCLUDES LOCAL ANESTHESIA			
PULPOTOMY			
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 per 3 years per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not reimbursable with D3310, D3320, or D3330. This is not to be construed as the first stage of root canal therapy. Not to be used for apexogenesis.
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW UP CARE)			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3320, or D3330
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 or C, H, Q, N must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D3330. To be performed on primary or permanent teeth.
D3330	Endodontic therapy, molar (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 1-3, 14-19, 30-32 and primary teeth # A,B,I,J,K,L,S, and T, if no permanent successor present, must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D3320
ENDODONTIC RETREATMENT			

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D3346	Retreatment of previous root canal therapy-anterior	1 tooth number per lifetime	Tooth numbers 6-11 and 22-27, must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post operative treatments and may not be billed separately.
D3347	Retreatment of previous root canal therapy-bicuspid	1 tooth number per lifetime	Tooth numbers 4,5,12,13,20,21,28, and 29 must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post operative treatments and may not be billed separately.
D3348	Retreatment of previous root canal therapy-molar	1 tooth number per lifetime	Tooth numbers 1-3, 14-19, and 30-32 must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post operative treatments and may not be billed separately.
APEXIFICATION/RECALCIFICTION PROCEDURES			
D3351	Apexification/recalcification/ pulpal regeneration-initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)		Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.
D3352	Apexification/recalcification/ pulpal regeneration-interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	3 treatment per tooth number per lifetime	Tooth numbers 1-32 must be documented on claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.
D3353	Apexification/recalcification-final visit (includes completed root canal therapy-apical closure/calcify repair of perforations, root resorption, etc.)	1 tooth number per lifetime	Tooth numbers 1-32 must be documented on claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.
APICOECTOMY/PERIRADICULAR SERVICES			
D3410	Apicoectomy/periradicular surgery-anterior	1 tooth number per lifetime	Requires PA with documentation, tooth number(s), and radiographs as appropriate. Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D3421	Apicoectomy/periradicular surgery-bicuspid (first root)	1 tooth number per lifetime	Requires PA with documentation, tooth number(s), and radiographs as appropriate. Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 must be documented on the claim form for payment consideration.
D3999	Unspecified endodontic procedure, by report		This code should be used only if a more specific CDT code is not available. Requires PA with radiographs, documentation and description of procedure to be performed.
PERIODONTICS			
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)			
D4210	Gingivectomy or Gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant(s) and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4211.
D4211	Gingivectomy or Gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4210.
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4210. Must be billed with the number codes.
D4261	Osseous surgery (including flap entry and closure) one to three contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4210.
NON-SURGICAL PERIODONTAL SERVICE			
D4341	Periodontal scaling and root planing- four/more teeth per quadrant	1 quadrant per 1 calendar year	Requires PA. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4342.
D4342	Periodontal scaling and root planing- one - three teeth, per quadrant	1 quadrant per 1 calendar year	Requires PA. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4341.
D4355	Full mouth debridement to enable comprehensive	1 per 6 months	Requires PA. Only covered when there is substantial gingival inflammation (gingivitis in all 4 quadrants).

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	evaluation and diagnosis		
OTHER PERIODONTAL SERVICES			
D4999	Unspecified periodontal procedure, by report		This code should be used only if a more specific CDT code is not available. Requires PA with radiographs, documentation and description of procedure to be performed.
PROSTHODONTICS (REMOVABLE)			
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)			
D5110	Complete denture- maxillary	1 per 5 years	Requires PA
D5120	Complete denture- mandibular	1 per 5 years	Requires PA
D5130	Immediate denture – maxillary	1 per 5 years	Requires PA
D5140	Immediate denture – mandibular	1 per 5 years	Requires PA
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)			
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires PA Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires PA Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 per 5 years	Requires PA Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
ADJUSTMENTS TO DENTURES			
D5410	Adjust complete denture-maxillary	3 per calendar year	Adjustments not covered within 3 months of placement
D5411	Adjust complete denture-mandibular	3 per calendar year	Adjustments not covered within 3 months of placement
D5421	Adjust partial denture –	3 per calendar year	Adjustments not covered within 3 months of placement

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	maxillary		
D5422	Adjust partial denture – mandibular	3 per calendar year	Adjustments not covered within 3 months of placement
REPAIRS TO COMPLETE DENTURES			
D5510	Repair broken complete denture base	2 per calendar year per arch	Upper arch, Low arch must be documented on the claim form for payment consideration.
D5520	Replace missing or broken teeth- complete denture (each tooth)	2 per calendar year per tooth number	Tooth numbers 1-32 must be documented on the claim form for payment consideration.
REPAIRS TO PARTIAL DENTURES			
D5610	Repair resin denture base	2 per calendar year per arch	Upper arch, Lower arch must be documented on the claim form for payment consideration. Must be billed with the number codes.
D5620	Repair cast framework	2 per calendar year per arch	Upper arch, Lower arch must be documented on the claim form for payment consideration. Must be billed with the number codes.
D5630	Repair or replace broken clasp	2 per calendar year	
D5640	Replace broken teeth- per tooth	2 per calendar year	Tooth number 1-32 must be documented on the claim form for payment consideration.
D5650	Add tooth to existing partial denture	2 per calendar year	Tooth number 1-32 must be documented on the claim form for payment consideration
D5660	Add clasp to existing partial denture		
DENTURE REBASED PROCEDURES			
D5710	Rebase complete maxillary denture	1 per 5 years	
D5711	Rebase complete mandibular denture	1 per 5 years	
D5720	Rebase maxillary partial denture	1 per 5 years	
D5721	Rebase mandibular partial denture	1 per 5 years	
DENTURE RELINE PROCEDURES			
D5730	Reline complete maxillary denture (chairside)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture.
D5731	Reline complete mandibular	1 per 2 years	Not covered within first 6 months of placement unless it is for an

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	denture (chairside)		immediate denture.
D5740	Reline maxillary partial denture (chairside)	1 per 2 years	Not covered within first 6 months of placement.
D5741	Reline mandibular partial denture (chairside)	1 per 2 years	Not covered within first 6 months of placement.
D5750	Reline complete maxillary denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5751	Reline complete mandibular denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5760	Reline maxillary partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5761	Reline mandibular partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5899	Unspecified removable prosthodontics procedure, by report		Require PA with documentation and radiographs as appropriate. Procedure must be documented on the claim form.
MAXILLOFACIAL PROSTHETICS			
D5911	Facial moulage (sectional)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5912	Facial moulage (complete)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5913	Nasal prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5914	Auricular prosthesis	1 in 5 years	Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5915	Orbital prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5916	Ocular prosthesis Prosthetic eye, plastic, custom Prosthetic eye, other type		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5919	Facial prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist required.
D5924	Cranial prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist required.
D5925	Facial augmentation implant prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D5931	Obturator prosthesis, surgical		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5932	Obturator prosthesis, definitive (post-surgical)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5933	Obturator prosthesis, modification (re-fitting)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5934	Mandibular resection pros-thesis with guide flange		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5935	Mandibular resection prosthesis without guide flange		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5937	Trismus appliance (not for temporomandibular joint dysfunction treatment)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5951	Feeding aid		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5952	Speech aid prosthesis, pediatric		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5954	Palatal augmentation prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5955	Palatal lift prosthesis, definitive		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5982	Surgical stent		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5983	Radiation carrier		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5984	Radiation shield		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5985	Radiation cone locator		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5986	Fluoride gel carrier		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5987	Commissure splint		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5999	Unspecified maxillofacial prosthesis, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation and description of procedure to be performed. Oral and maxillofacial or prosthodontist certification required.
PROSTHODONTIC FIXED			

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
FIXED PARTIAL DENTURE PONTICS – EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A BRIDGE			
D6211	Pontic- cast predominantly base metal	1 per 5 years	Requires PA Tooth numbers 1-32 must be documented on the claim form for payment consideration.
D6241	Pontic- porcelain fused to predominantly base metal	1 per 5 years	Requires PA Tooth numbers 1-32 must be documented on the claim form for payment consideration.
D6545	Retainer case metal for resin bonded fixed prosthesis	1 per 5 years	Requires PA Tooth numbers 1-32 must be documented on the claim form for payment consideration.
OTHER FIXED DENTURE SERVICES			
D6930	Recement fixed partial denture	1 per calendar year	
D6999	Unspecified, fixed prostho-dontic procedures, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation and description of procedure to be performed.
ORAL AND MAXILLOFACIAL SURGERY			
Extraction - includes local anesthesia and post operative care Any necessary suture included in fee for extraction.			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7220	Removal of impacted tooth-soft tissue	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7230	Removal of impacted tooth-partially bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7240	Removal of impacted tooth-completely bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
OTHER SURGICAL PROCEDURES			
D7260	Oral antral fistula closure		

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D7270	Tooth reimplantation &/or stabilization of accidentally evulsed or displaced tooth. (includes splinting or stabili-zation)		Tooth numbers 1-32 and primary teeth # A, B, I, J, K, L, S, and T must also be documented on the claim form for payment consideration.
D7280	Surgical access of an unerupted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.
D7283	Placement of device to facilitate eruption of impacted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.
D7285	Biopsy of oral tissue - hard (bone, tooth)		
D7286	Biopsy of oral tissue - soft		
ALVELOLPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURE			
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime.	Quadrant UR, UL, LL, LR must also be documented on the claim form for payment consideration. Alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime.	Quadrant UR, UL, LL, LR must also be documented on the claim form for payment consideration.
VESTIBULOPLASTY			
D7340	Vestibuloplasty – ridge extension (2nd epithelialization)		Requires PA with documentation and radiographs as appropriate.
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment & management of hypertrophied &hyperplastic tissue)		Requires PA with documentation and radiographs as appropriate.
D7410	Excision of benign lesion up		

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	to 1.25cm		
D7411	Excision of benign lesion greater than 1.25cm		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25cm		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25cm		
EXCISION OF BONE TISSUE			
D7471	Removal of lateral exostosis (maxilla or mandible)		UA, LA must be documented on the claim form for payment consideration. Must be billed with the number codes.
D7472	Removal of torus palatinus		
D7473	Removal of torus mandibularis		
D7485	Surgical reduction of osseous tuberosity		
D7490	Radical resection of maxilla or mandible		Requires PA with documentation and radiographs as appropriate.
SURGICAL INCISION			
D7510	Incision and drainage of abscess - intraoral soft		

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	tissue		
D7520	Incision and drainage of abscess - extraoral soft tissue		
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone		This code should only be used if a more specific code is not available. Requires PA with documentation.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		
TREATMENT OF FRACTURES (SIMPLE)			
D7610	Maxilla - open reduction (teeth immobilized, if present)		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)		
D7640	Mandible - closed reduction (teeth immobilized, if present)		
D7671	Alveolus - open reduction, may include stabilization of teeth		
D7680	Facial bones- complicated reduction with fixation and multiple surgical approaches		Requires PA with documentation and radiographs as appropriate
TREATMENT OF FRACTURES (COMPOUND)			
D7710	Maxilla - open reduction		
D7720	Maxilla - closed reduction		

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D7730	Mandible, open reduction		
D7740	Mandible, closed reduction		
D7750	Malar and/or zygomatic arch - open reduction		
D7770	Alveolus - open reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		Requires PA
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS			
D7810	Open reduction of dislocation		Requires PA
D7820	Closed reduction of dislocation		Requires PA
D7830	Manipulation under anesthesia		Requires PA
D7850	Surgical discectomy with/without implant		Requires PA. Not reimbursable with D7852
D7852	Disc repair		Requires PA Not reimbursable with D7850
D7858	Joint reconstruction		Requires PA
D7865	Arthroplasty		Requires PA
D7870	Arthrocentesis		Requires PA
D7872	Arthroscopy - diagnosis with biopsy or without		Requires PA
D7873	Arthroscopy - surgical; lavage & lysis of adhesions		Requires PA
D7874	Arthroscopy - surgical; disc repositioning & stabilization		Requires PA
D7876	Arthroscopy - surgical; discectomy		Requires PA
D7877	Arthroscopy - surgical; debridement		Requires PA
D7880	Occlusal orthotic device, by report		Requires PA with documentation and radiographs as appropriate. Covered only for temporomandibular pain dysfunction or associated musculature.
D7910	Suture of recent small		Excludes closure of surgical incisions

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	wounds up to 5 cm		
D7911	Complicated suture - up to 5cm	1 unit: not reimbursable with D7912	Excludes closure of surgical incisions
D7912	Complicated suture - greater than 5cm	1 unit: not reimbursable with D7911	Excludes closure of surgical incisions
D7920	Skin graft (identify defect covered, location & type of graft)		Requires PA
D7941	Osteotomy - mandibular rami		Requires PA
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft		Requires PA
D7944	Osteotomy - segmented or subapical - per sextant or quadrant		Requires PA
D7946	LeFort I (maxilla - total)		Requires PA
D7947	LeFort I (maxilla - segmented)		Requires PA
D7948	LeFort II or LeFort III (osteo-plasty of facial bones for mid-face hypoplasia or retrusion) - without bone graft		Requires PA
D7949	LeFort II or LeFort III - with bone graft		Requires PA
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report		Requires PA
D7955	Repair of maxillofacial soft and/or hard tissue defect		Requires PA
D7960	Frenuloplasty	2 per site per lifetime	Requires PA

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D7970	Excision of hyperplastic tissue - per arch		Requires PA UALAmust be documented on the claim form for payment consideration. Must be billed with the number codes.
D7980	Sialolithotomy		Requires PA
D7981	Excision of salivary gland, by report		Requires PA
D7982	Sialodochoplasty		Requires PA
D7991	Coronoidectomy		Requires PA
D7999	Unspecified oral surgery procedure, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation, and description of procedure to be performed.
		ORTHODONTICS	
D8010	Limited orthodontic treatment of the primary dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8020	Limited orthodontic treatment of the transitional dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8030	Limited orthodontic treatment of the adolescent dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8040	Limited orthodontic treatment of the adult dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8050	Interceptive orthodontic treatment of the primary dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8060	Interceptive orthodontic treatment of the transitional dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8070	Comprehensive orthodontic treatment of the transitional dentition	1 per lifetime	Requires PA with documentation, radiographs and dental molds.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1 per lifetime	Requires PA with documentation, radiographs and dental molds.

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D8090	Comprehensive orthodontic treatment of the adult dentition	1 per lifetime	Requires PA with documentation, radiographs and dental molds.
D8210	Removable appliance therapy	2 per lifetime	
D8220	Fixed appliance therapy	2 per calendar year	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)		Requires PA with documentation, radiographs and dental molds.
D8692	Replacement of lost or broken retainer	2 per lifetime	
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	1 per lifetime	Requires PA
D8999	Unspecified orthodontic procedure, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation, and description of procedure to be performed.
ANESTHESIA			
D9220	Deep sedation/general anesthesia – first 30 min.	Maximum 1 unit/day	Class 4 anesthesia permit required
D9221	Deep sedation/general anesthesia – each additional 15 minutes		Class 4 anesthesia permit required; Must be billed with D9220
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Maximum 1 unit/day	
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	Maximum 1 unit	Class 3 or 4 permit required
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	Maximum 2 units	Class 3 or 4 permit required; Must be billed with D9241
OTHER SERVICES			
D9310	Consultation (diagnostic service provided by dentist or physician other than		Not reimbursable on same day as D1020, D1040, D1045, D0150

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	practitioner providing treatment		
D9420	Hospital or ambulatory surgical center call		
D9940	Occlusal guard, by report		Requires PA
D9951	Occlusal adjustment - limited		Requires PA
D9952	Occlusal adjustment - complete		Requires PA
D9999	Unspecified adjunctive procedure, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation and description of procedure to be performed is required.

CHAPTER 505
DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
NOVEMBER 1, 2010

APPENDIX B
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
ADULTS OVER 21 YEARS OF AGE

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
DIAGNOSTIC			
CLINICAL ORAL EVALUATION			
D0140	Limited oral evaluation - problem focused	EMERGENT	
RADIOGRAPH/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)			
D0220	Intraoral - periapical, first film	1 per day	
D0230	Intraoral - periapical, each additional film	8 per 3 months	
D0330	Panoramic film	1 per 3 years	
D0474	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	None	
ORAL PATHOLOGY LABORATORY			
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	None	To be used in pathology laboratory reporting transepithelial, disaggregated cell samples by brush biopsy technique.
ORAL AND MAXILLOFACIAL SURGERY (INCLUDES LOCAL ANESTHESIA AND ROUTINE POSTOPERATIVE CARE)			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 numbered tooth per lifetime	Specific tooth numbers 1-32 must be included on claim form for payment consideration. Documentation must be maintained in the member's individual file.
SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)			
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 numbered tooth lifetime	See D7140 Special Instructions
D7220	Removal of impacted tooth - soft tissue	1 numbered tooth per lifetime	See D7140 Special Instructions
D7230	Removal of impacted tooth - partially bony	1 numbered tooth per lifetime	See D7140 Special Instructions

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
D7240	Removal of impacted tooth - completely bony	1 numbered tooth per lifetime	See D7140 Special Instructions
OTHER SURGICAL PROCEDURES			
D7260	Oroantral fistula closure		
D7285	Biopsy of oral tissue - hard (bone, tooth)		
D7286	Biopsy of oral tissue - soft		
SURGICAL EXCISIONS OF SOFT TISSUE LESIONS			
D7410	Excision of benign lesion up to 1.25cm		
D7411	Excision of benign lesion greater than 1.25 cm		
SURGICAL EXTRACTIONS OF INTRA-OSSEOUS LESIONS			
D7440	Excision of malignant tumor - lesion diameter up to 1.25cm		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm		
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm		
D7451	Removal of benign odontogenic cyst or tumor lesion diameter greater than 1.25 cm		
D7460	Removal of benign nonodontogenic cyst or tumor lesion diameter up to 1.25 cm		
D7461	Removal of benign nonodontogenic cyst or tumor lesion diameter greater than 1.25 cm		
SURGICAL INCISION			
D7510	Incision and drainage of abscess - intraoral soft tissue		
D7520	Incision and drainage of abscess - extraoral soft tissue		

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		
TREATMENT OF FRACTURES – SIMPLE			
D7610	Maxilla - open reduction (teeth immobilized, if present)		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)		
D7640	Mandible - closed reduction (teeth immobilized, if present)		
D7671	Alveolus - open reduction, may include stabilization of teeth		
D7680	Facial bones—complicated reduction with fixation and multiple surgical approaches		**Requires PA** and documentation
TREATMENT OF FRACTURES - COMPOUND			
D7710	Maxilla - open reduction		
D7720	Maxilla - closed reduction		
D7730	Mandible, open reduction		
D7740	Mandible, closed reduction		
D7750	Malar and/or zygomatic arch- open reduction		
D7770	Alveolus - open reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		**Requires PA** with documentation and radiographs as appropriate.
COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE) EXCLUDES CLOSURE OF SURGICAL INCISIONS.			
D7910	Suture of recent small wounds up to 5 gm		
D7911	Complicated suture - up to 5cm	1 unit: not reimbursable with D7912	Excludes closure of surgical incisions

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
D7912	Complicated suture – greater than 5cm	1 unit: not reimbursable with D7911	Excludes closure of surgical incisions
D7999	Unspecified oral surgery procedure, by report	**PA**	This code should be used only if a more specific code is not available. **Requires PA** with radiographs, documentation and description of procedure to be performed.
D9220	Deep sedation/general anesthesia – first 30 minutes	Maximum 1 unit/day	Class 4 permit required
D9221	Deep sedation/general anesthesia – each additional 15 minutes		Class 4 permit required; Must be billed with D9220
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	**Maximum 1 unit/day**	
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	Maximum 1 unit	Class 3 or 4 permit required
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes.	Maximum 2 units	Class 3 or 4 permit required; Must be billed with D9241

CHAPTER 505
DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
NOVEMBER 1, 2010

APPENDIX C
INFANT AND CHILD HEALTH FLUORIDE VARNISH POLICY FOR PRIMARY CARE PRACTITIONERS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

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Commissioner's Office
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Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

Bureau for Medical Services
Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners
Coverage Criteria

Physician fluoride varnish (FV) services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations specified below in this document. The American Dental Association (ADA) expert panels have reviewed evidence-based (class 1a) studies and concluded that "Fluoride varnish applied every six months is effective in preventing caries in the primary and permanent dentition of children and adolescents." Please see JADA executive Summary 2006 recommendations attached.

Fluoride varnish is a thin coating of resin that is applied to the tooth surface to protect it from decay. According to the Food & Drug Administration (FDA), fluoride varnish falls under the category of "drugs and devices" that presents minimal risk and is subject to the lowest level of regulation. The purpose of applying fluoride varnish is to retard, arrest, and reverse the process of cavity formation.

Fluoride varnish is easy to apply, does not require special dental equipment or a professional cleaning prior to application. It also requires minimal training, and is inexpensive. Fluoride varnish dries immediately upon contact with saliva and is safe and well tolerated by infants, young children, and individuals with special needs.

Effective January 16, 2012, the Bureau for Medical Services (BMS) will start reimbursing primary care providers who have been certified through a face-to-face training for fluoride varnish application offered through the West Virginia University School of Dentistry for the application of fluoride varnish to children ages 6 months to 36 months (3 years) who are at high risk of developing dental caries. The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist.

A child is considered at high risk of developing cavities if he or she:

- ✓ Has had cavities in the past or has white spot lesions and stained fissures
- ✓ Continues to use the bottle past one year of age or sleeps with a bottle containing liquids other than water
- ✓ Breastfeeds on demand at night
- ✓ Has a developmental disability
- ✓ Chronically uses high sugar oral medications
- ✓ Has family members with histories of caries
- ✓ Engages in prolonged or ad lib use throughout the day of a bottle or "sippy" cup containing liquids other than water

Who is not Covered:

- ✓ Children with a low risk of cavity formation who consume optimally fluoridated water or children who receive routine fluoride treatments through a dental office.

BMS recognizes the following types of primary care providers to be eligible for payment of this service:

- ✓ Pediatricians
- ✓ General and Family Practice Doctors
- ✓ Nurse Practitioners
- ✓ Physician Assistants (in FQHC settings only)

Provider Eligibility to Bill for Program Services

Providers must have completed a certified training course from the WVU School of Dentistry prior to performing and billing for these services. The WVU School of Dentistry will provide a list of all current certifications monthly in 2011 and thereafter to BMS and its fiscal agent in order to create a file of reimbursable providers. Information about this course is available at www.hsc.wvu.edu/sod/oral-health.

Reimbursement for the Services

BMS allows coverage of two fluoride varnish applications per year (one every six months). The first application must be provided and billed in conjunction with a comprehensive well-child exam as reported under the CPT codes listed in the table below. The second fluoride varnish application can be reimbursed during the 12-month subsequent period, and may be billed in conjunction with the HCPCS code outlined in the table below.

BMS will use the following codes to reimburse primary care providers for fluoride varnish application:

Code	Description	Comments
99381-99382 99391-99392	Comprehensive well-child exam codes for children less than 1 year and up to age 4 (note FV coverage under this program is only through age 3)	Oral evaluation and counseling are components of comprehensive well –child exams
T1503	Administration of medication, other than oral and/or injectable by a health care agency/professional, per visit Note: Use this code to bill for the topical fluoride varnish; therapeutic application for moderate to high caries risk patients. By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D1206-Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	Covered 2 times per year for children up to age 3; 1st application must be billed in conjunction with one of the comprehensive well child exam codes listed above
T1503-DA	Use Code T1503 with modifier-DA (Oral health assessment by a licensed health professional other than a dentist) to bill for oral evaluation of patient under three years of age and counseling with primary caregiver. Note: By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D0145 – Oral Evaluation for patient under three years of age and counseling with primary caregiver.	Covered once per year in conjunction with 2nd fluoride varnish application; cannot be covered when comprehensive well-child exam is billed on the same day and at least 180 days after billing for the comprehensive well child-exam
V20.2	Routine infant or child health check	Primary diagnosis used when billing well-child exam
V82.89	Special screening for other specified conditions	Secondary diagnosis used when billing comprehensive well-child exam
V72.2	Dental Exam	Primary diagnosis used when billing D0145 – dental exam; cannot report in combination with V20.2

Reimbursement will be made using the dental fee schedule effective on the date of service. The current fee for T1503 (D1206) will be $20.00 and T1503-DA (D0145) will be $25.00.

CHAPTER 506 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME MEDICAL SUPPLIES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	01/16/08	01/01/08
Attachment II	Non-Covered DME/Medical Supplies for Unlisted Codes	01/16/08	01/01/08
Section 506.2.1	Prescribing Practitioner	10/01/07	11/01/07
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Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	10/01/07	11/01/07
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Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	06/01/06	07/01/06
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Section 506.1	Definitions	04/01/06	05/01/06
Section 506.2.1	Prescribing Practitioner	04/01/06	05/01/06
Section 506.2.2	DME/Medical Supply Provider	04/01/06	05/01/06
Section 506.2.3	Home IV Infusion Therapy	04/01/06	05/01/06

Replace	Title	Change Date	Effective Date
Section 506.3.1.b	Repair	04/01/06	05/01/06
Section 506.4	Documentation Requirements	04/01/06	05/01/06
Section 506.5	Prior Authorization	04/01/06	05/01/06
Section 506.8	Non-Covered Durable Medical Equipment and Medical Supplies	04/01/06	05/01/06
Section 506.9	Billing and Reimbursement	04/01/06	05/01/06
Attachment III	Certificates of Medical Necessity	04/01/06	05/01/06
Add	Table of Contents	01/01/06	02/16/06
Introduction	Introduction	01/01/06	02/16/06
Section 506.1	Definitions	01/01/06	02/16/06
Section 506.2	Provider Participation Requirements	01/01/06	02/16/06
Section 506.3	Covered Durable Medical Equipment and Medical Supplies	01/01/06	02/16/06
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Section 506.7	Out-of State Service	01/01/06	2/16/06
Section 506.8	Non-Covered Durable Medical Equipment and Medical Supplies	01/01/06	02/16/06
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Section 506.10	Managed Care	01/01/06	02/16/06

Replace	Title	Change Date	Effective Date
Attachment I	HCPCS Codes for Durable Medical Equipment & Supplies	01/01/06	02/16/06
Attachment II	Non-Covered DME/Medical Supplies for Unlisted HCPCS Codes	01/01/06	02/16/06
Attachment III	WV Medicaid DME/Medical Supplies Authorization Request Form	01/01/06	03/15/06
Introduction	Introduction		05/01/05
Section 506.3	Covered Durable Medical Equipment & Medical Supplies		05/01/05
Section 506.4	Documentation Requirements		05/01/05
Section 506.5	Prior Authorization		05/01/05
Section 506.12	Miscellaneous		05/01/05
Attachment I	HCPCS Codes for Durable Medical Equipment		05/01/05
Attachment I	HCPCS Codes for Durable Medical Equipment		07/01/05
Attachment II	Non-Covered DME/Medical Supplies for Unlisted HCPCS Codes		05/01/05
Attachment III	DME CMN with Instructions		07/01/05
Attachment IV	Apnea Monitor Initial & Request for Extension CMN's		07/01/05

CHAPTER 500 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME MEDICAL SUPPLIES

JANUARY 1, 2008

Attachment I

Introduction: Covered/Non-Covered DME/Medical Supply Services with Assigned HCPCS Codes
New Policy: Updated HCPCS Codes
Directions: Replace Attachment I

Attachment II

Introduction: Non-Covered DME/Medical Supply for Unlisted HCPCS Codes
New Policy: Updated Unlisted Codes
Directions: Replace Attachment

NOVEMBER 1, 2007

SECTION 506.2.1

Introduction: Section 506.2.1, 2nd paragraph, 1st sentence
Old Policy: The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services.
New Policy: The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding BMS.
Directions: Replace page

Introduction: Section 506.2.1, 1st paragraph (17)
Old Policy: (17) provide any changes to original enrollment application (i.e., personnel, licensure, certification, registration, demographics) to Unisys, Provider Services, PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days of change.
New Policy:(17) provide any changes to original enrollment application (i.e., personnel, licensure, certification, registration, demographics) to Unisys, Provider Services, PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days. Copies of updated license, certification and/or registration must be submitted to Unisys annually.
Directions: Replace page

SECTION 506.5

Introduction: Section 506.5, 3rd paragraph, 6th bullet
Old Policy: Home Oxygen Therapy (E0424, E0431, E0434, E0439).
Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of

the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request. Note: The number of unused months of oxygen systems placed in the home for individual Medicaid members prior to March 15, 2006 is to be submitted to WVMI before June 1, 2006. However, if information is not received by WVMI within the specified time frame, DME providers are not eligible for reimbursement by WV Medicaid.
New Policy: Home Oxygen Therapy (E0424, E0431, E0434, E0439).
Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request.
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 11th bullet
Old Policy: Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161, E1231, E1232, E1233, E1234)
New Policy: Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161)
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 12th bullet
Old Policy: Manual Wheelchairs, Specialized (E1231, E1233, E1234, E1235, E1237, E1238, K0005, K0009)
New Policy: Delete
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 15th bullet
Old Policy: N/A
New Policy: Pediatric Mobility Equipment (E1231, E1232, E1233, E1234, E1235, E1237, E1238, K0890, K0891)
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 16th bullet
Old Policy: Power Operated Vehicles (POV) (E1230)
New Policy: Power Operated Vehicles (POV) (K0800, K0801, K0802, K0806, K0807, K0808, K0812)
Directions: Replace page

Introduction: Section 506.5, 3rd paragraph, 17th bullet
Old Policy: Power Wheelchairs (K0010, K0011, K0012, K0014)
New Policy: Power Wheelchairs (K0813, K0814, K0815, K0826, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886)
Directions Replace page

Introduction: Section 506.5, 3rd paragraph, 19th bullet
Old Policy: Support Surfaces (E0180, E0181 E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)
New Policy: Support Surfaces (E0181 E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199,

E0277, E0371)
Directions: Replace page

Attachment I

Introduction: Covered/Non-Covered DM/Medical Supply Services with Assigned HCPCS Codes
New Policy: Updated HCPCS Codes
Directions: Replace Attachment I

JULY 1, 2006

SECTION 506.5

Introduction: Section 506.5, 5th paragraph, 3rd bullet
Old Policy: (3) within 7 days post hospital discharge for apnea monitors and oxygen systems
New Policy: (3) within 7 days post hospital discharge for apnea monitors, oxygen systems, nebulizers
Directions: Replace page

Attachment I

Introduction: HCPCS Codes for DME & Supplies Changes: Special Instructions
Old Policy: N/A
New Policy: New HCPCS Codes K0733, K0734, K0735, K0736, and K0737 effective July 1, 2006 are non-covered
Directions: Replace page

MAY 1, 2006

Introduction: 4th paragraph, 3rd sentence
Old Policy: This review may include recouping of reimbursement based on inadequate documentation to support medical necessity.
New Policy: Delete
Direction: Replace page.

SECTION 506.1

Introduction: Section 506.1, 2nd paragraph.
Old Policy: Certificate of Medical Necessity: A two-fold document completed by a prescribing practitioner and the DME provider. The CMN is utilized to document the member's medical necessity for DME/medical supplies requiring prior authorization. **Discontinued 03/14/2006.**
New Policy: Delete
Directions: Replace page.

Introduction: Section 506.1, 6th paragraph, add to last sentence
Old Policy: power operated vehicles and scooters.
New Policy: "power operated vehicles and strollers.
Directions: Replace page.

Introduction: Section 506.1, 7th paragraph
Old Policy: Identified as an M.D., D.O., DPM, Nurse Practitioner, or Physician Assistant.
New Policy: Identified as an M.D., D.O., DPM, Nurse Practitioner (NP), or Physician Assistant (PA) under the supervision of a participating physician. WV Medicaid does not recognize hospital residents as prescribing practitioners.
Directions: Replace page.

Introduction: Section 506.1, 8th paragraph
Old Policy: **WVMI Medicaid DME/Medical Supplies Authorization Request Form – Effective 03/15/2006 – Replaces DME/Medical Supplies CMN.** This form is used by the prescribing practitioner to document the medical necessity utilizing InterQual or DMERC criteria for DME/Medical Supply items requiring prior authorization (PA). Refer to Section 506.2.1.
New Policy: Delete.
Directions: Replace page.

SECTION 506.2.1

Introduction: Section 506.2.1, lst & 2nd paragraph
Old Policy: The current DME/Medical Supplies CMN will no longer be valid after March 15, 2006. The current CMN will be replaced by the West Virginia Medical Institute (WVMI) Medicaid DME/Medical Supplies Authorization Request Form **(Attachment III)**. The prescribing practitioner is responsible for providing WVMI with medical necessity documentation via fax to 1-304-346-8185, telephonically at 1-800-296-9849 or 1-304-346-9167, option 5, or via mail to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. The WVMI Medicaid DME/Medical Supplies Authorization Request Form will be available at www.wvmi.org and www.wvdhhr.org websites. The Internet is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.
New Policy: In addition to Chapter 300 Provider Participation Requirements, MDs, DOs, DPMs, NPs, and PAs under the supervision of a participating physician, prescribing DME/medical supplies and related items must:

(1) be actively enrolled in Medicaid;
(2) inquire if the member has a DME provider of choice;
(3) provide a written prescription to the member;
(4) provide clinical documentation for medical necessity to include diagnosis code, frequency of use, duration, quantity, and any relevant information to WVMI. Documentation may be submitted to WVMI in writing (with legal signature of prescribing practitioner), fax or telephonically;
(5) maintain all appropriate medical documentation in the Medicaid member's individual file; and,
(6) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.
Directions: Replace page

SECTION 506.2.2

Introduction: 506.2.2, 2nd paragraph
Old Policy: (13) contact WVMI to obtain PA number before services are rendered;
New Policy: Delete #13 and re-number the remaining requirements
Directions: Replace page

SECTION 506.2.3

Introduction: 506.2.3, 1st paragraph, 2nd sentence
Old Policy: This change includes HCPCS codes A4221, A4222, A4223, B9004, B9006, and E0781.
New Policy: This change includes HCPCS codes A4221, A4222, A4223, B4164-B4224, B5000, B5100, and B5200
Directions: Replace page.

Introduction: 506.2.3, 2nd paragraph, 2nd sentence
Old Policy: Refer to Chapter 518, Pharmacy Manual, for additional information.
New Policy: Delete sentence
Directions: Replace page.

SECTION 506.3.1.b

Introduction: 506.3.1.b, 1st paragraph, 1st sentence
Old Policy: WV Medicaid's coverage for repair of equipment is limited to items that have been fully purchased by WV Medicaid including items in which the cap-rental timeframe has been exhausted, the medical need is expected to continue, and the repair is more economical than replacement.
New Policy: WV Medicaid's coverage for repair of equipment is limited to:

(1) items that have been fully purchased by WV Medicaid or by the Children with Special Healthcare Needs Program (CSHCN);
(2) equipment provided by CSHCN is covered by Medicaid;
(3) items in which the cap-rental time frame has been exhausted;
(4) the medical need is expected to continue; and
(5) the repair is more economical than replacement.

Directions: Replace page.

SECTION 506.4

Introduction: 506.4, 2nd paragraph (1)
Old Policy: Effective March 15, 2006, WVMI Medicaid DME Authorization Request Form is required to provide WVMI medical necessity documentation for items or services prescribed by the treating practitioner.
New Policy: (1) Effective May 1, 2006, formal certificate of medical necessity forms (i.e, the WVMI Medicaid DME Authorization Request Form, the DME/Medical Supply Certificate of Medical Necessity, the Apnea Monitor Initial and Recertification Certificates of Medical Necessity) are not required to document medical necessity of items requiring prior authorization. However, as an enrolled participant of WV Medicaid, practitioners and DME providers are required to maintain individual Medicaid member files

with documentation to assure that all services provided to Medicaid members are medically necessary and that billing of such services are accurate. **Attachment III** provides forms that may be submitted via fax to 1-304-346-8185 or 1-877-762-4338 or in writing to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. Telephonic reviews for urgent or emergency requests are available at 1-304-414-2551 or 1-800-296-9849.

Introduction: 506.4, 2nd paragraph (2)
Old Policy: (2) Effective March 15, 2006, a written prescription which includes the member's name, date of prescription, appropriate HCPCS code for item requested, description of code, estimated length of need in months, quantity of item(s), frequency of use and prescribing practitioner's signature, is to be given to the member by the prescribing practitioner. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/Medical Supplies.
New Policy: Effective May 1, 2006, delete "appropriate HCPCS code for item requested".
Directions: Replace page.

Introduction: 506.4, 2nd paragraph (3)
Old Policy: (3) Effective March 15, 2006, a signed delivery document by the member or caregiver and documentation of education for the DME item provided must be maintained in the individual member's record.
New Policy: The DME provider must maintain a delivery document signed …"
Direction: Replace page.

Introduction: 506.4, 2nd paragraph (5)
Old Policy: (5) Medical documentation submitted for review must not be more than six (6) months old at the time the prescription is written.
New Policy: "The prescriber's medical …"
Direction: Replace page.

SECTION 506.5

Introduction: 506.5, 1st paragraph, 1st, 2nd, and 3rd
Old Policy: For DME services and items requiring review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate form to WVMI. The Authorization Form must be renewed at the end of the prescription period specified or within one (1) year whichever comes first.
New Policy: For DME services and items requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the written prescription (see Section 504, 2nd paragraph, (2) for clarification) and any other relevant information. Additionally, a licensed physical therapist or licensed occupational therapist who is fiscally, administratively and contractually independent from the DME provider may also submit clinical documentation for review when requested by the prescribing practitioner. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first.

Introduction: 506.5, 1st paragraph - Insert as 4th sentence
Old Policy: N/A
New Policy: It is strongly recommended that DME providers, in partnership with prescribing practitioners, assist in obtaining prior authorizations. Prescribing practitioners must provide clinical information and a written prescription while DME providers submit the appropriate HCPCS code and

billing information.
Directions: Replace page.

Introduction: 506.5, 2nd paragraph, Insert as 4th sentence.
Old Policy: N/A
New Policy: The explanation of benefit (EOB) must accompany the claim. An EOB documenting reasons for the denial of TPL for services requested must be provided to WVMI when requesting prior authorization review.

Introduction: 506.5, 3rd paragraph, 6th bullet
Old Policy: Home Oxygen Therapy (E0424, E0431, E0434, E0439)
New Policy: Add – Effective March 15, 2006, any new oxygen system requested for medical necessity must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request. Note: The number of unused months of oxygen systems placed in the home for individual Medicaid members prior to March 15, 2006 is to be submitted to WVMI before June 1, 2006. However, if information is not received by WVMI within the specified time frame, DME providers are not eligible for reimbursement by WV Medicaid.

Introduction: 506.5, 4th paragraph, 1st & 2nd sentences.
Old Policy: Practitioners are required to provide medical necessity documentation via mail, fax or telephonically to WVMI prior to items/services provided. Documentation form for DME PA will be available at www.wvmi.org and www.wvdhhr.org/bms.
New Policy: Delete

Introduction: 506.5, 4th paragraph, 3rd sentence
Old Policy: Items not listed above
New Policy: Items requiring PA not listed above will follow Palmetto, Region C, medical necessity criteria for covered services.
Directions: Replace page

Introduction: 506.5, 5th paragraph, 1st sentence
Old Policy: Retrospective authorization is only available under the following certain circumstances: (1) services covered by private insurance; (2) termination of Medicaid coverage; (3) Medicaid retro eligibility; and (4) an apnea monitor seven (7) days post hospital discharge.
New Policy: Retrospective authorization is available (1) for items denied due to TPL; (2) retrospective Medicaid eligibility; (3) within 7 days post hospital discharge for apnea monitors and oxygen systems; and, (4) for items other than referenced here on a case-by-case basis.
Directions: Replace page.

Introduction: 506.8, 1st paragraph, #6
Old Policy: by BMS
New Policy: Insert “or CSCHN” after BMS
Direction: Replace page.

Introduction: 506.8 1st paragraph, #8
Old Policy: through DME
New Policy: Insert “suppliers” after DME
Direction: Replace page.

Introduction: 506.8 1st paragraph, #9
Old Policy: through DME
New Policy: Insert "suppliers" after DME
Direction: Replace page.

Introduction: 506.8 1st paragraph, #10
Old Policy: through DME
New Policy: Insert "suppliers" after DME
Direction: Replace page.

Introduction: 506.9, 5th paragraph, 7th sentence
Old Policy: In those instances where liability cannot be currently established; i.e., accident or injury, Medicaid benefits will not be withheld.
New Policy: Delete sentence.
Direction: Replace page.

Introduction: 506.9, 5th paragraph, 8th sentence
Old Policy: "on-setting adjustment"
New Policy: Delete "on-setting"
Direction: Replace page.

Attachment III

Introduction: Attachment III
Old Policy: N/A
New Policy: Add BMS Durable Medical Equipment/Medical Supplies Certificate of Medical Necessity

•BMS Certificate of Medical Necessity, Initial Infant Apnea Monitor

•BMS Certificate of Medical Necessity, Infant Apnea Monitor Request for Extension

FEBRUARY 16, 2006

TABLE OF CONTENTS
Introduction: Page 1
Old Policy: Not Applicable
New Policy: Add Table of Contents
Directions: Insert page

Introduction: delete 5th paragraph with bullets; change 6th paragraph to 5th paragraph and change wording
Old Policy: "This chapter describes WV Medicaid's major coverage policies for DME/Medical Supplies as below:"
New Policy: "This chapter describes WV Medicaid's major coverage policies for DME/Medical Supplies as noted in the following Sections:"
Directions: Replace page

SECTION 506.1

Introduction: Section 506.1**,** 2nd paragraph
Old Policy: "**Certificate of Medical Necessity (CMN)** - A two-fold document completed by a prescribing practitioner and the DME provider. The CMN is utilized to document the member's medical necessity for DME/medical supplies requiring prior authorization."
New Policy: "Certificate of Medical Necessity (CMN) – A two-fold document completed by a prescribing practitioner and the DME provider. The CMN is utilized to document the member's medical necessity for DME/medical supplies requiring prior authorization. **Discontinued 03/14/2006."**
Directions: Replace page.

Introduction: Section 506.1, insert 6th paragraph
Old Policy: Not Applicable
New Policy: Mobility Assistive Equipment (MAE) – Items that offer assistance to members who have a physical impairment that results in a mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, power operated vehicles and scooters.
Directions: Replace page.

Introduction: Section 506.1, insert 8th paragraph
Old Policy: Not Applicable
New Policy: "**WVMI Medicaid DME/Medical Supplies Authorization Request Form – Effective 03/15/2006 – Replaces DME/Medical Supplies CMN.** This form is used by the prescribing practitioner to document the medical necessity utilizing InterQual or DMERC criteria for DME/Medical Supply items requiring prior authorization (PA). Refer to Section 502.1."
Directions: Replace page.

SECTION 506.2

Introduction: Section 506.2, change heading
Old Policy: "Provider Participation Requirements" In addition to Chapter 300, Provider Participation Requirement, DME/medical supply providers must:

- maintain a physical facility. (PO Box, commercial mailbox, residence or homestead is prohibited) located within WV or within thirty (30) miles of WV's border. This requirement does not apply to Medicare crossover providers.

- maintain a retail store open to the public at least forty (40) hours per week. A notarized letter must be attached to the enrollment form indicating that the physical facility is a retail store.

- post a visible sign indicating hours of operation. Hours of operation and availability of emergency coverage must be stated on the WV Medicaid enrollment form.

- employ a WV licensed respiratory therapist that provides twenty-four (24) hour emergency coverage, if respiratory/oxygen equipment and/or supplies are to be provided to the Medicaid members.

- maintain inventory of equipment/supplies and display at least one of each item listed on an inventory and made readily available for delivery.

- maintain a business telephone that is listed locally under the name of the business. A toll-free number must be provided for Medicaid members. Exclusive use of a beeper number, answering service, pager, facsimile machine, car phone or an answering machine does not constitute a primary business telephone.

- maintain adequate space to store inventory, business and member records.
  have at least one public handicapped-accessible door from the street and/or parking lot.

- have handicapped-accessible parking.

- obtain individual WV Medicaid provider numbers for each physical facility under the same ownership. Satellite businesses affiliated with a provider are not covered under the provider's contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, unless the satellite enrolls as a separate entity and receives a separate provider number.

- employ or have the appropriate licensed or credentialed individuals on staff, depending on type of service provided (e.g., mastectomy fitter and/or orthotic fitter must be accredited by a nationally accrediting body that is certified by National Commission for Certifying Agencies (NCCA); e.g., American Board for Certification in Orthotics and Prosthetics, Board for Orthotist/Prosthetist Certification.)

- include the names of certified/licensed personnel on the enrollment form and attach copies of certification or license that demonstrates type, number and expiration date to the enrollment form.

- if any circumstances change that were part of the original application, including personnel, licensure, certification, or demographics, those changes must be provided in writing within 15 days and sent to Unisys, Provider Services, PO Box 2002, Charleston, WV 25327-2002 .

New Policy: "Section 506.2 Prescribing Practitioner and Provider Participation Requirements**"**

SECTION 506.2.1

New Policy:506.2.1 Prescribing Practitioner
The current DME/Medical Supplies CMN will no longer be valid after March 15, 2006. The current CMN will be replaced by the West Virginia Medical Institute (WVMI) Medicaid DME/Medical Supplies Authorization Request Form **(Attachment III)**. The prescribing practitioner is responsible for providing WVMI with medical necessity documentation via fax to 1-304-346-8185, telephonically at 1-800- 296-9849 or 1-304- 346-9167, option 5, or via mail to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. The WVMI Medicaid DME/Medical Supplies Authorization Request Form will be available at www.wvmi.org and www.wvdhhr.org websites. The Internet is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.

Related to DME/Medical Supplies the Prescribing Practitioner must:

(1) be actively enrolled in Medicaid;
(2) ask member where they wish to obtain prescribed DME

(3) provide a written prescription to the member and instruct the member to present the prescription to the DME provider of choice;
(4) provide WVMI with the medical necessity documentation for items/services prescribed and obtain an assigned PA number, if approved;
(5) inform WVMI of the member's choice for DME provider;
(6) maintain all appropriate medical documentation in the Medicaid member's individual file; and,
(7) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

SECTION 506.2.2

New Policy: 506.2.2 Durable Medical Equipment/Medical Supply Provider (Includes respective Pharmacies, Home IV Infusion Therapy and Home Health Agencies with DME and/or medical supply provider specialty)

The DME/Medical Supply Provider must:
(1) be actively enrolled in Medicaid;
(2) maintain a retail store open to the public at least forty (40) hours per week with a toll free telephone number and handicapped accessibilities. The store must be located within thirty (30) miles of the WV border;
(3) post a visible sign indicating hours of operation. Hours of operation and availability of emergency coverage must be stated on the WV Medicaid enrollment form;
(4) maintain inventory of equipment/supplies and display at least one of each item listed on an inventory and made readily available for delivery;
(5) maintain adequate space to store inventory, business and member records;
(6) obtain individual WV Medicaid provider numbers for each physical facility under the same ownership;
(7) provide DME/Medical Supplies per treating practitioner's prescription;
(8) assure the item/service provided is appropriate to the member's needs;
(9) assure the item/service can be used by the member;
(10) provide an appropriate replacement at no extra cost if the member is unable to use the equipment provided;
(11) agree to accept Medicaid's reimbursement as payment in full for all covered items/services;
(12) provide most economical items/services that meet the member's basic health care needs. Expensive items are not covered when less costly items/services are available;
(13) contact WVMI to obtain PA number before services are rendered;
(14) maintain all medical documentation and proof of delivery of all DME/medical supplies in the member's individual file;
(15) participate in on-site reviews and/or provide medical documentation upon request by BMS;
(16) employ current WV licensed respiratory therapist, registered professional nurse OR physician to provide 24 hour coverage if respiratory/related accessory services/items are offered. A maximum call response time is within thirty (30) minutes. Refer to West Virginia Board of Respiratory Care online at www.wvborc.org for additional information;
(17) employ current licensed or credentialed mastectomy, pedorthotist and/or orthotic fitter certified by National Commission for Certifying Agencies (NCCA), if providing orthotic and/or prosthetic services. Certifying Agencies e.g., American Board for Certification in Orthotics and Prosthetics (ABC), or Board for Orthotist/Prosthetist Certification (BOC), or Board for Certification

in Pedorthotics; and,
(18) provide any changes to original enrollment application (i.e., personnel, licensure, certification, demographics) to Unisys, Provider Services, and PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days of change.

SECTION 506.2.3

Introduction: Section 506.5, 3rd paragraph
Old Policy: **"NOTE:** Prior authorization is required from Rational Drug Therapy Program (RDTP) for home IV services. However, if equipment and supplies are required, a completed CMN and a copy of the final determination (RDTP) must be submitted to the UMC for assignment of a PA number. This number may be assigned before or after the IV therapy services are provided. Information from RDTP must contain language which clearly states that the member requires such services or supplies. RDTP may be contacted at 1-800-847-3859 or by fax to 1-800-531-7787."
New Policy: 506.2.3 Home Intravenous Infusion Therapy Suppliers
"Effective February 16, 2006, Home IV Infusion Therapy equipment and medical supplies provided through DME will not require prior authorization by WVMI. This change includes HCPCS codes A4221, A4222, A4223, B9004, B9006, and E0781. Services limits for medical supplies are based on Rational Drug Therapy Program's (RDTP) prior authorization of number(s) of bags or cassettes approved within a specified time frame. For example; if RDTP approves 63 bags or cassettes, the maximum medical supply units is 63; if 10 bags or cassettes are approved, the maximum medical supply units is 10, etc. Service limits for equipment is unchanged. PA from RDTP for medications is also unchanged. RDTP may be contacted at 1-800-847-3859 or fax to 1-800-531-7787. Refer to Chapter 518, Pharmacy Manual, for additional information."

SECTION 506.2.4

New Policy: 506.2.4 Home Health Agencies
"Refer to Chapter 508, Home Health Manual, Section 508.5, Medical Supplies, for additional information."
Directions: Replace/insert pages for Section 506.2

SECTION 506.3

Introduction: Section 506.3, delete 4th paragraph and replace with:
Old Policy: "Unless otherwise specified, WV Medicaid follows Medicare DMERC, Region B criteria for review of medical necessity for covered services/items. BMS Utilization Management Contractor (UMC) is available for information regarding medical necessity."
New Policy: "The most economical items/services will be provided. Expensive items are not covered when less costly items/services are available."
Directions: Replace page.

SECTION 506.3.1

Introduction: Section 506.3.1, lst paragraph, insert 2nd sentence, change second sentence to 3rd sentence
Old Policy: N/A
New Policy: "All DME repairs and replacement require PA through WVMI."

Introduction: Section 506.3.1.b, lst paragraph, delete 2nd, 3rd, & 4th sentences
Old Policy: "Charges should include the materials necessary to complete the repair, including HCPCS codes for any parts with the RP modifier and a period of necessary repair. Labor services are to be billed separately with the units equal to the number of hours of labor. DME providers are not reimbursed for setup or delivery following repair or for service calls that do not involve actual labor time for repairs**."**

New Policy: "DME providers may be reimbursed for materials necessary to complete the repair; however, providers are not eligible for reimbursement of setup or delivery following repair or service calls that do not involve actual labor time for repairs. Labor services are to be billed separately with the units equal to the number of labor hours.
Directions: Replace page.

SECTION 506.4

Introduction: Section 506.4, lst paragraph
Old Policy: "In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete, accurate and legible records documenting medical necessity for equipment and/or supplies provided to meet the basic health care needs of the individual Medicaid member."

New Policy: "In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete individual, accurate and legible records. Records must include documentation of medical necessity for equipment and/or supplies provided to meet the basic health care needs of the member."

Introduction: Section 506.4, 2nd paragraph, number 1
Old Policy: "CMN must be completed in its entirety for DME /medical supplies and other related services/items requiring prior authorization. For BMS purposes, the CMN is considered a prescription once signed by the practitioner; therefore, a separate written prescription is not required. The prescribing practitioner must have examined **the** patient within the last six months. A copy of the manufacturer's cost invoice must be attached to the CMN for unlisted HCPCS codes and for items/services noted in Attachment I. The CMN must be renewed at the end of the prescription period specified or within one (1) year whichever comes first. (See Attachment III for the DME CMN with Instructions.)
New Policy: "Effective March 15. 2006, WVMI Medicaid DME Authorization Request Form is required to provide WVMI medical necessity documentation for items or services prescribed by the treating practitioner. The Authorization Form must be renewed at the end of the prescription period specified or within one (1) year whichever comes first.

Introduction: Section 506.4, 2nd paragraph, number 2
Old Policy: "A written prescription signed by the prescribing practitioner for DME/medical supplies that do not require prior authorization must be maintained in the individual member's records. Diagnosis, signature and date are required. Rubber stamp is prohibited. The written prescription must be renewed at the end of the prescriptive period specified or within one (1) year whichever comes first. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/medical supplies."
New Policy: "Effective March 15, 2006, a written prescription which includes the member's name, date

of prescription, appropriate HCPCS code for item requested, description of code, estimated length of need in months, quantity of item(s), frequency of use and prescribing practitioner's signature, is to be given to the member by the prescribing practitioner. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/Medical Supplies.

Introduction: Section 506.4, 2nd paragraph, number 3
Old Policy: "Proof of delivery (date and mode) and education to the member and/or caregiver must be documented in the individual member's record".
New Policy: "Effective March 15, 2006, a signed delivery document by the member or caregiver and documentation of education for the DME item provided must be maintained in the individual member's record."
Directions: Replace pages.

SECTION 506.5

Introduction: Section 506.5, delete
Old Policy: "Codes requiring PA must be reviewed and approved by the UMC before service is rendered. These specific services are identified in Attachment I of this manual. The exception to this rule is HCPCS Code E0619, Infant Apnea Monitor with recording feature. The "Initial Infant Apnea Monitor" CMN must be submitted to WVMI seven (7) calendar days post hospital discharge. If the monitor is medically necessary beyond the initial approval, the "Request for Extension" CMN must be submitted to WVMI prior to the end of the initial authorization. These CMN's are included in Attachment IV. Unless otherwise, specified, WV Medicaid follows Medicare DMERC, Region B, medical necessity criteria for covered services. All required documentation noted in Section 504 must be attached to a completed CMN and mailed or faxed to:

West Virginia Medical Institute (WVMI)
3001 Chesterfield Place
Charleston, WV 25304
Fax Number: 304-346-8185
Attn: DME/Medical Supply Review

When documentation submitted fails to justify medical necessity for DME or medical supplies, the UMC may request additional information, and/or deny the request for lack of medical necessity. Information must be member specific and not copied from the DMERC Medicare Manual. Retroactive or verbal authorization is not accepted. The issuance of an authorization from the UMC does not guarantee payment.

NOTE: Prior authorization is required from Rational Drug Therapy Program (RDTP) for home IV services. However, if equipment and supplies are required, a completed CMN and a copy of the final determination (RDTP) must be submitted to the UMC for assignment of a PA number. This number may be assigned before or after the IV therapy services are provided. Information from RDTP must contain language which clearly states that the member requires such services or supplies. RDTP may be contacted at 1-800-847-3859 or by fax to 1-800-531-7787.
New Policy: "For DME services and items requiring review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate form to WVMI. If items and/or services provided before the PA is confirmed, the DME will not be reimbursed. PA does not guarantee payment. Refer to Attachment I for specific DME/medical supplies requiring PA and service limits for covered services.

Effective, January 1, 2006, Medicaid covered services which currently require a PA will no longer require a PA if the primary insurance approves the service. The EOB must accompany the claim. If the service is not allowed by the primary insurance, but is a covered service for Medicaid and the service requires a PA from the WVMI, Medicaid policy will be enforced. Please refer to Chapter 600 – Payment Methodologies for additional information.

Effective March 15, 2006, InterQual General Durable Medical Equipment Criteria, will be utilized by WVMI for determining medical necessity for DME items. These items include the following:

- Adaptive Strollers (E1232, E1236, E0950, E0966, E0978, E1029, E1030)
- Aerosol Delivery Devices (E0565, E0570)
- Augmentative and Alternative Communication Devices (E2508, E2510) - Refer to Speech/Audiology Manual for additional information
- Bone Growth Stimulators, Noninvasive (E0747, E0748, E0760)
- Continuous Passive Motion Device (CPM), Knee (E0935)
- Home Oxygen Therapy (E0424, E0431, E0434, E0439)
- Hospital Beds (E0250, E0255, E0260, E0303, E0304, E0910, E0911,E0912)
- Insulin Pump, Ambulatory (E0784)
- Lymphedema Compression Devices (E0650, E0651, E0652)
- Manual Wheelchairs (K0001, K0002, K0003, K0004, K0006, K0007)
- Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161, E1231, E1232, E1233, E1234)
- Manual Wheelchairs, Specialized (E1231, E1233, E1234, E1235, E1237, E1238, K0005, K0009)
- Negative Pressure Wound Therapy (NPWT) Pump (E2404, A6550)
- Noninvasive Airway Assist Devices (E0470, E0471, E0472, E0601)
- Power Operated Vehicles (POV) (E1230)
- Power Wheelchairs (K0010, K0011, K0012, K0014)
- Secretion Clearance Devices (E0480, E0483, E0484)
- Support Surfaces (E0180 – E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)
- Transcutaneous Electrical Nerve Stimulation (TENS) (E0720, E0730)
- Wheelchair Cushions/Seating System (E2603, E2604, E2605, E2606, E2607, E2608, E2609, E2611, E2612, E2617).

Practitioners are required to provide medical necessity documentation via mail, fax or telephonically to WVMI prior to items/services provided. Documentation form for DME PA will be available at www.wvmi.org and www.wvdhhr.org/bms . Items not listed above, will follow DMERC, Region B, medical necessity criteria for covered services. When documentation fails to meet criteria, WVMI may request additional information to be submitted within seven (7) days. If information is not received by WVMI within seven (7) days, the request will be denied for lack of documentation to support medical necessity.

Retrospective authorization is only available under the following certain circumstances: (1) services covered by private insurance; (2) termination of Medicaid coverage; (3) Medicaid retro eligibility; and (4) an apnea monitor seven (7) days post hospital discharge. A request for consideration of retrospective authorization does not guarantee approval or payment.

Directions: Replace Pages

SECTION 506.6

Introduction: Sections erroneously numbered in previous manual.
Old Policy: Not Applicable
New Policy: Section 506.6 – Nursing Facilities
Directions: Replace Page

SECTION 506.7

Introduction: Sections erroneously numbered in previous manual.
Old Policy: Not Applicable
New Policy: Section 506.7 – Out-Of-State Services
Directions: Replace page.

Introduction: Section 506.7, 1st paragraph, last sentence
Old Policy: "All DME policies apply."
New Policy: Delete last sentence
Directions: Replace page

SECTION 506.8

Introduction: Sections erroneously numbered in previous manual
Old Policy: Not Applicable
New Policy: Section 506.8 – Non-Covered Durable Medical Equipment and Supplies
Directions: Replace page

Introduction: Section 506.8, 1st paragraph
Old Policy: "Attachment II describes unlisted HCPCS codes for items/services not covered by WV Medicaid. In addition, WV Medicaid does not cover DME/medical supplies and other related services/items provided through DME as stated below. Non-covered service/items cannot be prior authorized nor an exception made for reimbursement."
New Policy: "In addition to non-covered services listed on Attachments I and II, the following items are not covered by WV Medicaid."

Introduction: Section 506.8, lst paragraph, insert 5th bullet
Old Policy: N/A
New Policy: "DME travel, setup or delivery following repairs.

Introduction: Section 506.8, 1st paragraph, change 6th bullet
Old Policy: "Repairs or replacement for equipment not purchased or rented by BMS (i.e., "loan closet", Muscular Dystrophy, Easter Seals, family, friend, yard/rummage sales, etc.)
New Policy: "Maintenance, repair"

Introduction: Section 506.8, 1st paragraph, 7th bullet
Old Policy: N/A
New Policy: "Service calls that do not involve actual labor time for repairs."

SECTION 506.9

Introduction: Sections erroneously numbered in previous manual
Old Policy: Not Applicable
New Policy: Section 506.9 – Billing and Reimbursement
Directions: Replace page

Introduction: Section 506.9; delete paragraphs 1, 2, 3, and 4
Old Policy: "Medicaid payment is made on a rental or purchase basis. The total payment for rental equipment may not exceed the cost of purchasing the equipment and is reimbursed on a cap rental basis depending on the item requested.

Medicaid payment is based, where possible, on a percentage of Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

The general requirements and procedures for billing are identified in Chapter 600. The professional claim form CMS-1500, or ASCX12N837P (004010X098A1) must be used to bill for DME/Medical supplies. Required attachments to the CMS 1500 are: (1) a manufacturer's cost invoice for unlisted or miscellaneous HCPCS codes, (2) a copy of the Medicare EOB for Medicare cross-over, and (3) medical documentation as previously stated in this chapter. The assigned PA number must be documented on the CMS-1500 for consideration of payment.

Repair and replacement of DME requires an RP modifier. Options or accessories that are included in the code for the base item may not be billed separately.
New Policy: "WV Medicaid requires practitioners, DME/medical supply providers and other appropriate individuals/groups to be enrolled as a Medicaid provider to be eligible for reimbursement of services rendered with exception of an emergent/medically necessary circumstance. Billing prior to rendering services/items is prohibited.

Medicaid payment for DME/Medical Supplies is made on a rental or purchase basis. The total payment for rental equipment may not exceed the cost of purchasing the equipment and is reimbursed on a cap-rental basis depending on the item requested. The billing period for rental equipment begins the day equipment is placed in the home to the next month. When submitting the claim for payment consideration the dates should be spanned; e.g. if DME is placed on 1/3/06, the billing period begins on 1/3/06 to 2/2/06; 2/3/06 to 3/2/06; 3/3/06 to 4/2/06, etc. Only dates that the equipment is in use may be billed. If the member becomes ineligible, the billing span is the begin date of the billing period to the last date of eligibility.

When billing for unlisted and/or unpriced HCPCS DME/Medical Supply codes (A4335, A4649, A6215, A6261, A6262, A6450, A6501 – A6513, A6538, A6540-A6543, A7523, A7524, B9998, B9999, E0240, E0247 – E0248, E1239, E1399, E2216-E2218, E2372, E2399, K0009, K0014, K0108, K0669) the description of the item provided must be entered on the claim form. An unaltered cost invoice is to be submitted to WVMI for pricing of unlisted/unpriced codes. Refer to Attachment I for specific codes and special instructions.

The professional claim form, CMS 1500 or ASCX12N837P (004010X098A1 must be used to bill DME/medical supplies. Repair and replacement of DME requires an RP modifier. Options or accessories included in the base item code will not be reimbursed.

Medicaid is payer of last resort. Third-party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The third-party may be an individual, institution, corporation or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS, Medicare, Hospice, etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan. In those instances where liability cannot be currently established; i.e., accident or injury, Medicaid benefits will not be withheld. Subsequent establishment of liability which provides compensation and payment for the costs of such medical care requires that an on-setting adjustment be made by the provider to the Medicaid agency for benefits paid. Prior authorization is not required for services reimbursed by third-party payers. All claims must be submitted to Unisys at PO Box 3767, Charleston, WV 25337 for reimbursement consideration.

Medicaid payment is based, where possible, on a percentage of the Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

SECTION 506.10

Introduction: Sections erroneously numbered in previous manual
Old Policy: Not Applicable
New Policy: Section 506.10 – Managed Care
Directions: Replace page

Introduction: Section 506.10
Old Policy: "Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO), if the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement and those requirements may be different than BMS'. If a Medicaid member is a member of the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for the DME ordered prior to rendering the services. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met.
New Policy: "Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement."
Direction: Replace page

Attachment I

Introduction: HCPCS Codes for DME & Supplies Changes: Special Instructions
New Policy: A4217 – Change in ICD-9 Codes

A4221, A4222, A4223, A4349 see Special Instructions

A4223- remove PA, see Special Instructions

A4402, A7003-A7006, A7013, A7015, E0470-E0472, E0480, E0483, E0601, E0650-E0652, E0655-

E0673, E2609, E0747, E0748 E0760, E0784, E0935, E0955-E0957 – Remove ICD-9 Codes

A4619, E0570, E1372, E2603-E2609, E2613-E2616, E2620-E2621 – Add PA and Remove ICD-9 Codes

A7000 – opened effective 01/01/2006

A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7045, A7046, E0424, E0431, E0434, E0439, E0441, E0443, E0445, E0450, E0460RR, E0463RR, E0464RR, E0470RR, E0471RR, E0472RR, E0561, E0562, E0565 and E0601 – added "Must have West Virginia certified respiratory therapist or professional registered nurse or physician on staff"

B4034, B4035, B4036, B4164-B4180, B4185-B5200 – Remove PA and add Service Limits

B9000, B9002, B9004, B9006, E0781 – Remove PA

E0180, E0181, E0184-E0187, E0196-E0199, E0424, E0431, E0434, E0439, E0484, E0910, E2601-E2602, E2611-E2612, E2619RP, K001-K0003 – Add PA

E1014 - Removed cost invoice

E1340 – added "travel not covered"

E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599, L8500, L8501, L8505, L8510, V5336 - Refer to Speech/Audiology Manual
Directions: Replace pages

ATTACHMENT II

Introduction: **Non**-Covered DME/Medical Supplies for Unlisted HCPCS Codes
New Policy: Delete Remote Control (remote pilot/remote box) for power wheelchair – Included in HCPCS codes E2310 and E2311

Add Male Vacuum Erection System

Add Canopy for Stroller

Add Hip Protector
Directions: Replace pages

ATTACHMENT III

Introduction: DME CMN with instructions
Old Policy: Delete DME CMN with instructions
New Policy: WVMI Medicaid DME/Medical Supply Authorization Request Form
Directions: Replace pages

ATTACHMENT IV

Introduction: Apnea Monitor – Initial and Request for Extension CMN's
New Policy: Delete Attachment IV

JULY 1, 2005

Introduction: 5th paragraph, 4th bullet, 1st sentence
Old Policy: "physician's order and/or a certificate of medical (CMN)"
Change: "practitioner's order and/or a certificate of medical necessity (CMN)". "Services requiring a PA must have a CMN".
Directions: Replace page

Introduction: 5th paragraph, 14th bullet
Old Policy: "A respiratory therapist**"**
Change: "A WV licensed respiratory therapist**"**
Directions: Replace page

Introduction: Section 506.3, 2nd paragraph, 1st sentence
Old Policy: "DME are seen in Attachment I"
Change: "**DME are seen in Attachments I and II"**
Directions: Replace page

Introduction: Section 506.3, 2nd paragraph, 2nd sentence
Old Policy: "This document describes"
Change: "Attachment I describes"
Directions: Replace page

Introduction: Section 506.3, 2nd paragraph, 4th sentence
Old Policy: "Note: If a DME/medical supply HCPCS code is not included in Attachment I or II, it is considered non-covered by WV Medicaid".
Change: "Attachment II describes DME/medical supply items, without HCPCS codes, that are non-covered by WV Medicaid".
Directions: Replace page

Introduction: Section 506.3, 3rd paragraph, 2nd sentence
Old Policy: "retains ownership of the"
Change: "maintains responsibility for the"
Directions: Replace page

Introduction: Section 506.4, 2nd paragraph, 1st bullet, 1st sentence
Old Policy: "services/items provide through DME requiring prior authorization."
Change: "services/items requiring prior authorization".
Directions: Replace page

Introduction: Section 506.4, 2nd paragraph, 1st bullet, 4th sentence
Old Policy: "for items/services noted in Attachment III"
Change: "for items/services noted in Attachment I"

Directions: Replace page

Introduction: Section 506.5, 1st paragraph, 3rd, 4th, 5th and 6th sentence
Old Policy: Non-applicable
Change: Addition of new sentence to state "The exception to this rule is HCPCS Code E0619, Infant Apnea Monitor with recording feature. The "Initial Infant Apnea Monitor" CMN must be submitted to WVMI seven (7) calendar days post hospital discharge. If the monitor is medically necessary beyond the initial approval, the "Request for Extension" CMN must be submitted to WVMI prior to the end of the initial authorization. These CMN's are included in Attachment IV".
Directions: Replace page

Introduction: Section 506.12
Old Policy: Miscellaneous
Change: Delete section. Information documented in Section 505
Directions: Replace page

Attachment I

Introduction: ICD 9 Codes and Modifier Changes in Special Instructions
Change: A4362-A4369, A4371-A4373, A4375-A4378, A4384,-A4390, A4394-A4427, A4455 - added ICD-9 V44.6 and V55.6

A4619 -removed ICD-9 codes 591.1 and added code range 519.0 - 519.9

E0424, E0431, E0434, E0439, E1390 added "Arterial Oxygen Saturation"

A4619, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038 A7039, A7045, A7046E0424, E0431. E0434, E0439, E0445, E0450, E0460, E0463, E0464, E0470 E471, E0472, E0561, E0562, E0565, E0601, and E1390 – added "Must have West Virginia Certified Respiratory Therapist on Staff".

E0450 and E0601 – removed "RR" modifier

E0470 – removed "non- reimbursable with A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7046, E0561, E0562"

E0471 and E0472 - removed ICD 9 codes 780.51, 780.53, 780.57 and added ICD- 9 code 518.81

E0565 - removed ICD-9 codes 591.1 and added ICD9 code range 519.0 – 519.1

E0618 closed code effective 4/30/05

E0619, E1020 re-opened with Special Instruction effective 5/1/05

E0650, E0651, E0652, E0655, E0660, E0665, E0666, E0667, E0668, E0669, E0671, E0672, E0673 - Removed ICD-9 codes 547.0 and 547.1 and added ICD-9 codes 457.0 and 457.1

E0747 - removed ICD-9 code 815-55-815.19 and added ICD-9 code 815.00 - 815.19

E0760 - removed ICD-9 codes 809.9 and added ICD9 code 809.1

E0955, E0956, E0957, E0960 – added ICD-9 range 343.0 – 343.9

E1009, E1010 – added ICD-9 range 344.0 – 344.04

E1028 re-opened and added PA and Special Instruction effective 5/1/05
Directions: Replace pages

Attachment I

Introduction: ICD 9 Codes and Modifier Changes in Special Instructions effective 7/01/05
Change: E1015 and E1016 codes opened effective 7/01/05
Directions: Replace pages

Attachment II

Introduction: Removed items from Non-Covered List
Change: Removed "Snug Seat
Directions: Replace page 116

Introduction: Add items to Non-Covered List
Change: Bacterial Filter, Glucowatch, Medical Identification Bracelet, Uplift Seat Assist
Directions: Replace Attachment II

Attachment III
Introduction: DME CMN with Instructions
Change: CMN Form – Section I added Member Medicaid ID # and Servicing Provider ID #
CMN Instructions - Section I added "Completed by Servicing Provider"
CMN Instructions – Section II added "Completed by Practitioner"
CMN Instructions – Section III, 1st, 3rd, 4th, and 5th bullets, added "Completed by Practitioner"
CMN Instructions – Section III, 2nd bullet added "Completed by Servicing Provider"
CMN Instructions – Section IV added "Completed by Practitioner"
Directions: Replace Attachment III

Attachment IV

Introduction: Apnea Monitor – Initial and Request for Extension CMN's
Change: Initial Infant Apnea Monitor CMN added DME Provider Medicaid ID # and Telephone # areas

Initial Infant Apnea Monitor CMN added "Request for prior authorization must be submitted to West Virginia Medical Institute seven (7) calendar days post hospital discharge" at the bottom of the page.

Request for Extension CMN added DME Provider Medicaid ID
Directions: Replace Attachment IV

CHAPTER 506 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME/MEDICAL SUPPLIES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

CHAPTER 506-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DME/MEDICAL SUPPLIES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

WV Medicaid Program offers a comprehensive scope of Durable Medical Equipment (DME)/Medical Supply services to Medicaid members, subject to medical necessity, appropriateness criteria and prior authorization requirements. DME/Medical Supply covered services are provided by approved DME providers, home IV infusion therapy suppliers, pharmacies and home health agencies in accordance with State and Federal regulations.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the WV Code. BMS in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program. This program, therefore, must also function within federally defined parameters.

Durable Medical Equipment/medical supply approved providers are subject to review of individual Medicaid member records by BMS, whether the service/item requires prior authorization (PA) or not. Providers must maintain current and accurate documentation and make available to BMS upon request.

This chapter describes WV Medicaid's major coverage policies for DME/Medical Supplies as noted in the following Sections:

506.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200. In addition, the following definitions also apply to the requirements for payment of the services described in this chapter.

Customized Equipment - Uniquely constructed for a specific member according to the description and order of the member's treating physician. Specific to wheelchairs and wheelchair accessories: A wheelchair which has been (1) measured, fitted or adapted in consideration of the patient's body size, disability, period of need or intended use; (2) ordered from a manufacturer who make available customized features or components for wheelchairs; and (3) is intended for an individual member's use in accordance with instructions from the member's physician would be considered "customized".

DME Provider - An individual or entity approved by WV Medicaid to provide DME /medical supplies, repair and replacement of equipment to Medicaid members. (See Section 506.2 for specifics).

Medical Supplies - Medically necessary non-durable medical or surgical items prescribed by a practitioner that are consumable, expendable and appropriate for use in a member's home.

Mobility Assistive Equipment (MAE) – Items that offer assistance to members who have a physical impairment that results in a mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, power operated vehicles and strollers.

Prescribing Practitioner: Identified as an MD, DO, DPM, Nurse Practitioner (NP), or Physician Assistant (PA) under the supervision of a participating physician. WV Medicaid does not recognize hospital residents as prescribing practitioners.

506.2 PRESCRIBING PRACTITIONER AND PROVIDER PARTICIPATION REQUIREMENTS

506.2.1 Prescribing Practitioner

In addition to Chapter 300 Provider Participation Requirements, MDs, DOs, DPMs, NPs, and PAs under the supervision of a participating physician, prescribing DME/medical supplies and related items must:

(1) be actively enrolled in Medicaid;
(2) inquire if the member has a DME provider of choice;
(3) provide a written prescription to the member;
(4) provide clinical documentation for medical necessity to include diagnosis code, frequency of use, duration, quantity, and any relevant information to WVMI. Documentation may be submitted to
(5) WVMI in writing (with legal signature of prescribing practitioner), fax or telephonically;
(6) maintain all appropriate medical documentation in the Medicaid member's individual file; and,
(7) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

The Bureau's website @ www.wvdhhr.org is the most efficient means of keeping current on updates and information regarding BMS. If you do not have the Internet, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.

506.2.2 Durable Medical Equipment/Medical Supply Provider (Includes respective Pharmacies, Home IV Infusion Therapy and Home Health Agencies with DME and/or medical supply provider specialty)

The DME/Medical Supply Provider must:

(1) be actively enrolled in Medicaid;
(2) maintain a retail store open to the public at least forty (40) hours per week with a toll free telephone number and handicapped accessibilities. The store must be located within thirty (30) miles of the WV border;
(3) post a visible sign indicating hours of operation. Hours of operation and availability of

emergency coverage must be stated on the WV Medicaid enrollment form;

(4) maintain inventory of equipment/supplies and display at least one of each item listed on an inventory and made readily available for delivery;

(5) maintain adequate space to store inventory, business and member records;

(6) obtain individual WV Medicaid provider numbers for each physical facility under the same ownership;

(7) provide DME/Medical Supplies per treating practitioner's prescription;

(8) assure the item/service provided is appropriate to the member's needs;

(9) assure the item/service can be used by the member;

(10) provide an appropriate replacement at no extra cost if the member is unable to use the equipment provided;

(11) agree to accept Medicaid's reimbursement as payment in full for all covered items/services;

(12) provide most economical items/services that meets the member's basic health care needs. Expensive items are not covered when less costly items/services are available;

(13) maintain all medical documentation and proof of delivery of all DME/medical supplies in the member's individual file;

(14) participate in on-site reviews and/or provide medical documentation upon request by BMS;

(15) employ current WV licensed respiratory therapist, registered professional nurse OR physician to provide 24 hour coverage if respiratory/related accessory services/items are offered. A maximum call response time is within thirty (30) minutes. Refer to West Virginia Board of Respiratory Care online at www.wvborc.org for additional information;

(16) employ current licensed or credentialed mastectomy, pedorthotist and/or orthotic fitter certified by National Commission for Certifying Agencies (NCCA), if providing orthotic and/or prosthetic services. Certifying Agencies e.g., American Board for Certification in Orthotics and Prosthetics (ABC), or Board for Orthotist/Prosthetist Certification (BOC), or Board for Certification in Pedorthotics; and

(17) provide any changes to original enrollment application (i.e., personnel, licensure, certification, registration, demographics) to Unisys, Provider Services, PO Box 2002, Charleston, WV, 25327-2002 within fifteen (15) days. Copies of updated license, certification and/or registration must be submitted to Unisys annually.

506.2.3 Home Intravenous Infusion Therapy Suppliers

Effective February 16, 2006, Home IV Infusion Therapy equipment and medical supplies provided through DME will not require prior authorization by WVMI. This change includes HCPCS codes A4221, A4222, A4223, B4164-B4224, B5000, B5100, B5200, B9004, B9006, and E0781. Services limits for medical supplies are based on Rational Drug Therapy Program's (RDTP) prior authorization of number(s) of bags or cassettes approved within a specified time frame. For example; if RDTP approves 63 bags or cassettes, the maximum medical supply units is 63; if 10 bags or cassettes are approved, the maximum medical supply units is 10, etc. Service limits for equipment is unchanged. Prior Authorization from RDTP for medications is also unchanged.

RDTP may be contacted at 1-800-847-3859 or fax to 1-800-531-7787.

506.2.4 Home Health Agencies

Refer to Chapter 508, Home Health Manual, Section 508.5, Medical Supplies, for additional information.

506.3 COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Durable Medical Equipment/medical supplies and other related services/items provided through DME are considered for reimbursement by WV Medicaid when requested by a prescribing practitioner and determined medically necessary to meet the basic health care needs of the member.

A complete list of covered and non-covered DME/medical supplies and other related services/items provided through DME are seen in **Attachments I and II. Attachment I** describes the DME/medical supplies through current HCPCS codes, description of each code, replacement code for closed codes (as appropriate), service limits, prior authorization requirements and special coverage instructions. Dispensing of medical supplies for more than a one (1) month time frame or shipping supplies on an unsolicited or automatic basis is prohibited. **Attachment II** describes DME/medical supply items, without HCPCS codes, that are non-covered by WV Medicaid

Durable Medical Equipment/medical supply coverage is based on product category not specific item, brand or manufacturer. Medical supplies are purchased items, while equipment may be initially purchased or reimbursed on a cap-rental basis. Following the established cap-rental timeframe, DME items are determined purchased and the provider that received the last cap-rental reimbursement maintains responsibility for the item and must provide repairs and/or modification as needed.

The most economical items/services will be provided. Expensive items are not covered when less costly items/services are available.

506.3.1 WARRANTY, REPAIR, AND REPLACEMENT

Durable Medical Equipment and/or accessory repairs and replacements are limited to medically necessary items purchased by BMS or Children with Special Healthcare Needs Program (CSHCN). All DME repairs and replacement require PA through WVMI. Only one (1) MAE of the same category will be maintained or repaired by BMS at any time. Manufacturer's warranty for DME is required for not less than one (1) year.

Medicaid's initial payment for DME includes all adjustments and/modifications needed to make the item functional for delivery to the member. The supplier must provide training and instruction to the member and/or caregiver on the safe, effective and appropriate use of the appliance.

506.3.1. a Warranty

All standard durable medical equipment must have a manufacturer's warranty of at least one year. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs and replacements for the first year. The warranty begins on the date of the delivery (date of service) to the member. The original warranty must be given to the member and a copy is maintained in the member's individual medical record. A copy of the warranty is provided to WV Medicaid or WVMI

upon request.

506.3.1. b Repair

WV Medicaid's coverage for repair of equipment is limited to:

(1) items that have been fully purchased by WV Medicaid or by the Children with Special Healthcare Needs Program (CSHCN);
(2) equipment provided by CSHCN is covered by Medicaid;
(3) items in which the cap-rental timeframe has been exhausted;
(4) the medical need is expected to continue; and
(5) the repair is more economical than replacement.

Durable Medical Equipment providers may be reimbursed for materials necessary to complete the repair; however, providers are not eligible for reimbursement of setup or delivery following repair or service calls that do not involve actual labor time for repairs. Labor services are to be billed separately with the units equal to the number of labor hours.

DME repairs are covered when all of the following conditions are met:

(1) Prior authorization is received before repairs are initiated – appropriate HCPCS Code and RP modifier must be included on the request.

(2) Substitute comparable or like equipment at no additional cost when broken or damaged equipment is being repaired.

(3) No other party is financially liable for the needed repair.

(4) Equipment remains medically necessary.

(5) Damage to the item is not due to the member's abuse or misuse.

506.3.1. c Replacement

Replacement of DME equipment may be covered by WV Medicaid on an as-needed basis due to acute rapid changes in the member's physical condition, wear, theft, irreparable damage, or loss by disasters. For consideration of equipment replacement, the provider must obtain prior authorization. The request must be submitted to WVMI **prior to rendering services.** Documentation to medically justify replacement must accompany all requests. A police or insurance report is required with all requests for replacement of stolen equipment. A report of insurance liability is required with requests for replacement of equipment lost or destroyed. In cases of neglect and/or wrongful misuse of DME, requests for replacement will be denied if such circumstances are confirmed.

506.4 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete, individual, accurate and legible records. Records must include documentation of medical necessity for equipment and/or supplies provided to meet the basic health care needs of the member.

Documentation must include, but is not limited to:

(1) Effective May 1, 2006, formal certificate of medical necessity forms (i.e., the WVMI Medicaid DME Authorization Request Form, the DME/Medical Supply Certificate of Medical Necessity, the Apnea Initial and Recertification Certificates of Medical Necessity) are not required to document medical necessity of items requiring prior authorization. However, as an enrolled participant of WV Medicaid, practitioners and DME providers are required to maintain individual Medicaid member files with documentation to assure that all services provided to Medicaid members are medically necessary and that billing of such services are accurate. **Attachment III** provides forms that may be submitted via fax to 1-304-346-8185 or 1-877-762-4338 or in writing to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304. Telephonic reviews for urgent or emergency requests are available at 1-304-414-2551 or 1-800-296-9849.

(2) Effective May 1, 2006, a written prescription which must include the member's name, date of prescription, description of code, estimated length of need in months, quantity of item(s), frequency of use and prescribing practitioner's signature and given to the member by the prescribing practitioner. A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for DME/Medical Supplies.

(3) The DME provider must maintain a delivery document signed by the member or caregiver and documentation of education for the DME item provided must be maintained in the individual member's record.

(4) DME Provider must be able to track serial, lot, and product numbers for purposes of recall.

(5) The prescriber's medical documentation submitted for review must not be more than six (6) months old at the time the prescription is written.

506.5 PRIOR AUTHORIZATION

For DME services and items requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the written prescription (see 506.4, 2nd paragraph, (2) for clarification) and any other relevant information. Additionally, a licensed physical therapist or licensed occupational therapist who is fiscally, administratively and contractually independent from the DME provider may also submit clinical documentation for review when requested by the prescribing practitioner. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. It is strongly recommended that DME providers, in partnership with prescribing practitioners, assist in obtaining prior authorizations. Prescribing practitioners must provide clinical information and a written prescription while DME providers may submit the appropriate HCPCS code and billing information. If items and/or services provided before the PA is confirmed, the DME will not be reimbursed. PA does not guarantee payment. Refer to Attachment I for specific DME/medical supplies requiring PA and service limits for covered services.

Effective, January 1, 2006, Medicaid covered services which currently require a PA will no longer require a PA if the primary insurance approves the service. The explanation of benefits (EOB) must

accompany the claim. An EOB documenting the reasons for the denial of TPL for services requested must be provided to WVMI when requesting prior authorization review. If the service is not allowed or covered by the primary insurance, but is a covered service for Medicaid and the service requires a PA from WVMI, Medicaid policy will be enforced. If administrative denials are given by the primary payer, Medicaid will not reimburse for services. Please refer to Chapter 600 – Payment Methodologies for additional information.

Effective March 15, 2006, InterQual General Durable Medical Equipment Criteria, will be utilized by WVMI
for determining medical necessity for DME items. These items include the following:

- Adaptive Strollers (E1232, E1236, E0950, E0966, E0978, E1029, E1030)
- Aerosol Delivery Devices (E0565, E0570)
- Augmentative and Alternative Communication Devices (E2508, E2510) - Refer to Speech/Audiology Manual for additional information
- Bone Growth Stimulators, Noninvasive (E0747, E0748, E0760)
- Continuous Passive Motion Device (CPM), Knee (E0935)
- Home Oxygen Therapy (E0424, E0431, E0434, E0439).
  Effective March 15, 2006, any new oxygen system requested for medical necessity
  must follow InterQual criteria to include documentation of initial lab results. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. Date of lab results must be within 6 months of the oxygen request.
- Hospital Beds (E0250, E0255, E0260, E0303, E0304, E0910, E0911, E0912)
- Insulin Pump, Ambulatory (E0784)
- Lymphedema Compression Devices (E0650, E0651, E0652)
- Manual Wheelchairs (K0001, K0002, K0003, K0004, K0005 K0006, K0007)
- Manual Wheelchairs, Recliner/Tilt (K0001 + E1226, E1161)
- Negative Pressure Wound Therapy (NPWT) Pump (E2404, A6550)
- Noninvasive Airway Assist Devices (E0470, E0471, E0472, E0601)
- Pediatric Mobility Equipment (E1231, E1232, E1233, E1234, E1235, E1237, E1238, K0890, K0891)
- Power Operated Vehicles (POV) (K0800, K0801, K0802, K0806, K0807, K0808, K0812)
- Power Wheelchairs (K0813, K0814, K0815, K0826, K0820, K0821, K0822,
- K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886)
- Secretion Clearance Devices (E0480, E0483, E0484)
- Support Surfaces (E0181 E0182, E0184, E0185, E0186, E0187, E0196, E0197 – E0199, E0277, E0371)
- Transcutaneous Electrical Nerve Stimulation (TENS) (E0720, E0730)
- Wheelchair Cushions/Seating System (E2603, E2604, E2605, E2606, E2607,

E2608, E2609, E2611, E2612, E2617, K0734, K0735, K0736, K0737)

Items requiring PA not listed above will follow Palmetto, Region C, medical necessity criteria for covered services. When documentation fails to meet criteria, WVMI may request additional information to be submitted within seven (7) days. If information is not received by WVMI within seven (7) days, the request will be denied for lack of documentation to support medical necessity.

Retrospective authorization is available (1) for items denied due to TPL; (2) retrospective Medicaid eligibility; (3) within 7 days post hospital discharge for apnea monitors, oxygen systems, nebulizers; (4) for items other than those referenced here on a case-by-case basis; and (5) the **next** business day following DME placement occurring on weekends and holidays, or at times when the utilization management agency review process is unavailable. A request for consideration of retrospective authorization does not guarantee approval or payment.

506.6 NURSING FACILITIES

Reimbursement to nursing and intermediate care facilities (ICF/MR) is intended to cover the total cost of care provided in the nursing home, including durable medical equipment and supplies.

Durable Medical Equipment and medical supplies may be reported in the nursing home cost report and are subsequently reflected in their per diem rate. Therefore, none of these items will be reimbursed to a DME company/medical supplier as a direct billing to Medicaid if the Medicaid member is a resident of the nursing facility at the time the DME is issued.

506.7 OUT-OF-STATE SERVICES

For WV Medicaid members receiving covered services from an out-of–state facility and requiring DME/medical supplies and other related services/items that are medically necessary at discharge, a written prescription by the respective out-of-state attending physician must be presented to a WV provider for provision of services requested. West Virginia DME policies apply. This process is required for warranty validity and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WV Medicaid members.

506.8 NON-COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

In addition to non-covered services listed on Attachments I and II, the following items are not covered by WV Medicaid:

(1) Use of an unlisted code when a national HCPCS code is available

(2) Unbundled HCPCS codes

(3) Services rendered prior to obtaining prior authorization

(4) Routine or periodic maintenance (i.e., testing, cleaning, regulating)

(5) DME travel, set-up or delivery following repairs.

(6) Maintenance, repairs or replacement for equipment not purchased or rented by BMS or CSHCN (i.e., "loan closet", Muscular Dystrophy, Easter Seals, family, friend, yard/rummage sales, etc.)

(7) Service calls that do not involve actual labor time for repairs.

(8) DME/medical supplies and other related services/items provided through DME suppliers to Nursing Facilities (ICF/MR), Hospice

(9) DME/medical supplies and other related services/items provided through DME suppliers to participants enrolled in the Division of Rehabilitative Services and/or Workers Compensation

(10) DME/medical supplies and other related service/items provided through DME suppliers to members enrolled in a Medicaid MCO.

(11) DME/medical supplies and other related service/items provided through DME to members enrolled in the PAAS Program without a referral from the PCP.

506.9 BILLING AND REIMBURSEMENT

WV Medicaid requires practitioners, DME/medical supply providers and other appropriate individuals/groups to be enrolled as a Medicaid provider to be eligible for reimbursement of services rendered with exception of an emergent/medically necessary circumstance. Billing prior to rendering services/items is prohibited.

Medicaid payment for DME/Medical Supplies is made on a rental or purchase basis. The total payment for rental equipment may not exceed the cost of purchasing the equipment and is reimbursed on a cap-rental basis depending on the item requested. The billing period for rental equipment begins the day equipment is placed in the home to the next month. When submitting the claim for payment consideration the dates should be spanned; e.g. if DME is placed on 1/3/06, the billing period begins on 1/3/06 to 2/2/06; 2/3/06 to 3/2/06; 3/3/06 to 4/2/06, etc. Only dates that the equipment is in use may be billed. If the member becomes ineligible, the billing span is the begin date of the billing period to the last date of eligibility.

When billing for unlisted and/or unpriced HCPCS DME/Medical Supply codes (A4335, A4649, A6215, A6261, A6262, A6450, A6501 – A6513, A6538, A6540-A6543, A7523, A7524, B9998, B9999, E0240, E0247 – E0248, E1239, E1399, E2216-E2218, E2372, E2399, K0009, K0108, K0669, K0898, K0899) the description of the item provided must be entered on the claim form. An unaltered cost invoice is to be submitted to WVMI for pricing of unlisted/unpriced codes. Refer to Attachment I for specific codes and special instructions.

The professional claim form, CMS 1500 or ASCX12N837P (004010X098A1 must be used to bill DME/medical supplies. Repair and replacement of DME requires an RP modifier. Options or accessories included in the base item code will not be reimbursed.

Medicaid is payer of last resort. Third-party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The third-party may be an individual, institution, corporation or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS, Medicare, Hospice, etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan. Subsequent establishment of liability which provides compensation and payment for the costs of such medical care requires that an adjustment be made by the provider to the Medicaid agency for benefits paid. Prior authorization is not required for services reimbursed by third-party payers. All claims must be submitted to Unisys at PO Box 3767, Charleston, WV 25337 for reimbursement consideration.

Medicaid payment is based, where possible, on a percentage of the Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

Certain supplies used by eligible diabetic Medicaid members (ICD-9-CM codes 250.00 – 250.93 or 648.8X**)** are covered through the outpatient pharmacy program. A prescription issued from a qualified practitioner within the scope of his/her practice is required for coverage of these items. Verbal prescriptions which meet federal and state regulations are permitted. Prescriptions must define the number of tests to be performed per day. Co-payments are not required on prescriptions for these items. Needles and syringes dispensed in this program are to be used only for the administration of insulin. Insulin syringe and needle combinations and pen needles are not covered for non-insulin dependent diabetic patients or those patients with other diagnoses through the pharmacy program.

Diabetic testing supplies and syringes/needles are not covered for members residing in skilled nursing or ICF/MR facilities. Blood glucose testing monitors, other types of diabetic testing supplies, insulin pumps and supplies, and/or syringes and needles for other purposes must be submitted as medical claims.

Covered supplies through the pharmacy program include: (See Pharmacy Manual)

- Blood glucose testing strips
- Urine testing tablets and strips
- Lancets
- Insulin syringe and needle combinations for the administration of insulin
- Needles for insulin pen systems

Diabetic medical supplies that include lancets, glucose strips and insulin syringes are covered by Medicaid through a retail pharmacy or through a DME company even if the member is enrolled in an MCO. All other equipment necessary for diabetic members who are members of the MCO is the responsibility of the MCO and the MCO's requirements must be met for reimbursement. If the MCO's requirements are not met, Medicaid will not reimburse for services provided.

506.10 MANAGED CARE

Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement. If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for the DME ordered prior to rendering the services. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met.

CHAPTER 506

DME/MEDICAL SUPPLIES

MAY 1, 2005

ATTACHMENT I

COVERED/NON-COVERED DME/MEDICAL SUPPLY SERVICES WITH ASSIGNED HCPCS CODES

REVISED JANUARY 1, 2008

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4206	SYRINGE WITH NEEDLE, STERILE 1CC **OR LESS**, EACH		100 PER ROLLING MONTH	
A4207	SYRINGE WITH NEEDLE, STERILE 2CC, EACH		100 PER ROLLING MONTH	
A4208	SYRINGE WITH NEEDLE, STERILE 3CC, EACH		100 PER ROLLING MONTH	
A4209	SYRINGE WITH NEEDLE, STERILE 5CC OR GREATER, EACH		100 PER ROLLING MONTH	
A4210	NEEDLE-FREE INJECTION DEVICE, EACH		NON-COVERED	
A4211	SUPPLIES FOR SELF-ADMINISTERED INJECTIONS		NON-COVERED	
A4212	NON-CORING NEEDLE OR STYLET WITH OR WITHOUT CATHETER		NON-COVERED	
A4213	SYRINGE, STERILE, 20 CC OR GREATER, EACH		60 PER ROLLING MONTH	
A4215	NEEDLE, STERILE, ANY SIZE EACH	A4656	100 PER ROLLING MONTH	
A4216	STERILE WATER, SALINE AND/OR DEXTROSE DILUENT/FLUSH, 10 ML			
A4217	STERILE WATER/SALINE, 500 ML			COVERAGE LIMITED TO TRACHEAL SUCTIONING ONLY. REQUIRES ICD-9-CM DIAGNOSIS CODE: 011.50-011.56, 277.02, 494.0, 494.1, 519.1, 748.61, V44.0 OR V55.0
A4218	STERILE SALINE OR WATER, METERED DOSE DISPENSER 10 ML		NON-COVERED	NEW CODE 01/01/2006
A4220	REFILL KIT FOR IMPLANTABLE INFUSION PUMP		NON-COVERED	
A4221	SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)	A4230 A4231	4 PER ROLLING MONTH	SUPPLIES INCLUDE: HEPLOCK START KITS, CENTRAL LINE KITS, INSYTES, ETOH SWABS, HUBER NEEDLES, SUB-Q- NEEDLE, SUB-Q KIT NON-REIMBURSABLE WITH A4230 OR A4231
A4222	INFUSION SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)	A4230 A4231		SUPPLIES INCLUDE: TUBING, BATTERIES, CLAVE VALVE, CLAVE, VIAL ACCESS, SYRINGES (3CC, 5CC, 10CC) 7" EXTENSION SETS SERVICE LIMIT BASED ON RATIONAL DRUG THERAPY PROGRAM AUTHORIZATION FOR NUMBER OF BAGS OR CASSETTES RDTP AUTHORIZATION FORM MUST BE ATTACHED TO CMS 1500 CLAIM FORM NON-REIMBURSABLE WITH A4230 OR A4231

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4223	INFUSION SUPPLIES NOT USED WITH EXTERNAL INFUSION PUMP, PER CASSETTE OR BAG (LIST DRUGS SEPARATELY)			SUPPLIES INCLUDE: TUBING, CENTRAL LINE KIT, INSYTES PERIPHERAL LINE, HUBER NEEDLES, CLAVE CONNECTOR, CLAVE VALVE, CLAVE VIAL ACCESS, LUMENS (TRIPLE, SINGLE, DOUBLE) SYRINGES (3CC, 5CC, 10CC) 7" EXTENSION SETS, HEPLOCK KITS, IV HOOK/POLE SERVICE LIMIT BASED ON RATIONAL DRUG THERAPY PROGRAM AUTHORIZATION FOR NUMBER OF BAGS OR CASSETTES RDTP AUTHORIZATION FORM MUST BE ATTACHED TO CMS 1500 CLAIM FORM NON-REIMBURSABLE WITH A4230 OR A4231
A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLE CANNULA TYPE		12 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93
A4231	INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE TYPE		12 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93
A4232	SYRINGE WITH NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE, 3CC		12 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93
A4233	REPLACEMENT BATTERY, ALKALINE 9 (OTHER THAN T CELL) FOR USE WITH MEDICALLY NCESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY THE PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4234	REPLACEMENT BATTERY, ALKALINE, J CELL, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4235	REPLACEMENT BATTERY, LITHIUM, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4236	REPLACEMENT BATTERY, SILVER OXIDE, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH	A4254	1 PER 2 ROLLING YEARS	NEW CODE 01/01/2006
A4244	ALCOHOL OR PEROXIDE, PER PINT		7 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4245
A4245	ALCOHOL WIPES, PER BOX		4 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4244
A4246	BETADINE OR PHISOHEX SOLUTION, PER PINT		6 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4247
A4247	BETADINE OR IODINE SWABS/WIPES, PER BOX		4 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4246
A4248	CHLOREHXIDINE CONTAINING ANTISEPTIC, 1 ML		NON-COVERED	
A4250	URINE TEST OR REAGENT STRIPS OR TABLETS (100 TABLETS OR STRIPS)		1 EVERY 3 ROLLING MONTHS	

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4252	BLOOD KETONE TEST OR REAGENT STRIP, EACH		NON-COVERED	NEW CODE 01/01/2008
A4253 KX	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS		3 BOXES PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X INSULIN DEPENDENT NON-REIMBURSABLE WITH A4253KS
A4253 KS	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS		2 BOXES PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X NON-INSULIN DEPENDENT NON-REIMBURSABLE WITH A4253KX
A4254	REPLACEMENT BATTERY, ANY TYPE, FOR USE WITH MEDICALLY NECESSARY HOME BLOOD GLUCOSE MONITOR OWNED BY PATIENT, EACH		NON-COVERED	DISCONTINUED BY CMS 12/31/2005
A4255	PLATFORMS FOR HOME BLOOD GLUCOSE MONITOR, 50 PER BOX		NON-COVERED	
A4256	NORMAL, LOW AND HIGH CALIBRATOR SOLUTION / CHIPS		1 PER 3 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X
A4257	REPLACEMENT LENS SHIELD CARTRIDGE FOR USE WITH LASER SKIN PIERCING DEVICE, EACH		NON-COVERED	
A4258	SPRING-POWERED DEVICE FOR LANCET, EACH		1 PER 2 ROLLING YEARS	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X
A4259 KX	LANCETS, PER BOX OF 100		2 BOX PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X INSULIN DEPENDENT NON-REIMBURSABLE WITH A4259KS
A4259 KS	LANCETS, PER BOX OF 100		1 BOX PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 THRU 250.93 OR 648.8X NON-INSULIN DEPENDENT NON-REIMBURSABLE WITH A4259KX
A4265	PARAFFIN, PER POUND		NON-COVERED	
A4280	ADHESIVE SKIN SUPPORT ATTACHMENT FOR USE WITH EXTERNAL BREAST PROSTHESIS, EACH		NON-COVERED	
A4281	TUBING FOR BREAST PUMP, REPLACEMENT		NON-COVERED	
A4282	ADAPTER FOR BREAST PUMP, REPLACEMENT		NON-COVERED	
A4283	CAP FOR BREAST PUMP BOTTLE, REPLACEMENT		NON-COVERED	
A4284	BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT		NON-COVERED	
A4285	POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT		NON-COVERED	

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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A4286	LOCKING RING FOR BREAST PUMP, REPLACEMENT		NON-COVERED	
A4310	INSERTION TRAY WITHOUT DRAINAGE BAG AND WITHOUT CATHETER (ACCESSORIES ONLY)		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4332
A4311	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER OR HYDROPHILIC, ETC.)		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4332, A4338
A4312	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4332, A4344
A4313	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE,THREE-WAY, FOR CONTINUOUS IRRIGATION LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER OR HYDROPHILIC, ETC.)		1 PER DAY X 14 DAYS	NON-REIMBURSABLE WITH A4310, A4332, A4346
A4314	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4311, A4331, A4332, A4338, A4354, A4357
A4315	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY,ALL SILICONE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4312, A4331, A4332, A4344, A4354, A4357
A4316	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, THREE-WAY, FOR CONTINUOUS IRRIGATION		1 PER DAY X 14 DAYS	NON-REIMBURSABLE WITH A4310, A4313, A4331, A4332, A4346, A4354, A4357
A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRINGE, ANY PURPOSE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4322
A4321	THERAPEUTIC AGENT FOR URINARY CATHETER IRRIGATION		NON-COVERED	
A4322	IRRIGATION SYRINGE, BULB OR PISTON, EACH		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4320
A4326	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION CHAMBER, ANY TYPE, EACH		2 PER ROLLING MONTH	FOR MALE USE ONLY
A4327	FEMALE EXTERNAL URINARY COLLECTION DEVICE; MEATAL CUP, EACH		1 PER WEEK	FOR FEMALE USE ONLY
A4328	FEMALE EXTERNAL URINARY COLLECTION DEVICE; POUCH, EACH		1 PER DAY	FOR FEMALE USE ONLY
A4330	PERIANAL FECAL COLLECTION POUCH WITH ADHESIVE, EACH		31 PER ROLLING MONTH	

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A4331	EXTENSION DRAINAGE TUBING, ANY TYPE, ANY LENGTH, WITH CONNECTOR/ADAPTOR, FOR USE WITH URINARY LEG BAG OR UROSTOMY POUCH, EACH		5 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4314, A4315, A4316, A4354, A4357, A4358, A5105; CAN ONLY BE BILLED WITH A5112
A4332	LUBRICANT, INDIVIDUAL STERILE PACKET, EACH		31 PER ROLLING MONTH	NON-REIMBURSABLE FOR CLEAN, NONSTERILE INTERMITTENT CATHETERIZATION
A4333	URINARY CATHETER ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT, EACH		12 PER ROLLING MONTH	
A4334	URINARY CATHETER ANCHORING DEVICE, LEG STRAP, EACH		1 PER ROLLING MONTH	
A4335	INCONTINENCE SUPPLY; MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED
A4338	INDWELLING CATHETER; FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, ELASTOMER, OR HYDROPHILIC, ETC.), EACH		2 PER ROLLING MONTH	
A4340	INDWELLING CATHETER; SPECIALTY TYPE, EG; COUDE, MUSHROOM, WING, ETC.), EACH		2 PER ROLLING MONTH	
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE, EACH		2 PER ROLLING MONTH	
A4346	INDWELLING CATHETER; FOLEY TYPE, THREE WAY FOR CONTINUOUS IRRIGATION, EACH		1 PER DAY X 14 DAYS	
A4348	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION COMPARTMENT, EXTENDED WEAR, EACH (E.G., 2 PER ROLLING MONTH)		NON-COVERED	
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	A4324 A4325 A4347	31 PER ROLLING MONTH	FOR MALE USE ONLY NON-REIMBURSABLE WITH ADHESIVE STRIPS OR TAPE
A4351	INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH		31 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4353
A4352	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH		8 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4353
A4353	INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES		31 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4332, A4351, A4352; COVERAGE LIMITED TO STERILE TECHNIQUE ONLY WHEN SPECIFICALLY PRESCRIBED IN WRITING BY PRESCRIBING PRACTITIONER SUPPLIES INCLUDE: TRAY/BAG IN STERILE PACKAGE INCLUDES SINGLE USE CATHETER, LUBICANT, GLOVES, ANTISEPTIC SOLUTION, APPLICATOR AND DRAPE
A4354	INSERTION TRAY WITH DRAINAGE BAG BUT WITHOUT CATHETER		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4310, A4331, A4332, A4357

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A4355	IRRIGATION TUBING SET FOR CONTINUOUS BLADDER IRRIGATION THROUGH A THREE-WAY INDWELLING FOLEY CATHETER, EACH		1 PER DAY X 14 DAYS	REIMBURSED FOR CONTINUOUS BLADDER IRRIGATION OR HISTORY OF CATHETER OBSTRUCTION
A4356	EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE (NOT TO BE USED FOR CATHETER CLAMP), EACH		1 PER 3 ROLLING MONTHS	
A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE, EACH		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4331, A5102
A4358	URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH		2 PER ROLLING MONTH	FOR MEMBERS WHO ARE AMBULATORY OR ARE CHAIR OR WHEELCHAIR BOUND ONLY NON-REIMBURSABLE WITH A5112, A4331, A5113, A5114
A4359	URINARY SUSPENSORY WITHOUT LEG BAG, EACH		1 PER ROLLING MONTH	CLOSED BY CMS 12/31/2006
A4361	OSTOMY FACEPLATE, EACH		3 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2 V55.2 , V44.3, V55.3, V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4375, A4376, A4377, A4378, A4379, A4380, A4381, A4382, A4383
A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4363	OSTOMY CLAMP, ANY TYPE, REPLACEMENT ONLY, EACH		NON-COVERED	NEW CODE 01/01/2006
A4364	ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PER OZ		4 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50		1 BOX PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4366	OSTOMY VENT, ANY TYPE, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4416, A4417, A4418, A4419, A4423, A4424, A4425, and A4427;
A4367	OSTOMY BELT, EACH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4368	OSTOMY FILTER, ANY TYPE, EACH		1 PER DAY	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC), PER OZ		2 OZ PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A 5119
A4371	OSTOMY SKIN BARRIER, POWDER, PER OZ		10 OZ. PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4372	OSTOMY SKIN BARRIER, SOLID 4 X 4 OR EQUIVALENT, STANDARD WEAR, WITH BUILT-IN CONVEXITY, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDIAN), WITH BUILT-IN CONVEXITY, ANY SIZE, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6

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A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, PLASTIC, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4361, A4377
A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4361, A4378;
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH: A4361, A4375;
A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, OR V55.3, V55.6 NON-REIMBURSABLE WITH: A4361, A4376;
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4381, and A4382
A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4383
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4379, A4382
A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, HEAVY PLASTIC, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4379, A4381
A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6 NON-REIMBURSABLE WITH: A4361, A4380
A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EACH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, EACH		15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4387	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4391	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED (1 PIECE), EACH		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6

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A4392	OSTOMY POUCH, URINARY, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4393	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4394	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH, LIQUID, PER FLUID OUNCE		16 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4395	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH, SOLID, PER TABLET		30 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4396	OSTOMY BELT WITH PERISTOMAL HERNIA SUPPORT		2 PER ROLLING YEAR	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4397	IRRIGATION SUPPLY; SLEEVE, EACH		4 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4398	OSTOMY IRRIGATION SUPPLY; BAG, EACH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER, INCLUDING BRUSH		2 PER 6 ROLLING MONTHS	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4400	OSTOMY IRRIGATION SET		1 PER ROLLING YEAR	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4402	LUBRICANT, PER OUNCE		4 OZ. PER ROLLING MONTH	
A4404	OSTOMY RING, EACH		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED, PASTE, PER OUNCE	K0561	4 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4406	OSTOMY SKIN BARRIER, PECTIN-BASED, PASTE, PER OUNCE	K0562	4 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4407	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	K0563	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4408	OSTOMY SKIN BARRIER, WTIH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, LARGER THAN 4 X 4 INCHES, EACH	K0564	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	K0565	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6

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A4410	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, ITHOUT BUILT-IN CONVEXITY, LARGER THAN 4 X 4 INCHES, EACH	K0566	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4411	OSTOMY SKIN BARRIER, SOLID 4 X 4 OR EQUIVALENT, EXTENDED WEAR, WITH BUILT-IN CONVEXITY, EACH		20 PER ROLLING MONTH	NEW CODE 01/01/2006
A4412	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FOR USE ON A BARRIER WITH FLANGE (2 PIECE SYSTEM), WITHOUT FILTER, EACH		20 PER ROLLING MONTH	NEW CODE 01/012006
A4413	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FOR USE ON A BARRIER WITH FLANGE (2 PIECE SYSTEM), WITH FILTER, EACH	K0569	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	K0570	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4415	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY, LARGER THAN 4X4 INCHES, EACH	K0571	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4416	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	K0581	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4417	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY, WITH FILTER (1 PIECE), EACH	K0582	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4418	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	K0583	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4419	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FILTER (2 PIECE), EACH	K0584	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4420	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH LOCKING FLANGE (2 PIECE), EACH	K0585	60 PER ROLLING MONTH	COST INVOICE REQUIRED REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, OR V55.3, V55.6
A4421	OSTOMY SUPPLY; MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6

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A4422	OSTOMY ABSORBENT MATERIAL (SHEET/PAD/CRYSTAL PACKET) FOR USE IN OSTOMY POUCH TO THICKEN LIQUID STOMAL OUTPUT, EACH		1 PER DAY	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4423	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FILTER (2 PIECE), EACH	K0586	60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4424	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	K0587	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4425	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH	K0588	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366
A4426	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH LOCKING FLANGE (2 PIECE SYSTEM), EACH	K0589	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4427	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH	K0590	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6 NON-REIMBURSABLE WITH A4366;
A4428	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0591	15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4429	OSTOMY POUCH, URINARY, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0592	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4430	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0593	15 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4431	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED, WITH FAUCET-TYPE TAP WITH VALVE (1 PIECE), EACH	K0594	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4432	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FAUCET-TYPE TAP WITH VALVE (2 PIECE), EACH	K0595	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4433	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH LOCKING FLANGE (2 PIECE), EACH	K0596	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4434	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FAUCET-TYPE TAP WITH VALVE (2 PIECE), EACH	K0597	20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES		40 UNITS PER ROLLING MONTH	

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A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES		40 UNITS PER ROLLING MONTH	
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE		16 OZ. PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES OF V44.2, V44.3, V44.6, V55.2, V55.3, OR V55.6
A4458	ENEMA BAG WITH TUBING, REUSABLE		NON-COVERED	
A4461	SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH	A4462	1 PER ROLLING YEARS	NEW CODE 01/01/2007
A4462	ABDOMINAL DRESSING HOLDER, EACH		1 PER ROLLING YEAR	CLOSED BY CMS 12/31/2006
A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH	A4462	1 PER ROLLING YEAR	NEW CODE 01/01/2007
A4465	NON-ELASTIC BINDER FOR EXTREMITY		NON-COVERED	
A4470	GRAVLEE JET WASHER		NON-COVERED	
A4480	VABRA ASPIRATOR		NON-COVERED	
A4481	TRACHEOSTOMA FILTER, ANY TYPE, ANY SIZE, EACH		31 PER ROLLING MONTH	
A4483	MOISTURE EXCHANGER, DISPOSABLE, FOR USE WITH INVASIVE MECHANICAL VENTILATION		NON-COVERED	
A4490	SURGICAL STOCKINGS ABOVE KNEE LENGTH, EACH		4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4495	SURGICAL STOCKINGS THIGH LENGTH, EACH		4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4500	SURGICAL STOCKINGS BELOW KNEE LENGTH, EACH		4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4510	SURGICAL STOCKINGS FULL LENGTH, EACH		2 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	A4521 THRU A4535	250 PER ROLLING MONTH	PRIOR AUTHORIZATION REQUIRED AVAILABLE ONLY FOR MEMBERS 3 YEARS OR OLDER. WHEN BILLING SINGLE INCONTINENT SUPPLIES (A4520 OR A4554) OR A COMBINATION OF THE TWO, THE TOTAL MAXIMUM IS 250 ITEMS PER MONTH. NO AUTHORIZATION WILL BE GIVEN OVER THIS MONTHLY ALLOWABLE.
A4550	SURGICAL TRAYS		NON-COVERED	

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A4554	DISPOSABLE UNDERPADS, ALL SIZES, (E.G., CHUX'S)		250 PER ROLLING MONTH	PRIOR AUTHORIZATION REQUIRED AVAILABLE ONLY FOR MEMBERS 3 YEARS OR OLDER. WHEN BILLING SINGLE INCONTINENT SUPPLIES (A4520 OR A4554) OR A COMBINATION OF THE TWO, THE TOTAL MAXIMUM IS 250 ITEMS PER MONTH. NO AUTHORIZATION WILL BE GIVEN OVER THIS MONTHLY ALLOWABLE.
A4556	ELECTRODES, (E.G., APNEA MONITOR), PER PAIR		15 PER ROLLING MONTH	COVERAGE LIMITED TO MAXIMUM AGE OF 12 MONTHS. NON-REIMBURSABLE WITH: E0720, E0730 SUPPLIES BUNDLED INTO A4595
A4557	LEAD WIRES, (E.G., APNEA MONITOR), PER PAIR		2 PER ROLLING MONTH	COVERAGE LIMITED TO MAXIMUM AGE OF 12 MONTHS. NON-REIMBURSABLE WITH: E0720, E0730 SUPPLIES BUNDLED INTO A4595
A4558	CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE (E.G.,TENS, NMES), PER OZ.		NON-COVERED	
A4561	PESSARY, RUBBER, ANY TYPE		1 PER LIFETIME	
A4562	PESSARY, NON RUBBER, ANY TYPE		1 PER LIFETIME	
A4565	SLINGS		1 PER LIFETIME	
A4570	SPLINT		2 PER 6 ROLLING MONTHS	
A4595	ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)		1 PER ROLLING MONTH FOR E0720 2 PER ROLLING MONTH FOR E0730	NON-REIMBURSABLE WITH: A4556, A4558 and A4630
A4601	LITHIUM ION BATTERY FOR NON-PROSTHETIC USE, REPLACEMENT	A4632	4 PER ROLLING YEAR	NEW CODE EFFECTIVE 0101/2007
A4604	TUBING WITH INTEGRATED HEARING ELEMENT FOR USE WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER ROLLING MONTH	NEW CODE 01/01/2006 NON-REIMBURSABLE WITH A7037, E0471 OR E0472
A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH	A4609 A4610	31 PER ROLLING MONTH	
A4606	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT		2 PER ROLLING MONTH	PRIOR AUTHORIZATION NON-REIMBURSABLE WITH E0445 WHEN UNIT IS UNDER CAP RENTAL
A4608	TRANSTRACHEAL OXYGEN CATHETER, EACH		NON-COVERED	
A4610	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, FOR 72 OR MORE HOURS OF USE, EACH		NON-COVERED	
A4611	BATTERY, HEAVY DUTY; REPLACEMENT FOR PATIENT OWNED VENTILATOR		NON-COVERED	
A4612	BATTERY CABLES; REPLACEMENT FOR PATIENT-OWNED VENTILATOR		NON-COVERED	

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A4613	BATTERY CHARGER; REPLACEMENT FOR PATIENT-OWNED VENTILATOR		NON-COVERED	
A4614	PEAK EXPIRATORY FLOW RATE METER, HAND HELD		1 PER LIFETIME	
A4615	CANNULA, NASAL		NON-COVERED	
A4616	TUBING (OXYGEN), PER FOOT		NON-COVERED	
A4617	MOUTH PIECE		NON-COVERED	
A4618	BREATHING CIRCUITS		NON-COVERED	
A4619	FACE TENT		1 PER ROLLING MONTH	PRIOR AUTHORIZATION REQUIRED REIMBURSABLE ONLY WITH: E0570
A4620	VARIABLE CONCENTRATION MASK		NON-COVERED	
A4623	TRACHEOSTOMY, INNER CANNULA		1 PER ROLLING MONTH	
A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED SYSTEM, EACH		90 PER ROLLING MONTH	NON-REIMBURSABLE WITH A 4628
A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTOMY		14 UNITS PER LIFETIME	NON-REIMBURSABLE WITH A4626 OR A4629
A4626	TRACHEOSTOMY CLEANING BRUSH, EACH		NON-COVERED	DISCONTINUED 04/01/2005
A4627	SPACER, BAG OR RESERVOIR, WITH OR WITHOUT MASK, FOR USE WITH METERED DOSE INHALER		1 PER LIFETIME	
A4628	OROPHARYNGEAL SUCTION CATHETER, EACH		90 PER ROLLING MONTH	
A4629	TRACHEOSTOMY CARE KIT FOR ESTABLISHED TRACHEOSTOMY		1 PER DAY	SERVICE REIMBURSABLE TWO WEEK POST SURGERY. NON-REIMBURSABLE WITH A4625 AND A4626
A4630	REPLACEMENT BATTERIES. MEDICALLY NECESSARY TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT		NON-COVERED	
A4632	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP, ANY TYPE, EACH		4 PER ROLLING YEAR	CLOSED BY CMS 12/31/2006
A4633	REPLACEMENT BULB/LAMP FOR ULTRAVIOLET LIGHT THERAPY SYSTEM, EACH		NON-COVERED	
A4634	REPLACEMENT BULB FOR THERAPEUTIC LIGHT BOX, TABLETOP MODEL		NON-COVERED	
A4635	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH E0110, E0111, E0112, E0113, E0114, OR E0116,
A4636	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH E0100, E0105, E0110, E0111, E0112, E0113, E0114, E0114, E0130, E0135, E0140, E0141, E0143, E0147, E0148, OR E0149

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A4637	REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH.		4 PER ROLLING YEAR	NON-REIMBURSABLE WITH E0100, E0105, E0110, E0111, E0112, E0113, E0114, E0114, E0130, E0135, E0140, E0141, E0143, E0147, E0148, OR E0149
A4638	REPLACEMENT BATTERY FOR PATIENT-OWNED EAR PULSE GENERATOR, EACH		NON-COVERED	
A4639	REPLACEMENT PAD FOR INFRARED HEATING PAD SYSTEM, EACH		NON-COVERED	
A4640	REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT			PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: E0180, E0181, OR E0182
A4649	SURGICAL SUPPLY; MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED
A4656	NEEDLE, ANY SIZE, EACH		NON-COVERED	
A4657	SYRINGE, WITH OR WITHOUT NEEDLE, EACH		NON-COVERED	
A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF AND STETHOSCOPE		NON-COVERED	
A4663	BLOOD PRESSURE CUFF ONLY		NON-COVERED	
A4670	AUTOMATIC BLOOD PRESSURE MONITOR		NON-COVERED	
A4927	GLOVES, NON-STERILE, PER 100		1 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: 042 OR 585
A4928	SURGICAL MASK, PER 20		NON-COVERED	
A4930	GLOVES, STERILE, PER PAIR		NON-COVERED	
A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EACH		NON-COVERED	
A4932	RECTAL THERMOMETER, REUSABLE, ANY TYPE, EACH		NON-COVERED	
A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTACHED (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED (1 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5053	OSTOMY POUCH, CLOSED; FOR USE ON FACEPLATE, EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5054	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH		60 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5055	STOMA CAP		31 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3

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A5061	OSTOMY POUCH, DRAINABLE; WITH BARRIER ATTACHED, (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3 NON-REIMBURSABLE WITH A5081, A6246
A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER ATTACHED (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, OR V55.3
A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH FLANGE (2 PIECE SYSTEM), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2 V44.3 OR V55.3
A5071	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A5072	OSTOMY POUCH, URINARY; WITHOUT BARRIER ATTACHED (1 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A5073	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.6 OR V55.6
A5081	CONTINENT DEVICE; PLUG FOR CONTINENT STOMA		31 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6 NON-REIMBURSABLE WITH A5055, A6216
A5082	CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA		1 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA		31 PER ROLLING MONTH	COST INVOICE REQUIRED NEW CODE 01/01/2008
A5093	OSTOMY ACCESSORY; CONVEX INSERT		10 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6
A5102	BEDSIDE DRAINAGE BOTTLE WITH OR WITHOUT TUBING, RIGID OR EXPANDABLE, EACH		2 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH A4357
A5105	URINARY SUSPENSORY **WITH LEG BAG**, WITH OR WITHOUT TUBE, **EACH**		1 PER ROLLING MONTH	NON-REIMBURSABLE WITH A4331, A4358, A4359, A5112, A5113, A5114
A5112	URINARY LEG BAG; LATEX		1 PER ROLLING MONTH	FOR MEMBERS WHO ARE AMBULATORY OR CHAIR OR WHEELCHAIR BOUND ONLY NONREIMBURSABLE WITH A4358, A5113, A5114
A5113	LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A5112, A5114
A5114	LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH A5112, A5113
A5119	SKIN BARRIER, WIPES OR SWABS, PER BOX 50		31 PER ROLLING MONTH	DISCONTINUED BY CMS 12/31/2005
A5120	SKIN BARRIER, WIPES OR SWABS, EACH	A5119	150 PER ROLLING MONTH	NEW CODE 01/01/2006
A5121	SKIN BARRIER; SOLID, 6 X 6 OR EQUIVALENT, EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3 OR V55.3
A5122	SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT, EACH		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3 OR V55.3

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A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD		20 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3 OR V55.3
A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTOMY APPLIANCES, PER 16 OZ.		1 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODES: V44.2, V55.2, V44.3, V55.3, V44.6 OR V55.6 ONLY USED WITH A5102 AND A5112
A5200	PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT		NON-COVERED	
A5500 - A5513	SHOES SUPPLIES FOR DIABETICS			REFER TO ORTHOTIC/PROSTHETIC MANUAL
A6000	NON-CONTACT WOUND WARMING WOUND COVER FOR USE WITH THE NON-CONTACT WOUND WARMING DEVICE AND WARMING CARD		NON-COVERED	
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, PER GRAM OF COLLAGEN		NON-COVERED	
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN		NON-COVERED	
A6021	COLLAGEN DRESSING, PAD SIZE 16 SQ. IN. OR LESS, EACH		NON-COVERED	
A6022	COLLAGEN DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH		NON-COVERED	
A6023	COLLAGEN DRESSING, PAD SIZE MORE THAN 48 SQ. IN., EACH		NON-COVERED	
A6024	COLLAGEN DRESSING WOUND FILLER, PER 6 INCHES		NON-COVERED	
A6025	GEL SHEET FOR DERMAL OR EPIDERMAL APPLICATION, (E.G., SILICONE, HYDROGEL, OTHER), EACH		NON-COVERED	
A6154	WOUND POUCH, EACH		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6197	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, PER 6 INCHES		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6204	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6205	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS, EACH DRESSING		5 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6207	CONTACT LAYER, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		5 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6208	CONTACT LAYER, MORE THAN 48 SQ. IN., EACH DRESSING		5 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6209	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6210	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6211	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6212	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6213	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6214	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6215	FOAM DRESSING, WOUND FILLER, PER GRAM		31 PER ROLLING MONTH	PRIOR AUTHORIZATION COST INVOICE REQUIRED REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6216	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	NON-REIMBURSABLE WITH: A5055, A5081
A6217	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6218	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		60 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		60 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6221	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		60 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6222	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6223	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 16 SQUARE INCHES, BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6224	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 48 SQUARE INCHES, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6228	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		NON-COVERED	
A6229	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAT 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6230	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		NON-COVERED	
A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING		12 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6232	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE GREATER THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		12 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6233	GAUZE, IMPREGNATED, HYDROGEL FOR DIRECT WOUND CONTACT, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING		12 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6234	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6235	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6236	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6237	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6238	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6239	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, PER FLUID OUNCE		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, PER GRAM		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6242	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6243	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6244	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6245	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6246	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6247	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE		15 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6250	SKIN SEALANTS, PROTECTANTS, MOISTURIZERS, OINTMENTS, ANY TYPE, ANY SIZE	Z7047	1 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING		31 PER ROLLING MONTH	REIMBURSED FOR STAGE III AND IV PRESSURE ULCERS ONLY WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.

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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6257	TRANSPARENT FILM, 16 SQ. IN. OR LESS, EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6258	TRANSPARENT FILM, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN., EACH DRESSING		15 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6260	WOUND CLEANSERS, ANY TYPE, ANY SIZE		1 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6261	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT ELSEWHERE CLASSIFIED		31 PER ROLLING MONTH	PRIOR AUTHORIZATION COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6262	WOUND FILLER, DRY FORM, PER GRAM, NOT ELSEWHERE CLASSIFIED		31 PER ROLLING MONTH	PRIOR AUTHORIZATION COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. .
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, ANY WIDTH, PER LINEAR YARD		31 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6404	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6407	PACKING STRIPS, NON-IMPREGNATED, UP TO 2 INCHES IN WIDTH, PER LINEAR YARD		90 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6410	EYE PAD, STERILE, EACH		NON-COVERED	
A6411	EYE PAD, NON-STERILE, EACH		NON-COVERED	
A6412	EYE PATCH, OCCLUSIVE, EACH		NON-COVERED	
A6413	ADHESIVE BANDAGE, FIRST-AID TYPE, ANY SIZE, EACH		NON-COVERED	NEW CODE 01/01/2008
A6441	PADDING BANDAGE, NON-ELASTIC, NON-WOVEN/NON-KNITTED, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6421	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6442	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6443	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6422	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6444	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, NON-STERILE, WIDTH GREATER THAN OR EQUAL TO 5 INCHES, PER YARD	A6424	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6445	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6446	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6426	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6447	CONFORMING BANDAGE, NON-ELASTIC, KNITTED/WOVEN, STERILE, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	A6428	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6448	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6449	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6430	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6450	LIGHT COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD	A6432	4 PER ROLLING MONTH	COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6451	MODERATE COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, LOAD RESISTANCE OF 1.25 TO 1.34 FOOT POUNDS AT 50% MAXIMUM STRETCH, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6434	4 PER ROLLING MONTH	COST INVOICE REQUIRED WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6452	HIGH COMPRESSION BANDAGE, ELASTIC, KNITTED/WOVEN, LOAD RESISTANCE GREATER THAN OR EQUAL TO 1.35 FOOT POUNDS AT 50% MAXIMUM STRETCH, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6436	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH LESS THAN THREE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6438	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NON-WOVEN, WIDTH GREATER THAN OR EQUAL TO FIVE INCHES, PER YARD		4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6456	ZINC PASTE IMPREGNATED BANDAGE, NON-ELASTIC, KNITTED/WOVEN, WIDTH GREATER THAN OR EQUAL TO THREE INCHES AND LESS THAN FIVE INCHES, PER YARD	A6440	4 PER ROLLING MONTH	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
A6457	TUBULAR DRESSING WITH OR WITHOUT ELASTIC, ANY WIDTH, PER LINEAR YARD	K0620	NON-COVERED	
A6501	COMPRESSION BURN GARMENT, BODYSUIT (HEAD TO FOOT), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6502	COMPRESSION BURN GARMENT, CHIN STRAP, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6503	COMPRESSION BURN GARMENT, FACIAL HOOD, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6504	COMPRESSION BURN GARMENT, GLOVE TO WRIST, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6505	COMPRESSION BURN GARMENT, GLOVE TO ELBOW, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6506	COMPRESSION BURN GARMENT, GLOVE TO AXILLA, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6507	COMPRESSION BURN GARMENT, FOOT TO KNEE LENGTH, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6508	COMPRESSION BURN GARMENT, FOOT TO THIGH LENGTH, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6509	COMPRESSION BURN GARMENT, UPPER TRUNK TO WAIST INCLUDING ARM OPENINGS (VEST), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6510	COMPRESSION BURN GARMENT, TRUNK, INCLUDING ARMS DOWN TO LEG OPENINGS (LEOTARD), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6511	COMPRESSION BURN GARMENT, LOWER TRUNK INCLUDING LEG OPENINGS (PANTY), CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6512	COMPRESSION BURN GARMENT, NOT OTHERWISE CLASSIFIED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6513	COMPRESSION BURN MASK, FACE AND/OR NECK, PLASTIC OR EQUAL, CUSTOM FABRICATED	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6530	GRADIENT COMPRESSION STOCKING, BELOW KNEE, 18-30 MMHG, EACH	L8100	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6531	GRADIENT COMPRESSIN STOCKING, BELOW KNEE, 30-40 MMHG, EACH	L8110	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6532	GRADIEN COMPRESSION STOCKING, BELOW KNEE, 40-50 MMHG, EACH	L8120	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6533	GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 18-30 MMHG, EACH	L8130	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6534	GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 30-40 MMHG, EACH	L8140	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6535	GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 30-40 MMHG EACH	L8150	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6536	GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 18-30 MMHG, EACH	L8160	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6537	GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 30-40 MMHG, EACH	L8170	4 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6538	GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 40-50 MMHG, EACH	L8180	4 PER 6 ROLLING MONTHS	COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6539	GRADIENT COMPRESSION STOCKING, WAIST LENGTH, 18-30 MMHG, EACH	L8190	2 PER 6 ROLLING MONTHS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6540	GRADIENT COMPRESSION STOCKING, WAIST LENGTH, 30-40 MMHG, EACH	L8195	2 PER 6 ROLLING MONTHS	COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6541	GRADIENT COMPRESSION STOCKING, WAIST LENGTH, 40-50 MMHG, EACH	L8200	2 PER 6 ROLLING MONTHS	COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6542	GRADIENT COMPRESSION STOCKING, CUSTOM MADE	L8210		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6543	GRADIENT COMPRESSION STOCKING, LYMPHEDEMA	L8220		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6544	GRADIENT COMPRESSION STOCKING, GARTER BELT	L8230	2 PER 2 ROLLING YEARS	REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS
A6549	GRADIENT COMPRESSION STOCKING, NOT OTHERWISE SPECIFIED	L8239		COST INVOICE REQUIRED REQUIRES FITTER'S CERTIFICATION BY THE AMERICAN BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS OR BOARD FOR CERTIFICATION OF ORTHOTICS & PROSTHETICS

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A6550	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES	K0539	15 KITS PER ROLLING MONTH PER WOUND	PRIOR AUTHORIZATION
A6551	CANISTER SET FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE, EACH	K0540	10 PER ROLLING MONTH	DISCONTINUED BY CMS 12/31/2005
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP, EACH		1 PER ROLLING MONTH	
A7001	CANISTER, NON-DISPOSABLE, USED WITH SUCTION PUMP, EACH		NON-COVERED	
A7002	TUBING, USED WITH SUCTION PUMP, EACH	A4616	1 UNIT PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0600 INCLUDED IN INITIAL DISPENSING OF EQUIPMENT
A7003	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	A4618	2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: A7004, A7005, OR A7006
A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, DISPOSABLE	A4618	2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: A7003, A7005 OR A7006
A7005	ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER, NON-DISPOSABLE	A4618	1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: A7003, A7004 OR A7006
A7006	ADMINISTRATION SET, WITH SMALL VOLUME FILTERED PNEUMATIC NEBULIZER	A4618	1 PER ROLLING MONTH	NON- REIMBURSABLE WITH: A7003, A7004, OR A7005
A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFILLED, USED WITH AEROSOL COMPRESSOR		NON-COVERED	
A7008	LARGE VOLUME NEBULIZER, DISPOSABLE, PREFILLED, USED WITH AEROSOL COMPRESSOR		NON-COVERED	
A7009	RESERVOIR BOTTLE, NON-DISPOSABLE, USED WITH LARGE VOLUME ULTRASONIC NEBULIZER		NON-COVERED	
A7010	CORRUGATED TUBING, DISPOSABLE, USED WITH LARGE VOLUME NEBULIZER, 100 FEET		NON-COVERED	
A7011	CORRUGATED TUBING, NON-DISPOSABLE, USED WITH LARGE VOLUME NEBULIZER, 10 FEET		NON-COVERED	
A7012	WATER COLLECTION DEVICE, USED WITH LARGE VOLUME NEBULIZER		NON-COVERED	
A7013	FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR		1 PER ROLLING MONTH	
A7014	FILTER, NONDISPOSABLE, USED WITH AEROSOL COMPRESSOR OR ULTRASONIC GENERATOR		NON-COVERED	
A7015	AEROSOL MASK, USED WITH DME NEBULIZER		2 PER ROLLING MONTH	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7016	DOME AND MOUTHPIECE, USED WITH SMALL VOLUME ULTRASONIC NEBULIZER		NON-COVERED	
A7017	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, NOT USED WITH OXYGEN		NON-COVERED	
A7018	WATER, DISTILLED, USED WITH LARGE VOLUME NEBULIZER, 1000 ML		NON-COVERED	
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH		NON-COVERED	
A7026	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH		NON-COVERED	
A7027	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSTIVE AIRWAY PRESSURE	K0553	NON-C0VERED	NEW CODE 01/01/2008
A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH	K0554	NON-COVERED	NEW CODE 01/01/2008
A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK,REPLACEMENT ONLY, PAIR	K0555	N0N-COVERED	NEW CODE 01/01/2008
A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7031	FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7032	CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRIGNIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP		1 PER 3 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7036	CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7037	TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7038	FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE		2 PER ROLLING MONTH	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7039	FILTER, NON DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE		1 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7040	ONE WAY CHEST DRAIN VALVE		NON-COVERED	
A7041	WATER SEAL DRAINAGE CONTAINER AND TUBING FOR USE WITH IMPLANTED CHEST TUBE		NON-COVERED	
A7042	IMPLANTED PLEURAL CATHETER, EACH		NON-COVERED	
A7043	VACUUM DRAINAGE BOTTLE AND TUBING FOR USE WITH IMPLANTED CATHETER		NON-COVERED	
A7044	ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH		NON-COVERED	
A7045	EXHALATION PORT WITH OR WITHOUT SWIVEL USED WITH ACCESSORIES FOR POSITIVE AIRWAY DEVICES, REPLACEMENT ONLY		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH: E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7046	WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH		2 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH: E0471, E0472, E0561, OR E0562 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
A7501	TRACHEOSTOMA VALVE, INCLUDING DIAPHRAGM, EACH		NON-COVERED	
A7502	REPLACEMENT DIAPHRAGM/FACEPLATE FOR TRACHEOSTOMA VALVE, EACH		NON-COVERED	
A7503	FILTER HOLDER OR FILTER CAP, REUSABLE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		NON-COVERED	
A7504	FILTER FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		NON-COVERED	
A7505	HOUSING, REUSABLE WITHOUT ADHESIVE, FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE, EACH		NON-COVERED	
A7506	ADHESIVE DISC FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH TRACHEOSTOMA VALVE, ANY TYPE EACH		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
A7507	FILTER HOLDER AND INTEGRATED FILTER WITHOUT ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		31 PER ROLLING MONTH	
A7508	HOUSING AND INTEGRATED ADHESIVE, FOR USE IN A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM AND/OR WITH A TRACHEOSTOMA VALVE, EACH		31 PER ROLLING MONTH	
A7509	FILTER HOLDER AND INTEGRATED FILTER HOUSING, AND ADHESIVE, FOR USE AS A TRACHEOSTOMA HEAT AND MOISTURE EXCHANGE SYSTEM, EACH		31 PER ROLLING MONTH	
A7520	TRACHEOSTOMY/LARYNGECTOMY TUBE, NON-CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH	A4622	4 PER ROLLING MONTH	
A7521	TRACHEOSTOMY/LARYNGECTOMY TUBE, CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH	A4622	4 PER ROLLING MONTH	
A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLESS STEEL OR EQUAL (STERILIZABLE AND REUSABLE), EACH	A4622	4 PER ROLLING MONTH	
A7523	TRACHEOSTOMY SHOWER PROTECTOR, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED
A7524	TRACHEOSTOMA STENT/STUD/BUTTON, EACH			PRIOR AUTHORIZATION
A7525	TRACHEOSTOMY MASK, EACH	A4621	4 PER ROLLING MONTH	
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER, EACH	A4621 S8181	4 PER ROLLING MONTH	
A7527	TRACHEOSTOMY/LARYNGECTOMY TUBE PLUG/STOP, EACH		2 PER ROLLING MONTH	
A9282	WIG, ANY TYPE, EACH		NON-COVERED	
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE **FED**, PER DAY		1 PER DAY	
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY		1 PER DAY	
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY		1 PER DAY	
B4081	NASOGASTRIC TUBING WITH STYLET		4 PER ROLLING MONTH	
B4082	NASOGASTRIC TUBING WITHOUT STYLET		4 PER ROLLING MONTH	
B4083	STOMACH TUBE - LEVINE TYPE		4 PER ROLLING MONTH	

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
B4086	GASTROSTOMY / JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, (STANDARD OR LOW PROFILE), EACH		2 PER 6 ROLLING MONTHS	NON-REIMBURSABLE WITH B9998 DISCONTINUED BY CMS 12/31/2007
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL ANY TYPE, EACH	B4086 B9998	2 PER 6 ROLLING MONTHS	NEW CODE 01/01/2008
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH	B4086 B9998	2 PER 6 ROLLING MONTHS	NEW CODE 01/01/2008
B4100	FOOD THICKENER, ADMINISTERED ORALLY, PER OUNCE		NON-COVERED	
B4102	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT		NON-COVERED	
B4103	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT		NON-COVERED	
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)		NON-COVERED	
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4150	ENTERAL FORMULA, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4152	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, CALORICALLY DENSE (EQUAL TO OR GREATER THAN 1.5 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G. GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G. GLUTAMINE, ARGININE), FAT (E.G. MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATION, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4158	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4159	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT		NON-COVERED	
B4164	PARENTERAL NUTRITION SOLUTION: CARBOHYDRATES (DEXTROSE), 50% OR LESS (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4168	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 3.5%, (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4172	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 5.5% THROUGH 7%, (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4176	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 7% THROUGH 8.5%, (500 ML = 1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4178	PARENTERAL NUTRITION SOLUTION: AMINO ACID, GREATER THAN 8.5% (500 ML = 1 UNIT) HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4180	PARENTERAL NUTRITION SOLUTION; CARBOHYDRATES (DEXTROSE), GREATER THAN 50% (500 ML=1 UNIT) - HOMEMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4184	PARENTERAL NUTRITION SOLUTION; LIPIDS, 10% WITH ADMINISTRATION SET (500 ML = 1UNIT)			DISCONTINUED BY CMS 12/31/2005
B4185	PARENTAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS	B4185 B4186	1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4186	PARENTERAL NUTRITION SOLUTION, LIPIDS, 20% WITH ADMINISTRATION SET (500 ML = 1UNIT)			DISCONTINUED BY CMS 12/31/2005
B4189	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 10 TO 51 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE

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B4193	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 52 TO 73 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4197	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 74 TO 100 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4199	PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, OVER 100 GRAMS OF PROTEIN - PREMIX		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4216	PARENTERAL NUTRITION; ADDITIVES (VITAMINS, TRACE ELEMENTS, HEPARIN, ELECTROLYTES) HOMEMIX PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4222	PARENTERAL NUTRITION SUPPLY KIT; HOME MIX, PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY		1 PER DAY	WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B5000	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, RENAL - AMIROSYN RF, NEPHRAMINE, RENAMINE - PREMIX			WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
B5100	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, HEPATIC - FREAMINE HBC, HEPATAMINE - PREMIX			WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B5200	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, STRESS - BRANCH CHAIN AMINO ACIDS - PREMIX			WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B9000	ENTERAL NUTRITION INFUSION PUMP - WITHOUT ALARM		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL

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B9002	ENTERAL NUTRITION INFUSION PUMP - WITH ALARM		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL
B9004	PARENTERAL NUTRITION INFUSION PUMP, PORTABLE		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B9006	PARENTERAL NUTRITION INFUSION PUMP, STATIONARY		1UNIT PER LIFETIME	ITEM IS 10 MONTH CAP RENTAL WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
B9998	NOC FOR ENTERAL SUPPLIES			PRIOR AUTHORIZATION COST INVOICE REQUIRED
B9999	NOC FOR PARENTERAL SUPPLIES			PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0100	CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4636, A4637OR E0105
E0105	CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4636, A4637 OR E0100
E0110	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WITH TIPS AND HANDGRIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0111, E112, E0113, E0114, 0R E0116
E0111	CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HANDGRIPS		2 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E112, E0113, E0114, 0R E0116
E0112	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0113, E0114, 0R E0116
E0113	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP		2 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0112, E0114, 0R E0116

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E0114	CRUTCHES UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS		1 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0112, E0113, 0R E0116
E0116	CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP HANDGRIP, WITH OR WITHOUT SHOCK ABSORBER, EACH		2 PER 2 ROLLING YEARS	ITEM IS PURCHASED WHEN PRESCRIBED BY A PRACTITIONER FOR A MEMBER WITH A CONDITION CAUSING IMPAIRED AMBULATION AND THERE IS A POTENTIAL FOR AMBULATION NON-REIMBURSABLE WITH A4635, A4636, A4637 E0110, E111, E0112, E0113, 0R E0114
E0117	CRUTCH, UNDERARM, ARTICULATING, SPRING ASSISTED, EACH		NON-COVERED	
E0118	CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS, EACH		NON-COVERED	
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636 or A4637
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636 or A4637
E0140	WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE		1 PER 3 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: A4636, A4637, E0155 or E0159
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: A4636, A4637, E0155 or E0159
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT		1 PER 3 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: A4636, A4637, E0155 or E0159
E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT		NON-COVERED	
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE		1 PER 3 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636, E0155 OR E0159
E0148	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636 OR A4637
E0149	WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: A4636, A4637, E0155 OR E0159
E0153	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH		2 PER 3 ROLLING YEARS	PURCHASE ITEM

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E0154	PLATFORM ATTACHMENT, WALKER, EACH		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: E0141, E0143, E0147, or E0149
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0156	SEAT ATTACHMENT, WALKER		1 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0157	CRUTCH ATTACHMENT, WALKER, EACH		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0158	LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4)		2 PER 3 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C MEDICAL CRITERIA FOR COVERAGE. NON-REIMBURSABLE WITH: E0141, E0143, E0147, or E0149
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH		1 PER ROLLING YEAR	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0160	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMODE		1 PER 2 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0161	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMODE, WITH FAUCET ATTACHMENT/S		1 PER 2 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0162	SITZ BATH CHAIR		1 PER 2 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH: E0167
E0163	COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS		1 PER 5 ROLLING YEARS	ITEM PURCHASED FOR MEMBER WEIGHING 300 LBS OR LESS WHEN PHYSICALLY INCAPABLE OF UTILIZING TOILET FACILITIES; I.E., CONFINED TO A SINGLE ROOM, OR CONFINED TO ONE LEVEL OF THE HOME WITHOUT TOILET FACILITIES, OR CONFINED TO THE HOME WITHOUT TOILET FACILITIES. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. NON-REIMBURSABLE WITH: E0165, E0167 or E0168
E0164	COMMODE CHAIR, MOBILE, WITH FIXED ARMS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0165	COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS		1 PER 5 ROLLING YEARS	ITEM PURCHASED FOR MEMBER WEIGHING 300 LBS OR LESS WHEN PHYSICALLY INCAPABLE OF UTILIZING TOILET FACILITIES.; I.E., CONFINED TO A SINGLE ROOM, OR CONFINED TO ONE LEVEL OF THE HOME WITHOUT TOILET FACILITIES, OR CONFINED TO THE HOME WITHOUT TOILET FACILITIES AND IF THE DETACHABLE ARM FEATURE IS NECESSARY TO FACILITY TRANSFERRING THE MEMBER OR HAS A BODY CONFIGURATION THAT REQUIRES EXTRA WIDTH. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. NON-REIMBURSABLE WITH: E0163, E0164, E0167 or E0168
E0166	COMMODE CHAIR, MOBILE, WITH DETACHABLE ARMS		NON-COVERED	
E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY		1 PER ROLLING YEAR	NON-REIMBURSABLE WITH: E0163, E0164, E0165 or E0168
E0168	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE, EACH		1 PER 5 ROLLING YEARS	ITEM PURCHASED FOR MEMBER WEIGHING 300 LBS OR MORE WHEN PHYSICALLY INCAPABLE OF UTILIZING TOILET FACILITIES; I.E., CONFINED TO A SINGLE ROOM, OR CONFINED TO ONE LEVEL OF THE HOME WITHOUT TOILET FACILITIES, OR CONFINED TO THE HOME WITHOUT TOILET FACILITIES. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. MEMBER'S FILE MUST CONTAIN THE ABOVE DOCUMENTATION INCLUDING WEIGHT. NON-REIMBURSABLE WITH: E0163, E0165 or E0167
E0169	COMMODE CHAIR WITH SEAT LIFT MECHANISM		NON-COVERED	
E0170	COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, ELECTRIC, ANY TYPE		NON-COVERED	
E0171	COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, NON-ELECTRIC, ANY TYPE	E0169	NON-COVERED	
E0172	SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET, ANY TYPE	E0169	NON-COVERED	
E0175	FOOT REST, FOR USE WITH COMMODE CHAIR, EACH		NON-COVERED	
E0180	PRESSURE PAD, ALTERNATING WITH PUMP		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: A4640 OR E0182 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY CMS 12/31/2006
E0181	POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: A4640 OR E0182 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

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E0182	PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS PURCHASED NON-REIMBURSABLE WITH: A4640, E0180, OR E0181 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0184	DRY PRESSURE MATTRESS		1 PER ROLLING YEAR	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0185	GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0186	AIR PRESSURE MATTRESS		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0187	WATER PRESSURE MATTRESS		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A4640, E0180, OR E0181 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0188	SYNTHETIC SHEEPSKIN PAD		2 PER 6 ROLLING MONTHS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0189	LAMBSWOOL SHEEPSKIN PAD, ANY SIZE		2 PER 2 ROLLING YEARS	PURCHASED ITEM WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORES	E0943	1 PER ROLLING YEAR	PURCHASED ITEM
E0191	HEEL OR ELBOW PROTECTOR, EACH		4 PER 6 ROLLING MONTHS	PURCHASED ITEM
E0192	LOW PRESSURE AND POSITIONING EQUALIZATION PAD, FOR WHEELCHAIR		NON-COVERED	
E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)		NON-COVERED	
E0194	AIR FLUIDIZED BED		NON-COVERED	
E0196	GEL PRESSURE MATTRESS		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0198	WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0199	DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0200	HEAT LAMP, WITHOUT STAND (TABLE MODEL), INCLUDES BULB, OR INFRARED ELEMENT		NON-COVERED	
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER		5 DAYS PER LIFETIME	REQUIRES ICD9-CM DIAGNOSIS CODES: 774.0-774.7 COVERAGE LIMITED FROM BIRTH TO 30 DAYS OF AGE
E0203	THERAPEUTIC LIGHTBOX, MINIMUM 10,000 LUX, TABLE TOP MODEL		NON-COVERED	
E0205	HEAT LAMP, WITH STAND, INCLUDES BULB, OR INFRARED ELEMENT		NON-COVERED	
E0210	ELECTRIC HEAT PAD, STANDARD		NON-COVERED	
E0215	ELECTRIC HEAT PAD, MOIST		NON-COVERED	
E0217	WATER CIRCULATING HEAT PAD WITH PUMP		NON-COVERED	
E0218	WATER CIRCULATING COLD PAD WITH PUMP		NON-COVERED	
E0220	HOT WATER BOTTLE		NON-COVERED	
E0221	INFRARED HEATING PAD SYSTEM		NON-COVERED	
E0225	HYDROCOLLATOR UNIT, INCLUDES PADS		NON-COVERED	
E0230	ICE CAP OR COLLAR		NON-COVERED	
E0231	NON-CONTACT WOUND WARMING DEVICE (TEMPERATURE CONTROL UNIT, AC ADAPTER AND POWER CORD) FOR USE WITH WARMING CARD AND WOUND COVER		NON-COVERED	
E0232	WARMING CARD FOR USE WITH THE NON CONTACT WOUND WARMING DEVICE AND NON CONTACT WOUND WARMING WOUND COVER		NON-COVERED	
E0235	PARAFFIN BATH UNIT, PORTABLE (SEE MEDICAL SUPPLY CODE A4265 FOR PARAFFIN)		NON-COVERED	

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E0236	PUMP FOR WATER CIRCULATING PAD		NON-COVERED	
E0238	NON-ELECTRIC HEAT PAD, MOIST		NON-COVERED	
E0239	HYDROCOLLATOR UNIT, PORTABLE		NON-COVERED	
E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE	E1399		PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0241	BATH TUB WALL RAIL, EACH		1 PER 2 ROLLING YEARS	
E0242	BATH TUB RAIL, FLOOR BASE		NON-COVERED	
E0243	TOILET RAIL, EACH		2 PER 2 ROLLING YEARS	
E0244	RAISED TOILET SEAT		1 PER 2 ROLLING YEARS	
E0245	TUB STOOL OR BENCH		1 PER 2 ROLLING YEARS	
E0246	TRANSFER TUB RAIL ATTACHMENT		NON-COVERED	
E0247	TRANSFER BENCH FOR TUB OR TOILET WITH OR WITHOUT COMMODE OPENING	E1399		PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0248	TRANSFER BENCH, HEAVY DUTY, FOR TUB OR TOILET WITH OR WITHOUT COMMODE OPENING	E1399		PRIOR AUTHORIZATION COST INVOICE REQUIRED
E0249	PAD FOR WATER CIRCULATING HEAT UNIT		NON-COVERED	
E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0255, E0260, E0271, E0272, E0277 E0303, E0304, E0305, OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0260, E0271, E0272, E0277 E0303, E0304, E0305, OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	

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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0260	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0255, E0271, E0272, E0277 E0303, E0304, E0305, OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0261	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0265	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0266	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0270	HOSPITAL BED, INSTITUTIONAL TYPE INCLUDES: OSCILLATING, CIRCULATING AND STRYKER FRAME, WITH MATTRESS		NON-COVERED	
E0271	MATTRESS, INNERSPRING			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH E0250, E0255, E0260, E0277, E0300, E0303, OR E0304
E0272	MATTRESS, FOAM RUBBER			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH E0250, E0255, E0260, E0300, E0303, OR E0304
E0273	BED BOARD		NON-COVERED	
E0274	OVER-BED TABLE		NON-COVERED	
E0275	BED PAN, STANDARD, METAL OR PLASTIC		1 PER 2 ROLLING YEARS	PURCHASED ITEM
E0276	BED PAN, FRACTURE, METAL OR PLASTIC		1 PER 2 ROLLING YEARS	PURCHASED ITEM
E0277	POWERED PRESSURE-REDUCING AIR MATTRESS		1UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0280	BED CRADLE, ANY TYPE		NON-COVERED	
E0290	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0291	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS). WITHOUT SIDE RAILS, WITH MATTRESS		NON-COVERED	
E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0300	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED	E1399	1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL COVERED FOR MEMBERS FROM BIRTH TO AGE 21 YEARS NON-REIMBURSABLE WITH: E0250, E0255, E0260
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS		NON-COVERED	
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	K0549	1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0271, E0272, E0277, E0305 or E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	K0550	1 UNIT PER LIFETIME	PRIOR AUTHRIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0255, E0260, E0271, E0272, E0303, E0304, E0305 OR E0310 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0305	BED SIDE RAILS, HALF LENGTH		2 PER LIFETIME	NON-REIMBURSABLE WITH E0250, E0255, E0260, E0277, E0300, E0303, or E0304
E0310	BED SIDE RAILS, FULL LENGTH		2 PER LIFETIME	NON-REIMBURSABLE WITH E0250, E0255, E0260, E0277, E0300, E0303, or E0304
E0315	BED ACCESSORY: BOARD, TABLE, OR SUPPORT DEVICE, ANY TYPE		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE		NON-COVERED	
E0325	URINAL; MALE, JUG-TYPE, ANY MATERIAL		2 PER 6 ROLLING MONTHS	FOR MALES ONLY
E0326	URINAL; FEMALE, JUG-TYPE, ANY MATERIAL		2 PER 6 ROLLING MONTHS	FOR FEMALES ONLY
E0328	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD, AND SIDE RAILS UP TO 24 IN. ABOVE THE SPRING, INCLUDES MATTRESS		NON-COVERED	NEW CODE 01/01/2008
E0329	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD, AND SIDE REAILS UP TO 24 IN. ABOVE THE SRPING, INCLUDES MATTRESS		NON-COVERED	NEW CODE 01/01/2008
E0350	CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/EVACUATION SYSTEM		NON-COVERED	
E0352	DISPOSABLE PACK (WATER RESERVOIR BAG, SPECULUM, VALVING MECHANISM AND COLLECTION BAG/BOX) FOR USE WITH THE ELECTRONIC BOWEL IRRIGATION/EVACUATION SYSTEM		NON-COVERED	
E0370	AIR PRESSURE ELEVATOR FOR HEEL		NON-COVERED	
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0250, E0255, E0260, E0303, OR E0304 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH		NON-COVERED	
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS		NON-COVERED	
E0424	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0425	STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING		NON-COVERED	
E0430	PORTABLE GASEOUS OXYGEN SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING		NON-COVERED	

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E0431	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0435	PORTABLE LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOWMETER, HUMIDIFIER, CONTENTS GAUGE, CANNULA OR MASK, TUBING AND REFILL ADAPTOR		NON-COVERED	
E0439	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0440	STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING		NON-COVERED	
E0441	OXYGEN CONTENTS, GASEOUS (FOR USE WITH OWNED GASEOUS STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1 UNIT		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0442	OXYGEN CONTENTS, LIQUID (FOR USE WITH OWNED LIQUID STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE LIQUID SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1 UNIT		NON-COVERED	
E0443	PORTABLE OXYGEN CONTENTS, GASEOUS (FOR USE ONLY WITH PORTABLE GASEOUS SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0444	PORTABLE OXYGEN CONTENTS, LIQUID (FOR USE ONLY WITH PORTABLE LIQUID SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT		NON-COVERED	

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E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH A4606 DURING THE CAP RENTAL PERIOD (10 MONTHS) MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0450	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0455	OXYGEN TENT, EXCLUDING CROUP OR PEDIATRIC TENTS		NON-COVERED	
E0457	CHEST SHELL (CUIRASS)		NON-COVERED	
E0459	CHEST WRAP		NON-COVERED	
E0460RR	NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY		1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0461	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)		NON-COVERED	
E0462	ROCKING BED WITH OR WITHOUT SIDE RAILS		NON-COVERED	
E0463RR	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G. TRACHEOSTOMY TUBE)	E0454	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0464RR	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)	E0454	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION ITEM IS MONTHLY RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E0470RR	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	K0532	10 UNITS PER LIFETIME	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

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E0471RR	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	K0533	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0472RR	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	K0534	1 UNIT PER ROLLING MONTH	PRIOR AUTHORIZATION MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES		NON-COVERED	
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA EFFECTIVE 12/01/2007
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VEST), EACH		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0484	OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH		1 PER ROLLING YEAR	PRIOR AUTHORIZATION MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT		NON-COVERED	
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR ON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT		NON-COVERED	
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION; MANUAL OR AUTOMATIC VALVES; INTERNAL OR EXTERNAL POWER SOURCE		NON-COVERED	
E0550	HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIVERY		NON-COVERED	
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER		NON-COVERED	

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E0560	HUMIDIFIER, DURABLE FOR SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENT OR OXYGEN DELIVERY		NON-COVERED	
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	K0268		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A7046, E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR REGISTERED PROFESSIONAL NURSE OR PHYSICIAN ON STAFF
E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	K0531		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A7046, E0471 OR E0472 MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR REGISTERED PROFESSIONAL NURSE OR PHYSICIAN ON STAFF
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF- CONTAINED OR CYLINDER DRIVEN		1 UNIT PER 3 ROLLING YEARS	PRIOR AUTHORIZATION ITEM 10 MONTH CAP RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR REGISTERED PROFESSIONAL NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0570	NEBULIZER, WITH COMPRESSOR		1 PER 3 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0571	AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER		NON-COVERED	
E0572	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE		NON-COVERED	
E0574	ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER		NON-COVERED	
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME		NON-COVERED	
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER		NON-COVERED	
E0585	NEBULIZER, WITH COMPRESSOR AND HEATER		NON-COVERED	
E0590	DISPENSING FEE COVERED DRUG ADMINISTERED THROUGH DME NEBULIZER		NON-COVERED	
E0600	RESPIRATORY SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC		1 PER 4 ROLLING YEARS	PURCHASED ITEM NON-REIMBURSABLE WITH A7002

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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE		10 UNITS PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0602	BREAST PUMP, MANUAL, ANY TYPE		1 UNIT PER 5 ROLLING YEARS	PURCHASED ITEM
E0603	BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE		1 UNIT PER ROLLING YEAR	PURCHASE ITEM INCLUDES ALL REQUIRED ACCESSORIES
E0604	BREAST PUMP, HOSPITAL GRADE, ELECTRIC (AC AND / OR DC)		NON-COVERED	
E0605	VAPORIZER, ROOM TYPE		1 PER 2 ROLLING YEARS	PURCHASED ITEM
E0606	POSTURAL DRAINAGE BOARD		1 PER LIFETIME	PURCHASE ITEM
E0607	HOME BLOOD GLUCOSE MONITOR		1 PER 3 ROLLING YEARS	REQUIRES DIAGNOSIS OF 250.00 THRU 250.93 OR 648.8X
E0610	PACEMAKER MONITOR, SELF-CONTAINED, (CHECKS BATTERY DEPLETION, INCLUDES AUDIBLE AND VISIBLE CHECK SYSTEMS)		NON-COVERED	
E0615	PACEMAKER MONITOR, SELF CONTAINED, CHECKS BATTERY DEPLETION AND OTHER PACEMAKER COMPONENTS, INCLUDES DIGITAL/VISIBLE CHECK SYSTEMS		NON-COVERED	
E0616	IMPLANTABLE CARDIAC EVENT RECORDER WITH MEMORY, ACTIVATOR AND PROGRAMMER		NON-COVERED	
E0617	EXTERNAL DEFIBRILLATOR WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS		NON-COVERED	
E0618	APNEA MONITOR, WITHOUT RECORDING FEATURE	E0608	NON-COVERED	
E0619	APNEA MONITOR, WITH RECORDING FEATURE	E0608	1 PER LIFETIME	PRIOR AUTHORIZATION (REQUEST FOR PA MUST BE SUBMITTED TO WVMI 7 CALENDAR DAYS POST HOSPITAL DISCHARGE) ITEM IS 10 MONTH CAP RENTAL AVAILABLE FOR MEMBERS 1 YEAR OF AGE OR YOUNGER. INCLUDES PNEUMOGRAM
E0620	SKIN PIERCING DEVICE FOR COLLECTION OF CAPILLARY BLOOD, LASER, EACH		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0621	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON		1 PER 2 ROLLING YEARS	NON-REIMBURSABLE WITH: E0630
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED		NON-COVERED	
E0627	SEAT LIFT MECHANISM INCORPORATED INTO A COMBINATION LIFT-CHAIR MECHANISM		NON-COVERED	
E0628	SEPARATE SEAT LIFT MECHANISM FOR USE WITH PATIENT OWNED FURNITURE-ELECTRIC		NON-COVERED	
E0629	SEPARATE SEAT LIFT MECHANISM FOR USE WITH PATIENT OWNED FURNITURE-NON-ELECTRIC		NON-COVERED	
E0630	PATIENT LIFT, HYDRAULIC **OR MECHANICAL, INCLUDES ANY SEAT, SLING, STRAPS(S), OR PADS**		1 UNIT PER LIFETIME	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH: E0621 WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING		NON-COVERED	
E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENTACCESSIBLE CONTROLS		NON-COVERED	
E0637	COMBINATION SIT TO STAND SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEATLIFT FEATURE, WITH OR WITHOUT WHEELS		NON-COVERED	
E0638	STANDING FRAME SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS		NON-COVERED	
E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES		NON-COVERED	
E0640	PATIENT LIFT, FIXED SYSTEM, INCLUDES ALL COMPONENTS/ACCESSORIES		NON-COVERED	
E0641	STANDING FRAME SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS		NON-COVERED	
E0642	STANDING FRAME SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC		NON-COVERED	
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE		1 PER LIFETIME	PRIOR AUTHORIZATION 10 MONTH CAP RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM			PRIOR AUTHORIZATION PURCHASE ITEM
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM			PRIOR AUTHORIZATION PURCHASE ITEM
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM			PRIOR AUTHORIZATION PURCHASE ITEM
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG			PRIOR AUTHORIZATION PURCHASE ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM			PRIOR AUTHORIZATION PURCHASE
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG			PRIOR AUTHORIZATION PURCHASE ITEM
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, OR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)		NON-COVERED	
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE		NON-COVERED	
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS		NON-COVERED	
E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 4 FOOT PANEL		NON-COVERED	
E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 6 FOOT PANEL		NON-COVERED	
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION		NON-COVERED	
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)		NON-COVERED	
E0701	HELMET WITH FACE GUARD AND SOFT INTERFACE MATERIAL, PREFABRICATED		NON-COVERED	
E0705	TRANSFER DEVICE, ANY TYPE, EACH	E0972		PRIOR AUTHORIZATION PURCHASED ITEM
E0710	RESTRAINTS, ANY TYPE (BODY, CHEST, WRIST OR ANKLE)		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0720	TRANSCUTANTEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A4556, A4557 OR E0730 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: A4556, A4557 OR E0730 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE IBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)		NON-COVERED	
E0740	INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONITOR, SENSOR AND/OR TRAINER		NON-COVERED	
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS		NON-COVERED	
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT		NON-COVERED	
E0746	ELECTROMYOGRAPHY (EMG), BIOFEEDBACK DEVICE		NON-COVERED	
E0747	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS			PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS			PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0749	OSTEOGENESIS STIMULATOR, ELECTRICAL, SURGICALLY IMPLANTED		NON-COVERED	
E0752	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH		NON-COVERED	
E0754	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR		NON-COVERED	
E0755	ELECTRONIC SALIVARY REFLEX STIMULATOR (INTRA-ORAL/NON-INVASIVE)		NON-COVERED	
E0756	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR		NON-COVERED	
E0757	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0758	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER		NON-COVERED	
E0759	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE SACRAL ROOT NEUROSTIMULATOR RECEIVER FOR BOWEL AND BLADDER MANAGEMENT, REPLACEMENT		NON-COVERED	
E0760	OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE			PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0761	NON-THERMAL PULSED HIGH FREQUENCY RADIOWAVES, HIGH PEAK POWER ELECTROMAGNETIC ENERGY TREATMENT DEVICE		NON-COVERED	
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES		NON-COVERED	
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	K0600	NON-COVERED	
E0765	FDA APPROVED NERVE STIMULATOR, WITH REPLACEABLE BATTERIES, FOR TREATMENT OF NAUSEA AND VOMITING		NON-COVERED	
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED		NON-COVERED	
E0776	IV POLE		NON-COVERED	
E0779	AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR GREATER		NON-COVERED	
E0780	AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION LESS THAN 8 HOURS		NON-COVERED	
E0781	AMBULATORY INFUSION PUMP, SINGLE OR MULTIPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATIVE EQUIPMENT, WORN BY PATIENT		1 UNIT PER LIFETIME	10 MONTH CAP RENTAL ITEM
E0782	INFUSION PUMP, IMPLANTABLE, NON-PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)		NON-COVERED	
E0783	INFUSION PUMP SYSTEM, IMPLANTABLE, PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)		NON-COVERED	

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E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN		1 PER 4 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0785	IMPLANTABLE INTRASPINAL (EPIDURAL/INTRATHECAL) CATHETER USED WITH IMPLANTABLE INFUSION PUMP, REPLACEMENT		NON-COVERED	
E0786	IMPLANTABLE PROGRAMMABLE INFUSION PUMP, REPLACEMENT (EXCLUDES IMPLANTABLE INTRASPINAL CATHETER)		NON-COVERED	
E0791	PARENTERAL INFUSION PUMP, STATIONARY, SINGLE OR MULTI-CHANNEL		NON-COVERED	
E0830	AMBULATORY TRACTION DEVICE, ALL TYPES, EACH		NON-COVERED	
E0840	TRACTION FRAME, ATTACHED TO HEADBOARD, CERVICAL TRACTION		NON-COVERED	
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	K0627	NON-COVERED	
E0850	TRACTION STAND, FREE STANDING, CERVICAL TRACTION		NON-COVERED	
E0855	CERVICAL TRACTION EQUIPMENT NOT REQUIRING ADDITIONAL STAND OR FRAME		NON-COVERED	
E0856	CERVICAL TRACTION DEVICE, CERVICAL COLLAR WITH INFLATABLE AIR BLADDER		NON-COVERED	NEW CODE 01/01/2008
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL		1 PER LIFETIME	ITEM PURCHASED WHEN THE FOLLOWING CRITERIA ARE MET: 1) THE PATIENT HAS A MUSCULOSKETAL OR NEUROLOGIC IMPAIRMENT REQUIRING TRACTION EQUIPMENT; AND 2) THE APPROPRIATE USE OF A HOME CERVICAL TRACTION DEVICE HAS BEEN DEMONSTRATED TO THE PATIENT AND THE PATIENT TOLERATED THE SELECTED DEVICE. ABOVE DOCUMENTATION MUST BE CONTAINED IN MEMBER'S FILE.
E0870	TRACTION FRAME, ATTACHED TO FOOTBOARD, EXTREMITY TRACTION, (E.G. BUCK'S)		NON-COVERED	
E0880	TRACTION STAND, FREE STANDING, EXTREMITY TRACTION, (E.G., BUCK'S)		NON-COVERED	
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION		NON-COVERED	
E0900	TRACTION STAND, FREE STANDING, PELVIC TRACTION, (E.G., BUCK'S)		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR		1 PER LIFETIME	PRIOR AUTHORIZATION PURCHASED ITEM FOR USE WITH HOSPITAL BED ONLY MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA NON-REIMBURSABLE WITH: E0940
E0911	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR		1 PER LIFETIME	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA NON-REIMBURSABLE WITH E0910, E0912 OR E0940
E0912	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR		1 PER LIFETIME	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA NON-REIMBURSABLE WITH E0910, E0911 OR E0940
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS		NON-COVERED	DISCONTINUED BY BMS 04/01/2005
E0930	FRACTURE FRAME, FREE STANDING, INCLUDES WEIGHTS		NON-COVERED	DISCONTINUED BY BMS 04/01/2005
E0935	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY		1 PER DAY NOT TO EXCEED 30 DAYS	PRIOR AUTHORIZATION RENTAL ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE		NON-COVERED	
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR		1 PER LIFETIME	PURCHASED ITEM NOT FOR USE WITH HOSPITAL BED NON-REIMBURSABLE WITH: E0250, E0255, E0260, E0277, E0300, E0303, E0304 OR E0910 WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE		NON-COVERED	
E0942	CERVICAL HEAD HARNESS/HALTER		1 PER ROLLING YEAR	PURCHASED ITEM NON-REIMBURSABLE WITH: E0860
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH	K0107		PRIOR AUTHORIZATION PURCHASED ITEM
E0951	HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITHOUT ANKLE STRAP, EACH	K0035		PRIOR AUTHORIZATION PURCHASED ITEM
E0952	TOE LOOP/HOLDER, ANY TYPE, EACH	K0036		PRIOR AUTHORIZATION PURCHASED ITEM
E0953	PNEUMATIC TIRE, EACH		NON-COVERED	
E0954	SEMI-PNEUMATIC CASTER, EACH		NON-COVERED	

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E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	K0108		PRIOR AUTHORIZATION PURCHASE ITEM
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E0958	MANUAL WHEELCHAIR ACCESSORY, ONE-ARM DRIVE ATTACHMENT, EACH	K0101		PRIOR AUTHORIZATION PURCHASED ITEM
E0959	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	K0100		PRIOR AUTHORIZATION PURCHASED ITEM
E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E0961	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK BRAKE EXTENSION (HANDLE), EACH	K0079		PRIOR AUTHORIZATION PURCHASED ITEM
E0966	MANUAL WHEELCHAIR ACCESSORY, HEADREST EXTENSION, EACH	K0025		PRIOR AUTHORIZATION PURCHASED ITEM
E0967	MANUAL WHEELCHAIR ACCESSORY, HAND RIM WITH PROJECTIONS, ANY TYPE, EACH	K0062 and K0063		PRIOR AUTHORIZATION PURCHASED ITEM
E0968	COMMODE SEAT, WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
E0969	NARROWING DEVICE, WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
E0970	NO.2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E0971	MANUAL WHEELCHAIR ACCESSORY, ANTI-TIPPING DEVICE EACH	K0021		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813THRU K0843 OR K0848 THRU K0891
E0972	WHEELCHAIR ACCESSORY, TRANSFER BOARD OR DEVICE, EACH	K0103		DISCONTINUED BY CMS 12/31/2005
E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT, DETACHABLE ARMREST, COMPLETE ASSEMBLY, EACH	K0016		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, K0017, K0018 OR K0019
E0974	MANUAL WHEELCHAIR ACCESSORY, ANTI-ROLLBACK DEVICE, EACH	K0080		PRIOR AUTHORIZATION PURCHASED ITEM

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E0977	WEDGE CUSHION, WHEELCHAIR		NON-COVERED	
E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH	K0030		PRIOR AUTHORIZATION PURCHASED ITEM
E0980	SAFETY VEST, WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH	K0032 and K0033		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0011, K0012 OR K0014
E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH	K0022 K0026 K0027		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0011, K0012 OR K0014
E0983	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL	K0460		PRIOR AUTHORIZATION PURCHASED ITEM
E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL	K0461		PRIOR AUTHORIZATION PURCHASED ITEM
E0985	WHEELCHAIR ACCESSORY, SEAT LIFT MECHANISM		NON-COVERED	
E0986	MANUAL WHEELCHAIR ACCESSORY, PUSH ACTIVATED POWER ASSIST, EACH		NON-COVERED	
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH	K0048		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0995, E1009, E1010, K0042, K0043, K0044, K0045, K0046, K0047, OR K0053
E0992	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT INSERT	K0030		PRIOR AUTHORIZATION PURCHASED ITEM
E0994	ARM REST, EACH		NON-COVERED	
E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD, EACH		NON-COVERED	
E0996	TIRE, SOLID, EACH		NON-COVERED	
E0997	CASTER WITH A FORK	K0108		PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
E0998	CASTER WITHOUT FORK	K0108		PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E0999	PNEUMATIC TIRE WITH WHEEL		NON-COVERED	
E1000	TIRE, PNEUMATIC CASTER		NON-COVERED	
E1001	WHEEL, SINGLE		NON-COVERED	
E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1003	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITHOUT SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1004	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1005	WHEELCHAIR ACCESSORY, POWER SEATNG SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020,K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1006	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1007	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1008	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0973, K0015, K00017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051
E1009	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM, INCLUDING PUSHROD AND LEG REST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE NONREIMBURSABLE WITH: E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1010	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEG REST, PAIR			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E1011	MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (NOT TO BE DISPENSED WITH INITIAL CHAIR)	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE
E1014	RECLINING BACK, ADDITION TO PEDIATRIC SIZE WHEELCHAIR	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERAGE LIMTED UP TO 21 YEARS OF AGE
E1015	SHOCK ABSORBER FOR MANUAL WHEELCHAIR, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E1016	SHOCK ABSORBER FOR POWER WHEELCHAIR, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E1017	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY MANUAL WHEELCHAIR, EACH		NON-COVERED	
E1018	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY POWER WHEELCHAIR, EACH		NON-COVERED	
E1019	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, HEAVY DUTY FEATURE, PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS AND LESS THAN OR EQUAL TO 400 POUNDS		NON-COVERED	
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR	K0108		PRIOR AUTHORIZATION PURCHASED ITEM STUMP SUPPORT FOR A LOWER LIMB AMPUTEE THAT IS ATTACHED TO A WHEELCHAIR BASE. IT CONTAINS A MECHANISM TO ALLOW THE SUPPORT TO SWING AWAY, FOLD DOWN, OR RETRACT.
E1021	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, EXTRA HEAVY DUTY FEATURE, WEIGHT CAPACITY GREATER THAN 400 POUNDS		NON-COVERED	
E1025	LATERAL THORACIC SUPPORT, NON-CONTOURED, FOR PEDIATRIC WHEELCHAIR, EACH (INCLUDES HARDWARE)	K0108		DISCONTINUED BY CMS 12/31/2005
E1026	LATERAL THORACIC SUPPORT, CONTOURED, FOR PEDIATRIC WHEELCHAIR, EACH (INCLUDES HARDWARE)	K0108		DISCONTINUED BY CMS 12/31/2005
E1027	LATERAL/ANTERIOR SUPPORT, FOR PEDIATRIC WHEELCHAIR, EACH (INCLUDES HARDWARE)	K0108		DISCONTINUED BY CMS 12/31/2005

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1028	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E1029	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E1030	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E1031	ROLLABOUT CHAIR, ANY AND ALL TYPES WITH CASTORS 5" OR GREATER		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL INCLUDES ALL OPTIONS AND ACCESSORIES NON-REIMBURSABLE WITH: K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813THRU K0843 OR K0848 THRU K0891
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER		NON-COVERED	
E1037	TRANSPORT CHAIR, PEDIATRIC SIZE		NON-COVERED	
E1038	TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		NON-COVERED	
E1039	TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY GREATER THAN 300 POUNDS		NON-COVERED	
E1050	FULLY-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1060	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1070	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1083	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG REST		NON-COVERED	
E1084	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1085	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1086	HEMI-WHEELCHAIR DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1087	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
	LEG RESTS			
E1088	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1089	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1090	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1092	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH), SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1093	WIDE HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1100	SEMI-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS		NON-COVERED	
E1110	SEMI-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGREST		NON-COVERED	
E1130	STANDARD WHEELCHAIR, FIXED FULL LENGTH ARMS, FIXED OR SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1140	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1150	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1160	WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1161	MANUAL ADULT SIZE WHEELCHAIR, INCLUDES TILT IN SPACE		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072- OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1170	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1171	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, WITHOUT FOOTRESTS OR LEGREST		NON-COVERED	
E1172	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) WITHOUT FOOTRESTS OR LEGREST		NON-COVERED	

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1180	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTRESTS		NON-COVERED	
E1190	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1195	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1200	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1210	MOTORIZED WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1211	MOTORIZED WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH SWING AWAY, DETACHABLE ELEVATING LEG REST		NON-COVERED	
E1212	MOTORIZED WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1213	MOTORIZED WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS		NON-COVERED	
E1220	WHEELCHAIR; SPECIALLY SIZED OR CONSTRUCTED, (INDICATE BRAND NAME, MODEL NUMBER, IF ANY) AND JUSTIFICATION		NON-COVERED	
E1221	WHEELCHAIR WITH FIXED ARM, FOOTRESTS		NON-COVERED	
E1222	WHEELCHAIR WITH FIXED ARM, ELEVATING LEGRESTS		NON-COVERED	
E1223	WHEELCHAIR WITH DETACHABLE ARMS, FOOTRESTS		NON-COVERED	
E1224	WHEELCHAIR WITH DETACHABLE ARMS, ELEVATING LEGRESTS		NON-COVERED	
E1225	WHEELCHAIR ACCESSORY, MANUAL SEMI-RECLINING BACK, (RECLINE GREATER THAN 15 DEGREES, BUT LESS THAN 80 DEGREES), EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E1226	WHEELCHAIR ACCESSORY, MANUAL FULLY RECLINING BACK, (RECLINE GREATER THAN 80 DEGREES), EACH	K0028		PRIOR AUTHORIZATION PURCHASED ITEM
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR		NON-COVERED	
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	K0009		PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASE ITEM COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL INCLUDES ALL OPTIONS AND ACCESSORIES MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072-OR WHEELCHAIR BASES: E1229, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231,E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEN	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232,E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1234	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233,E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072-OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1236	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1237	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1236, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009,K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1238	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	K0009	1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226,K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072-OR WHEELCHAIR BASES: E1229,E1231, E1232, E1233, E1234, E1235, E1236, E1237, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	K0014		PRIOR AUTHORIZATION PURCHASE ITEM COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E1240	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS, (DESK OR FULL LENGTH) SWING AWAY DETACHABLE, ELEVATING LEGREST		NON-COVERED	
E1250	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1260	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1270	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS		NON-COVERED	
E1280	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGRESTS		NON-COVERED	
E1285	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1290	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST		NON-COVERED	
E1295	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, ELEVATING LEGREST		NON-COVERED	
E1296	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR		NON-COVERED	
E1297	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY		NON-COVERED	
E1298	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION		NON-COVERED	
E1300	WHIRLPOOL, PORTABLE (OVERTUB TYPE)		NON-COVERED	
E1310	WHIRLPOOL, NON-PORTABLE (BUILT-IN TYPE)		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E1340	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES		16 UNITS PER ROLLING YEAR	PRIOR AUTHORIZATION TRAVEL NOT COVERED
E1353	REGULATOR		NON-COVERED	
E1355	STAND/RACK		NON-COVERED	
E1372	IMMERSION EXTERNAL HEATER FOR NEBULIZER		1 PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE		1 UNIT PER ROLLING MONTH	PROVIDER MUST MAINTAIN A PERSONALLY SIGNED AND DATED PRACTITIONER'S ORDER WITH DIAGNOSIS, DIRECTION FOR USE ALONG WITH ABG'S OR ARTERIAL OXYGEN SATURATION IN THE MEMBER'S FILE. WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C MEDICAL CRITERIA FOR COVERAGE. MUST HAVE WEST VIRGINIA CERTIFIED RESPIRATORY THERAPIST OR PROFESSIONAL REGISTERED NURSE OR PHYSICIAN ON STAFF
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH		NON-COVERED	
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	K0671	NON-COVERED	
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS			PRIOR AUTHORIZATION COST INVOICE REQUIRED
E1405	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY		NON-COVERED	
E1406	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY		NON-COVERED	
E1902	COMMUNICATION BOARD, NON-ELECTRONIC AUGMENTATIVE OR ALTERNATIVE COMMUNICATION DEVICE		NON-COVERED	
E2000	GASTRIC SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC		NON-COVERED	
E2100	BLOOD GLUCOSE MONITOR WITH INTEGRATED VOICE SYNTHESIZER		1 PER 3 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM REQUIRES ICD-9-CM DIAGNOSIS CODES: 250.00 - 250.93 OR 648.8X. WEST VIRGINIA MEDICAID FOLLOWS PALMETTO, REGION C, MEDICAL CRITERIA FOR COVERAGE.
E2101	BLOOD GLUCOSE MONITOR WITH INTEGRATED LANCING/BLOOD SAMPLE		NON-COVERED	
E2120	PULSE GENERATOR SYSTEM FOR TYMPANIC TREATMENT OF INNER EAR ENDOLYMPHATIC FLUID		NON-COVERED	

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2201	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME, WIDTH GREATER THAN OR EQUAL TO 20 INCHES AND LESS THAN 24 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2202	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2203	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 TO LESS THAN 22 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2204	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22 TO 25 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2205	MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS **(INCLUDES ERGONOMIC OR CONTOURED**), ANY TYPE, REPLACEMENT ONLY, EACH	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2206	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK ASSEMBLY, COMPLETE, EACH	K0081		PRIOR AUTHORIZATION PURCHASED ITEM
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	K0102		PRIOR AUTHORIZATION PURCHASED ITEM
E2208	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	K0104		PRIOR AUTHORIZATION PURCHASED ITEM
E2209	ACCESSORY, ARM TOUGH, WITH OR WITHOUT HANDSUPPORT, EACH	K0106		PRIOR AUTHORIZATION PURCHASED ITEM
E2210	WHEELCHAIR ACCESSORY, BEARNGS, ANY TYPE, REPLACEMENT ONLY, EACH	K0452		PRIOR AUTHORIZATION PURCHASED ITEM
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	K0067		PRIOR AUTHORIZATION PURCHASED ITEM
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	K0068		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E2223
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	K0064		PRIOR AUTHORIZATION PURCHASED ITEM
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	K0074		PRIOR AUTHORIZATION PURCHASED ITEM
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE EACH	K0078		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E2223

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2218	MANUAL WHEELCHAIR ACCESORY, FOAM PROPULSION TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	K0075		PRIOR AUTHORIZATION PURCHASED ITEM
E2220	MANUAL WHEELCHAIR ACCESORY, SOLID (RUBBER/PLASTIC) PROPULSION TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2221	MANUAL WHEELCHAIR ACESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, EACH	K0076		PRIOR AUTHORIZATION PURCHASED ITEM
E2222	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, EACH	K0076		PRIOR AUTHORIZATION PURCHASED ITEM
E2223	WHEELCHAIR ACCESSORY, VALVE, ANY TYPE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2224	MANUAL WHEELCHAIR ACCESSORY, PROPULSION WHEEL EXCLUDES TIRE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2225	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2226	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH			PRIOR AUTHORIZATION PURCHASE ITEM COST INVOICE REQUIRED NEW CODE 01/01/2008
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK,COMPLETE EACH			PRIOR AUTHORIZATION PURCHASE ITEM COST INVOICE REQUIRED NEW CODE 01/01/2008
E2291	BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2292	SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2293	BACK, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2294	SEAT, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE			PRIOR AUTHORIZATION COST INVOICE REQUIRED COVERED FOR MEMBERS UP TO 21 YEARS OF AGE
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM		NON-COVERED	
E2301	POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM		NON-COVERED	
E2310	POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND ONE POWER SEATING SYSTEM MOTOR, INCLUDING ALL RELATED ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2311	POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND TWO OR MORE POWER SEATING SYSTEM MOTORS, INCLUDING ALL RELATED ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2008
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2008
E2320	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
E2321	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, REMOTE JOYSTICK, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2322	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, MULTIPLE MECHANICAL SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2323	POWER WHEELCHAIR ACCESSORY, SPECIALTY JOYSTICK HANDLE FOR HAND CONTROL INTERFACE, PREFABRICATED	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2325	POWER WHEELCHAIR ACCESSORY, SIP AND PUFF INTERFACE, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND MANUAL SWINGAWAY MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1028
E2326	POWER WHEELCHAIR ACCESSORY, BREATH TUBE KIT FOR SIP AND PUFF INTERFACE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2327	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2328	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL OR EXTREMITY CONTROL INTERFACE, ELECTRONIC, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2329	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, CONTACT SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2330	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, PROXIMITY SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2331	POWER WHEELCHAIR ACCESSORY, ATTENDANT CONTROL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE		NON-COVERED	
E2340	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 20-23 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2342	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 OR 21 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2343	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22-25 INCHES	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED ONLY IF MEMBER'S DIMENSIONS JUSTIFY THE NEED
E2351	POWER WHEELCHAIR ACCESSORY, ELECTRONIC INTERFACE TO OPERATE SPEECH GENERATING DEVICE USING POWER WHEELCHAIR CONTROL INTERFACE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM COVERED IF MEMBER HAS A MEDICAID APPROVED SPEECH GENERATING DEVICE ONLY
E2360	POWER WHEELCHAIR ACCESSORY, 22 NF NON-SEALED LEAD ACID BATTERY, EACH	K0082	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED LEAD ACID BATTERY, EACH, (E.G. GEL CELL, ABSORBED GLASSMAT)	K0083	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	K0084	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	K0085	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEALED LEAD ACID BATTERY, EACH	K0086	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	K0087	2 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM
E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, SINGLE MODE, FOR USE WITH ONLY ONE BATTERY TYPE, SEALED OR NON-SEALED, EACH	K0088		PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL MODE, FOR USE WITH EITHER BATTERY TYPE, SEALED OR NON-SEALED, EACH	K0089	NON-COVERED	
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH			PRIOR AUTHORIZATION PURCHASED ITEM

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH			PRIOR AUTHORIZATION COST INVOICE REQUIRED PURCHASED ITEM
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, **COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE**			PRIOR AUTHORIZATION NEW CODE 01/01/2007
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPROTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FXED MOUNTING HARDWARE, REPLACEMENT ONLY	E2320		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATEDELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT	K0090		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0091		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2383	POWER WHEELCHAIR ACCESSSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY	K0094		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0095		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE REPLACEMENT ONLY, EACH	K0090		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0094		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	K0090		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH	K0094		PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATEDWHEEL, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM NEW CODE 01/01/2007
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH			PRIOR AUTHORIZATION PURCHASE ITEM COST INVOICE REQUIRED NEW CODE 01/01/2008
E2399	POWER WHEELCHAIR ACCESSORY, NOT OTHERWISE CLASSIFIED INTERFACE, INCLUDING ALL RELATED ELECTRONICS AND ANY TYPE MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION COST INVOICE REQUIRED THIS CODE IS APPROPRIATELY USED IN THE FOLLOWING SITUATIONS: 1) AN INTEGRATED PROPORTIONAL JOYSTICK AND CONTROLLER BOX ARE BEING REPLACED DUE TO DAMAGE. 2) THE ITEM BEING REPLACE IS A REMOTE JOYSTICK BOX ONLY (WITHOUT THE CONTROLLER). 3) THE ITEM BEING REPLACED IS ANOTHER TYPE OF INTERFACE, E.G., SIP AND PUFF, HEAD CONTROL (WITHOUT THE CONTROLLER). 4) THE ITEM BEING REPLACED IS THE CONTOLLER BOX ONLY (WITHOUT THE REMOTE JOYSTICK OR OTHER TYPE OF INTERFACE). 5) THERE IS NOT SPECIFIC E CODE WHICH DESCRIBES THE TYPE OF DRIVE CONTROL INTERFACE SYSTEM WHICH IS PROVIDED. IN THIS SITUATION, E2399 WOULD BE USED AT THE TIME OF INITIAL ISSUE OR IF THE ITEM WAS BEING PROVIDED AS A REPLACEMENT. REQUEST FOR AUTHORIZATION MUST CONTAIN THE FOLLOWING DOCUMENTATION: 1) A CLEAR NARRATIVE DESCRIPTION OF THE ITEM THAT IS BEING REQUESTED. 2) IF REQUESTING REPLACEMENT, THE DOCUMENTATION MUST DESCRIBE THE ITEM THAT IS BEING REPLACED AND THE REASON FOR REPLACEMENT.

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	K0538	1 UNIT PER LIFETIME	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2500 – E2599	SPEECH GENERATING DEVICES			**REFER TO SPEECH/AUDIOLOGY MANUAL**
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0650 K0651	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0650 K0651	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0652 K0653	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0652 K0653	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0654 K0655	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0654 K0655	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	K0656 K0657	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	K0656 K0657	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	K0658+K0666		PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2610	WHEELCHAIR SEAT CUSHION, POWERED		NON-COVERED	

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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0660 K0661	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0660 K0661	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0662 K0663	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0662 K0663	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 NCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0664 K0665	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0664 K0665	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	K0658+K0666	1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
E2618	WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), FOR USE WITH MANUAL WHEELCHAIR OR LIGHTWEIGHT POWER WHEELCHAIR, INCLUDES ANY TYPE MOUNTING HARDWARE	K0667		PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED DISCONTINUED BY CMS 12/31/2007
E2619RP	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH	K0668	4 PER ROLLING YEAR	PRIOR AUTHORIZATION PURCHASED ITEM
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	K0108		PRIOR AUTHORIZATION PURCHASED ITEM
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE			PRIOR AUTHORIZATION PURCHASED ITEM
E8000	GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS		NON-COVERED	

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
E8001	GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS		NON-COVERED	
E8002	GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS		NON-COVERED	
K0001	STANDARD WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0003, K0004, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0003	LIGHTWEIGHT WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001,K0002, K0004, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0004	HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0005, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0005	ULTRALIGHTWEIGHT WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0006, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0006	HEAVY DUTY WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0007	EXTRA HEAVY DUTY WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0009, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0009	OTHER MANUAL WHEELCHAIR/BASE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTHCAP RENTAL COVERAGE FOR MEMBERS WEIGHING 250 LBS OR LESS NON- REIMBURSABLE WITH: E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2223, E2224, E2225, E2226, , E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,K0069, K0070, K0071, K0072 OR WHEELCHAIR BASES: E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0800, K0801,K0802,K0806,K0807,K0808, OR K0812 THRU K0891 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0010	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL. NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0011, K0012, K0014 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
K0011	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL. NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0012, K0014 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION. ITEM IS 10 MONTH CAP RENTAL. NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0010, K0011, K0014 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED . NON-REIMBURSABLE WITH: E0971, E0981, E0982, E0995, E2366, E2367, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0081, K0090, K0092, K0094, K0096, K0098, K0099, K0452 OR WHEELCHAIR BASES E1161, E1231,E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0 MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA CLOSED BY BMS EFFECTIVE 6/30/2007
K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU
K0019	ARM PAD, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, K0813 THRU K0843 OR K0848 THRU K0891
K0037	HIGH MOUNT FLIP-UP FOOTREST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
K0038	LEG STRAP, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0039
K0039	LEG STRAP, H STYLE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0038
K0040	ADJUSTABLE ANGLE FOOTPLATE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 OR K0843
K0041	LARGE SIZE FOOTPLATE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
K0042	STANDARD SIZE FOOTPLATE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K001, K002, K0003, K0004, K0005, K0006, K0007, K0009, K0043, K0044, K0045, K0046, K0047, K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0043	FOOTREST, LOWER EXTENSION TUBE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K001, K002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044,K0045,K0046, K0047,K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0044	FOOTREST, UPPER HANGER BRACKET, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0045, K0046, K0047 OR K0053
K0045	FOOTREST, COMPLETE ASSEMBLY			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044, K0046, K0047, K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0046	ELEVATING LEGREST, LOWER EXTENSION TUBE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044, K0045, K0047, K0053,K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990,E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0042, K0043, K0044, K0045, K0046, K0053, K0195, K0813 THRU K0843 OR K0848 THRU K0891
K0050	RATCHET ASSEMBLY			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008, K0813 THRU K0843 OR K0848 THRU K0891
K0052	SWINGAWAY, DETACHABLE FOOTRESTS, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1002, E1003, E1004, E1005, E1006, E1007, E1008,, E1009, E1010, E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0813 THRU K0843 OR K0848 THRU K0891
K0053	ELEVATING FOOTRESTS, ARTICULATING (TELESCOPING), EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E0990, E0995,E1009,E1010, K0042, K0043, K0044, K0045, K0046, OR K0047
K0056	SEAT HEIGHT LESS THAN 17" OR EQUAL TO OR GREATER THAN 21" FOR A HIGH STRENGTH, LIGHTWEIGHT, OR ULTRALIGHTWEIGHT WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM
K0060	STEEL HANDRIM, EACH		NON-COVERED	
K0064	ZERO PRESSURE TUBE (FLAT FREE INSERTS), ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0065	SPOKE PROTECTORS, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
K0066	SOLID TIRE, ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0067	PNEUMATIC TIRE, ANY SIZE, EACH	E0953		DISCONTINUED BY CMS 12/31/2005
K0068	PNEUMATIC TIRE TUBE, EACH			DISCONTINUED BY CMS 12/31/2005
K0069	REAR WHEEL ASSEMBLY, COMPLETE, WITH SOLID TIRE, SPOKES OR MOLDED, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238,E2220, E2224, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0070	REAR WHEEL ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, SPOKES OR MOLDED, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238,E2211, E2212, E2223, E2224, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0071	FRONT CASTER ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, E2214, E2215, E2223, E2224, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SEMI-PNEUMATIC TIRE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E1161, E1231, E1233, E1234, E1235, E1236, E1237, E1238, E2219, E2225, E2226, K0001, K0002, K0003, K0004, K0005, K0006, K0007 OR K0009
K0073	CASTER PIN LOCK,EACH			PRIOR AUTHORIZATION PURCHASED ITEM
K0074	PNEUMATIC CASTER TIRE, ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0075	SEMI-PNEUMATIC CASTER TIRE, ANY SIZE, EACH	E0954		DISCONTINUED BY CMS 12/31/2005
K0076	SOLID CASTER TIRE, ANY SIZE, EACH			DISCONTINUED BY CMS 12/31/2005
K0077	FRONT CASTER ASSEMBLY, COMPLETE, WITH SOLID TIRE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: E2221, E2222, 32225 OR E2226
K0078	PNEUMATIC CASTER TIRE TUBE, EACH			DISCONTINUED BY CMS 12/31/2005
K0090	REAR WHEEL TIRE FOR POWER WHEELCHAIR, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012, K0014, K0091 OR K0092 CLOSED BY CMS 12/31/2006
K0091	REAR WHEEL TIRE TUBE OTHER THAN ZERO PRESSURE FOR POWER WHEELCHAIR, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0090 OR K0092 CLOSED BY CMS 12/31/2006

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
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HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
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HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0092	REAR WHEEL ASSEMBLY FOR POWER WHEELCHAIR, COMPLETE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012,K0014, K0090 OR K0091 CLOSED BY CMS 12/31/2006
K0093	REAR WHEEL, ZERO PRESSURE TIRE TUBE (FLAT FREE INSERT) FOR POWER WHEELCHAIR, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
K0094	WHEEL TIRE FOR POWER BASE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012,K0014, K0095 OR K0096 CLOSED BY CMS 12/31/2006
K0095	WHEEL TIRE TUBE OTHER THAN ZERO PRESSURE FOR EACH BASE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0094 OR K0095 CLOSED BY CMS 12/31/2006
K0096	WHEEL ASSEMBLY FOR POWER BASE, COMPLETE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012, K0014, K0094 OR K0095 CLOSED BY CMS 12/31/2006
K0097	WHEEL ZERO PRESSURE TIRE TUBE (FLAT FREE INSERT) FOR POWER BASE, ANY SIZE, EACH			PRIOR AUTHORIZATION PURCHASED ITEM CLOSED BY CMS 12/31/2006
K0098	DRIVE BELT FOR POWER WHEELCHAIR			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0813 THRU K0843 OR K0848 THRU K0891
K0099	FRONT CASTER FOR POWER WHEELCHAIR, EACH			PRIOR AUTHORIZATION PURCHASED ITEM NON-REIMBURSABLE WITH: K0010, K0011, K0012 OR K0014 DISCONTINUED BY CMS 12/31/2006
K0102	CRUTCH AND CANE HOLDER, EACH			DISCONTINUED BY CMS 12/31/2005
K0104	CYLINDER TANK CARRIER, EACH			DISCONTINUED BY CMS 12/31/2005
K0105	IV HANGER, EACH			PRIOR AUTHORIZATION PURCHASED ITEM
K0106	ARM TROUGH, EACH			DISCONTINUED BY CMS 12/31/2005
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED			PRIOR AUTHORIZATION COST INVOICE REQUIRED
K0195	ELEVATING LEG RESTS, PAIR (FOR USE WITH CAPPED RENTAL WHEELCHAIR BASE)			PRIOR AUTHORIZATION PURCHASED ITEM NON REIMBURSABLE WITH: E0995, E1009,E1010, K0042, K0043, K0044, K0045, K0046 OR K0047

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0415	PRESCRIPTION ANTIEMETIC DRUG, ORAL, PER 1 MG, FOR USE IN CONJUNCTION WITH ORAL ANTI-CANCER DRUG, NOT OTHERWISE SPECIFIED		NON-COVERED	
K0416	PRESCRIPTION ANTIEMETIC DRUG, RECTAL, PER 1 MG, FOR USE IN CONJUCTION WITH ORAL ANTI-CANCER DRUG, NOT OTHERWISE SPECIFIED		NON-COVERED	
K0452	WHEELCHAIR BEARINGS, ANY TYPE			DISCONTINUED BY CMS 12/31/2005
K0455	INFUSION PUMP USED FOR UNINTERRUPTED PARENTERAL ADMINISTRATION OF MEDICATION, (E.G., EPOPROSTENOL OR TREPROSTINOL)		NON-COVERED	
K0462	TEMPORARY REPLACEMENT FOR PATIENT OWNED EQUIPMENT BEING REPAIRED, ANY TYPE		NON-COVERED	
K0553	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSTIVE AIRWAY PRESSURE DEVICE, EACH		NON-COVERED	DISCONTINUED BY CMS 12/31/2007
K0554	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH		NON-COVERED	DISCONTINUED BY CMS 12/31/2007
K0555	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR		NON-COVERED	DISCONTINUED BY CMS 12/31/2007
K0600	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM		NON-COVERED	
K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 1.5 VOLT, EACH		NON-COVERED	
K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 3 VOLT, EACH		NON-COVERED	
K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, ALKALINE, 1.5 VOLT, EACH		NON-COVERED	
K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 3.6 VOLT, EACH		NON-COVERED	
K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 4.5 VOLT, EACH		NON-COVERED	
K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS, GARMENT TYPE			PRIOR AUTHORIZATION 10 MONTH CAP RENTAL NON-REIMBURSABLE WITH K0607, K0608 AND K0609MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
				EFFECTIVE 01/01/2008
K0607	REPLACEMENT BATTERY FOR AUTOMATED EXTERNAL DEFIBRILLATOR, GARMENT TYPE ONLY, EACH		NON-COVERED	
K0608	REPLACEMENT GARMENT FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, EACH		NON-COVERED	
K0609	REPLACEMENT ELECTRODES FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, GARMENT TYPE ONLY, EACH		NON-COVERED	
K0620	TUBULAR ELASTIC DRESSING, ANY WIDTH, PER LINEAR YARD		NON-COVERED	
K0669	WHEELCHAIR ACCESSORY, SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM SADMERC			PRIOR AUTHORIZATION COST INVOICE REQUIRED
K0730	CONTROLLED DOSE INHALATION DRUG DELIVERY SYSTEM		1 PER 5 ROLLING YEARS	RDTP AUTHORIZATION FORM FOR THE DRUG IIOPROST/VENTAVIS MUST BE ATTACHED TO CMS 1500 CLAIM FORM REQUIRES ICD-9 DIAGNOSIS CODE: 416.0 EFFECTIVE 01/01/2007
K0733	POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY EACH (E.G. GEL CELL, ABSORBED GLASSMAT)		NON COVERED	
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WITH LESS THAN 22 INCHES, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCDES, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH		1 PER 2 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASE ITEM MEDICAL NECESSITY REVIEW WILL BE BASED ON INTERQUAL DME GENERAL CRITERIA
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005 K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031,K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES. NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005 K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES NON REIMBURSABLE WITH: E1031, K0001, K0002, K0003, K0004, K0005, K0006, K0007, OR K0009 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	E1230	1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. INCLUDES ALL OPTIONS AND ACCESSORIES COST INVOICE REQUIRED MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
				CRITERIA NEW CODE 01/01/2007
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812 K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0040,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800THRU K0812, K0813 THRU K0843, OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION ITEM IS 10 MONTH CAP RENTAL. NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS		1 UNIT PER 5 ROLLING YEARS	PRIOR AUTHORIZATION PURCHASED ITEM COST INVOICE REQUIRED NON REIMBURSABLE WITH: E0971, E0978,E0981,E0982,E0995, E1225,E2366,E2367,E2368,E2369, 2370,E2374,E2375,E2376,E2381, E2382,E2383,E2384,E2385,E2386, E2387,E2388,E2389,E2390,E2391, E2392,E2393,E2394,E2395,E2396, K0015,K0017,K0018,K0019,K0020, K0037,K0041,K0042,K0043, K0044,K0045,K0046,K0047,K0051, K0052, K0098 OR WHEELCHAIR BASES: E1031, E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0007, K0009, K0800 THRU K0812, K0813 THRU K0843 OR K0848 THRU K0891 MEDICAL NECESSITY REVIEW BASED ON INTERQUAL DME GENERAL CRITERIA NEW CODE 01/01/2007
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED			PRIOR AUTHORIZATION COST INVOICE REQUIRED NEW CODE 01/01/2007
K0899	POWER MOBILITY DEVICE, NOT CODED BY SADMERC OR DOES NOT MEET CRITERIA			PRIOR AUTHORIZATION COST INVOICE REQUIRED NEW CODE 01/01/2007

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES
***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS CODES	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIAL INSTRUCTIONS
L8500 – L8510	PROSTHETIC IMPLANTS			REFER TO SPEECH/AUDIOLOGY MANUAL
S8490KX	INSULIN SYRINGES (100 SYRINGES, ANY SIZE)		1 UNIT OF 100 PER ROLLING MONTH	REQUIRES ICD-9-CM DIAGNOSIS CODE: 250.00 THRU 250.93 OR 648.8X NON-REIMBURSABLE WITH: A4206, A4207, A4208 OR A4209
S9435	MEDICAL FOODS FOR INBORN ERRORS OF METABOLISM		NON-COVERED	
V5336	REPAIR/MODIFICATION OF AUGMENTATIVE COMMUNICATIVE SYSTEM OR DEVICE (EXCLUDES ADAPTIVE HEARING AID)			REFER TO SPEECH/AUDIOLOGY MANUAL

CHAPTER 506

DME/MEDICAL SUPPLIES

MAY 1, 2005

ATTACHMENT II

NON-COVERED DME/MEDICAL SUPPLIES FOR UNLISTED HCPCS CODES

REVISED JANUARY 1, 2008

West Virginia Department of Health and Human Resources
Bureau for Medical Services

NON-COVERED DME/MEDICAL SUPPLIES FOR UNLISTED HCPCS CODES

DESCRIPTION/ITEM
Adaptive feeding tools
Armrest pouch
Backpack, medical necessity bag
Backpack clips
Bacterial Filter
Bath/Commode Transfer System
Bath Mat
Bathtub lift
Battery powered Nebulizer
Bed rail ---padded
Bed wetting monitors (enuresis alarm)
Bowel Management kit
Canopy for Stroller
Carrying case for enteral feeding pump
Ceiling track lift system
Combination standing seat (to stand patient in w/c)
Compression garments/pumps (Lymphedema) not otherwise categorized in E0650-E0673, e.g., Reid sleeves, Solaris etc.
Cotton tipped applicators
Customized power flip up foot plates
Craftmatic bed
Electric Crib Bed
Environmental Control Equipment & Supplies (Air Conditioners, Humidifiers, Dehumidifiers, Electrostatic Filters, Hepa filter, Air Purifier, etc.)
Equipment for nursing home, ICF/MR patients
Equipment for Hospice patients (should be covered by Hospice)
Exercise equipment (deluxe cycle, treadmill, etc.)
Extended warranties for any type of equipment
Fleet enemas
Floor sitters (feeding or positioning chair)
Gait belts
Gait trainers
Gloves-sterile
Glucowatch
Glycerin swabs
Hand held showers
Hip Protector
Hospital bed, institutional type, includes: Oscillating, circulating and stryker frames with mattress, e.g., Air fluidize, KenAir, Clinitron
Hospital gowns

DESCRIPTION/ITEM
Hot tubs
Hydraulic van and car lifts
Incline wedge/therapy wedge
Incontinent supplies for enuresis or toilet training or menses
Isolation masks
Male Vacuum Erection System
Medical Identification Bracelet
Medical necessities bag, backpack, etc.
Medical supplies for nursing home patients
Non-custom strollers
Orthopedic mattress
Padded bed rail
Pelvic support system
Personal Hygiene items (toothbrushes, mouthwash, deodorants, shampoo, etc)
Physical/occupational therapy equipment to be used @ home (e.g., physioball, table for therapy, etc)
Portable feeding pump
Portable room heaters
Positioning pillow/mattress with or without pump
Posture bench
Posture training system
Power adjustable seat kit
Power cord kit and rechargeable batteries for a suction machine
Pro-Time Microcoagulation Machine
Rain Cape for wheelchair
Reacher devices
Remote control (remote pilot/remote box) for power wheelchair
Reid Sleeve (See compression garments/pumps)
Repairs of equipment/accessories not purchased by Medicaid
Shampoo tray
Shower gurney
Sleepsafe Safety Bed
Soft Seat for Rehab Shower Chair
Spare Tires for wheelchairs
Stand and drive legrest assembly
Standers
Stairway elevators
Stools of any kind
Supine Board
Telephone alert systems
Therapeutic Light Box
Toileting System
Toothettes
Turny System
Uplift Seat Assist
Vehicle safety devices, e.g., EZ Vests, Transit systems, car seats and accessories, etc.

DESCRIPTION/ITEM
Vibrators
Water bed and/or mattress
Wheelchair bag (for back of wheelchair to carry items in)
Wheelchair gloves
Wheelchair headlight/light kit
Wheelchair ramp

CHAPTER 506

DME/MEDICAL SUPPLIES

MAY 1, 2005

ATTACHMENT III

WVMI MEDICAID DME/MEDICAL SUPPLY

AUTHORIZATION REQUEST FORM

PAGE 1 OF 5

REVISED JANUARY 1, 2008

Confidential

WVMI MEDICAID DME / MEDICAL SUPPLIES AUTHORIZATION REQUEST FORM

Fax: 304-346-8185 **or** 1-877-762-4338 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____Member's Medicaid ID #:_____ Date of Birth: _____
(If Medicaid not primary, denial for requested items must be attached)

A. **Member** Name: _____ Phone #:_____
Member Address: _____

B. **Prescribing Practitioner N**ame: _____
Mailing Address: _____

Contact Name: _____ Phone# (_____) _____ Ext: _____
Fax # (_____) _____ E-Mail Address:_____

C. Name of **DME Vendor** Selected by Member: _____
Physical Address: _____
Provider #: _____ Phone #:_____Fax #:_____

D.

ICD-9 Codes	Clinical Diagnosis	Date of Onset

E.

* Status	HCPCS Code	Item Description	Length of Need (# of Months)	Amt / Mo Requested	* Amt / Mo Approved

***** WVMI Use Only. Key: P=Pending, D=Denied

F. **Clinical Indication(s) for Item(s) requested:** _____
_____
_____
_____

G. **PRACTITIONER CERTIFICATION**

I certify that I have examined the member within the past 6 months and the equipment and/or supplies requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not a convenience item for the member or any individual involved with the member's care. I certify that the member or his representative have been offered a choice of vendors.

_____ _____ _____
Prescribing Practitioner's Signature ***(required)*** Medicaid ID# Date

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

For WVMI Use Only:

Approved: ___ Authorization Number: _____ Date: _____

Denied: ____ Detailed letter to follow

NOTICE OF CONFIDENTIALITY

Bureau for Medical Services
Certificate of Medical Necessity
Durable Medical Equipment/Medical Supplies

SECTION I

MEMBER DATA	**SERVICING PROVIDER**	**CMN Status**
Medicaid ID#_____	Provider ID#_____	
Name_____	Provider Name_____	____Initial
D.O.B._____	Contact Person_____	____Revised
Phone # (___) _____	Phone # (____) _____	____Renewed

Section II MEMBER INFORMATION

Answer all questions that are applicable to **DME/ Medical Supplies** services being requested. If answer is **Yes**. You must describe/ attach additional information to support medical justification..

DOES PATIENT:	**YES**	**NO**
1. Have impaired mobility?	___	___
2. Have impaired endurance?	___	___
3. Have restricted activity?	___	___
4. Have skin break down? (Attach description of site, size, depth, and drainage)	___	___
5. Have impaired respiration? (Results of recent PO2/ saturation levels must be on file)	___	___
6. Require assistance with ADL'S ?	___	___
7. Have impaired speech?	___	___
8. Is item suitable for use in home and does the member/caregiver demonstrate willingness and ability to use the equipment?	___	___

9. Height: _____ Weight: _____

DATE PATIENT LAST EXAMINED BY PRACTITIONER: _____/_____/_____

ICD 9- CODES	**CLINICAL DIAGNOSIS**	**DATE OF ONSET**

SECTION III

Begin Service Date	HCPCS Code	Item Description	Estimated Length of Need (# Months)	Quantity and Frequency Of Use	Dollar Amount

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective", and is not a convenience item for the member, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

Prescribing Practitioner's Name	**Practitioner's Signature**	**Date**	**ID #**	**Phone #**

WVDHHR/BMS/CMU/CMN/Revised 04/2005

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Initial Infant Apnea Monitor

Member's Name_____ Medicaid ID #_____

Member's Birthdate_____ Birth Weight _____ Gestational Age_____

Address_____

Parent/Guardian_____ Telephone #_____

Prescribing Practitioner_____Telephone #_____

Address_____

Diagnosis relating to need of Apnea Monitor (Must be <u>one</u> of the conditions below):
[ ] Sibling of SIDS
[ ] Apparent life threatening event (ALTE)
[ ] Infant with narcotic addict mother
[ ] Infant with high risk cardiac disease
[ ] Infant with tracheostomy
[ ] Prematurity

Date of ALTE_____ Number of episodes_____ How documented_____

Hospital_____

Admission date_____ Discharge date_____

Estimated length of need/frequency of use:
[ ] Short term (e.g., weaning from theophylline 1-2 weeks)
[ ] One Month [ ] Two Months [ ] Three Months [ ] Six Months

Frequency of use _____ Apnea delay rate_____

Follow-up appointment scheduled for_____ with_____

DME Provider_____Medicaid ID #_____

Address_____Telephone #_____

Date of monitor placement_____

I, the undersigned, certify the above prescribed equipment is medically necessary for the indications certified above, and at the termination of
the period of medical necessity, the monitor will be removed. If a renewal prescription is not issued, then the authorization for the monitor is
cancelled and it is reasonable for the DME provider to remove the equipment.

_____ _____
Practitioner's Signature Date Signed

I have read and understand that before the end of the estimated period of need, I must bring my infant to the prescribing practitioner's office or
clinic so that he/she can determine how my infant is progressing and if there is further need for the monitor. Should I not comply with this regulation, then the monitor will no longer be prescribed and may be removed by the DME provider.

_____ _____
Parent/Guardian's Signature Date Signed

<u>Request for prior authorization must be submitted to West Virginia Medical Institute seven (7) calendar days post hospital discharge</u>

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Infant Apnea Monitor
Request For Extension

Member's Name_____ Medicaid ID #_____

Address_____

Diagnosis relating to need of Apnea Monitor (Must be one of the conditions below):

[ ] Sibling of SIDS
[ ] Apparent life threatening event (ALTE)
[ ] Infant with narcotic addict mother
[ ] Infant with high risk cardiac disease
[ ] Infant with tracheostomy
[ ] Prematurity

DME Provider_____ Medicaid ID #_____

Date of initial monitor placement_____

Frequency of monitor use _____

Date, frequency and type of alarms in past month_____

Date of last appointment_____Practitioner_____

Date of next appointment_____Practitioner_____

Please describe the conditions requiring extension_____

_____

Period of Medical Necessity: [ ] One Month [ ] Two Months [ ] Three Months

Apnea delay rate_____ Bradycardia alarm limit_____

I, the undersigned, certify the above prescribed equipment is medically necessary for the indications certified above, and at the termination of the period of medical necessity, the monitor will be removed. If a renewal prescription is not issued, then the authorization for the monitor is cancelled and it is reasonable for the DME provider to remove the equipment.

_____ _____
Practitioner's Signature Date Signed

I have read and understand that before the end of the estimated period of need, I must bring my infant to the prescribing practitioner's office or clinic so that he/she can determine how my infant is progressing and if there is further need for the monitor. Should I not comply with this regulation, then the monitor will no longer be prescribed and may be removed by the DME provider.

_____ _____
Parent/Guardian's Signature Date Signed

CHAPTER 507–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR FREESTANDING AMBULATORY SURGICAL CENTER AND BIRTHING CENTER SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 507.3.1	Services Requiring Prior Authorization	01/06/06	02/15/06
Section 507.3.1	Services Requiring Prior Authorization	10/24/05	Postponed
Section 507.3.1	Services Requiring Prior Authorization	9/28/05	11/01/05

January 06, 2006

Section 507.3.1

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment I.

Change: First paragraph to read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment I, along with the PA form that may be utilized.

Directions: Change pages.

October 24, 2005

Section 507.3.1

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

September 28, 2005

Section 507.3.1

Introduction: Added section for more clarity.

Change: Added all surgeries performed in place of services 22 (Out patient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the services. Failure to obtain prior authorization will result in denial of the services; the Medicaid member can not be billed for failure to receive authorization for these services.

Prior authorization requirements governing the prevision of all West Virginia Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements, and Chapter 400, Section 440 Explanation of the Medicaid Beneficiary ID card, provider manual.

Directions: Replace pages.

CHAPTER 507—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR FREESTANDING AMBULATORY SURGICAL CENTER AND BIRTHING CENTER SERVICES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

CHAPTER 507–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR FREESTANDING AMBULATORY SURGICAL CENTER AND BIRTHING CENTER SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in this manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth requirements of the BMS regarding payment and processing of services provided by Freestanding Ambulatory Surgical Centers and Birthing Centers to eligible WV Medicaid beneficiaries.

The policies and procedures set forth herein are promulgated as regulations governing the provision of services by ASC and birthing centers in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

507.1 DEFINITIONS

The following are definitions specific to ASC and Birthing Center services.

Ambulatory Surgery Center (ASC) – Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and that has an agreement with CMS under Medicare to participate as an ASC and licensed by the appropriate State regulatory agency.

Birthing Center – Any distinct entity which operates exclusively for the purpose of providing birthing services (uncomplicated newborn deliveries) to patients not requiring hospitalization is licensed by the applicable state regulatory agency and has executed a provider enrollment/agreement with the Bureau For Medical Services to provide such services to Medicaid eligible individuals.

Covered ASC Surgical Procedures – Those surgical procedures which may safely be preformed in the ASC setting and which the ASC is authorized by Federal and State law and regulation to perform.

Birthing Center Covered Services – Those newborn deliveries which may safely be performed in the birthing center setting, and which do not require the level of support and medical service available only in the inpatient hospital setting.

Surgical Level – An acuity level assigned by Medicare to procedures covered in ASC facilities. The level includes an allowance for facility costs, e.g. operating room and anesthetic and usual supplies related to the procedure.

Case Reimbursement Birthing Center Service – The per case bundled rate reimbursed to a birthing center includes the facility cost, nursing and other personnel services, and usual supplies related to the uncomplicated newborn delivery. Physician or nurse midwife professional charges are reimbursed directly to the professional practitioner at the applicable reimbursement rates in effect as of the date of service.

507.2 PROVIDER PARTICIPATION

Refer to Chapter 300 for provider requirements. In addition to the basic requirements for participation, an ASC must be an independent freestanding facility that has been surveyed and approved by Medicare and licensed by the appropriate State regulatory agency. The birthing center must be licensed by the appropriate state regulatory agency. A condition of that licensure includes the requirement for transfer agreement between the birthing center and an acute care general hospital for patients who might experience complications in the delivery. The facility must also be a contracted provider within an HMO network if rendering services to HMO members.

507.3 COVERED SERVICES

The WV Medicaid Program covers medically necessary services provided by an ASC to eligible beneficiaries within coverage/benefit limitations in effect on the date of service. Coverage and benefit limitations are subject to change as Federal regulations and State policies dictate. Covered procedures are based on the Medicare designated procedures and their assigned acuity-based surgical levels. The state has opted to cover certain additional procedures based on common local practices and state assigned surgery levels, including minor surgical procedures performed under local anesthesia. Those minor procedures are covered under a state specific level, and reimbursed at a rate of $30.00 per procedure.

Birthing centers are reimbursed by Medicaid only for those services related to uncomplicated newborn delivery, as defined in Section 507.1 of this chapter.

507.3.1 SERVICES REQUIRING PRIOR AUTHORIZATION

Certain surgeries performed in place of services 22 (Outpatient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment I, along with the PA form that may be utilized.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the services. Failure to obtain prior authorization will result in denial of the services; the Medicaid member can not be billed for failure to receive authorization for these services.

Prior authorization requirements governing the prevision of all West Virginia Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements, and Chapter 400, Section 440 Explanation of the Medicaid Beneficiary ID card, provider manual.

507.4 NON-COVERED SERVICES

The following is a list of non-covered services for Ambulatory Surgery and Birthing Centers:

- Surgical procedures and deliveries that cannot be safely performed in an outpatient setting or without support of the full array of hospital diagnostic and treatment services and equipment.
- Procedures not covered by Medicaid including, but not limited to, cosmetic surgery.
- Medical equipment or supplies dispensed for use in the patient's home.

- Services provided to HMO members without appropriate prior authorization from the HMO.

507.5 SPECIAL DOCUMENTATION REQUIREMENTS

The following procedures require submission of supporting documentation:

- Sterilization – The individual must complete an Informed Consent Form. The individual to be sterilized must be 21 years of age or older at the time the consent form is signed. Coverage is not provided for mentally incompetent or institutionalized individuals. The physician must obtain and submit the consent. Payment will not be made to any involved providers until the consent is on file.
- Hysterectomy – This procedure requires a signed Acknowledgement Form, and is only covered for medical reasons. An Acknowledgement Form must be completed and submitted by the physician. Payment will not be made to any involved provider until the Acknowledgement Form is on file.

If the sterilization procedure did not render the patient sterile (i.e., a unilateral procedure was done) or the patient was sterile prior to the hysterectomy, documentation of the operative procedure or prior status must accompany the claim.

Detailed billing instructions are included in Chapter 600. In addition, procedure modifiers are required when billing bilateral (modifier 50) and multiple (modifier 51) surgical procedures. The primary procedure (usually the procedure with the highest complexity and therefore highest surgery level) is billed without modifier 51. Subsequent procedures are billed with modifier 51.

507.6 PAYMENT AND LIMITATIONS

Ambulatory Surgery Centers

Payment for services performed in an ASC are based on the Surgery Level assigned to the code by Medicare or BMS. BMS rates are updated periodically based on the rate update published by Medicare. In addition Medicaid assigns a BMS Medicaid specific rate for certain minimal procedures.

Fees for Surgical Levels one (1) through (9) are calculated at ninety percent (90%) of the Medicare fee for the level. Multiple procedures are paid at one hundred percent (100%) of the fee for the primary procedure and fifty percent (50%) of each additional procedure. Bilateral procedures are paid at one hundred and fifty percent (150%) of the single procedure rate. If the beneficiary is a member of an HMO, reimbursement will be made by the HMO based upon the contracted rate between the ASC and the HMO.

For specific information regarding Medicaid ambulatory surgery center fee updates, please refer to the Bureau's web page at www.wvdhhr.org/bms, section: Program Instructions.

Supplies and other items incidental to the surgical procedures performed are not covered for separate payment. The cost of such items is included in the Surgical Level for the procedure.

Birthing Center Services

Birthing Center Services are reimbursed on a per case bundled rate, which is intended to cover the facility's cost, nursing services, and other facility support staff, anesthetic and usual supplies

related to the uncomplicated newborn delivery procedure. Supplies and other items incidental to the delivery are not covered for separate reimbursement, the cost of such items is included in the case payment to the facility. Physician or nurse midwife professional charges are reimbursable to the Medicaid Program participating professional practitioner at RBRVS rates in effect for that particular procedure as of the date of service.

CHAPTER 507
AMBULATORY SURGERY CENTER & BIRTHING CENTER
JUNE 1, 2005

ATTACHMENT I
OUTPATIENT SURGERY PA REQUIREMENTS
PAGE 1 OF 16

Confidential

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____

A. **Member** Name: _____ Date of Birth: _____
Last First MI
Member Address: _____
Street City State Zip

B. **Surgical Procedure** Requested: _____
CPT Code **(Required)**: _____ ICD-9-CM Code **(Required)**: _____ Assistant surgeon? ☐ Yes ☐ No

Diagnosis Related to Surgical Procedure: _____

C. **Facility** Performing Surgical Procedure: _____
Facility ID # (10 digits): _____ Facility is: □ In WV □ Outside WV

Referring Physician Name: _____
Mailing Address: _____
Street City State Zip
Surgeon Name: _____
Mailing Address: _____
Street City State Zip

Contact Name: _____ Phone# (_____)_____-_____ Ext: _____
Fax # (_____)_____-_____

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): _____
_____
_____
_____ Date of Onset: _____

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):_____
_____
_____

F. **Related Medications, Treatments, and Therapies (include duration): _____**
_____
_____
_____

G. If procedure routinely performed in office, please document need for OP surgical setting: _____
_____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For <u>WVMI Use Only:</u>
Approved: ___ Authorization Number: _____ Date*: _____

***(Authorization expires 90 days from this date)**

Denied: ____ Detailed letter to follow

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X

11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X
11471	Removal, sweat gland lesion	X	X
11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X

12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	
14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	
14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	

19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	
19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	
19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	

21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	

21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	
22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	

25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	
26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	
26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	

27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	
28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	
28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	

29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	
29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	

37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	
42810	Excision of nect cyst	X	
42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	
43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	

49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	
54409	Removal of inflatable penile prosthesis	X	
54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	
57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	

58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	
64555	Implant neuroelectrodes	X	
64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	
64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervationof extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	

67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	
69632	Rebuild eardrum structures	X	
69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	
76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	

51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	

CHAPTER 508 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOME HEALTH
CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 508.4	Covered Services	May 1, 2010	July 1, 2010
Section 508.4.1	Skilled Nursing Visit	May 1, 2010	July 1, 2010
Section 508.4.2	Medical Social Work Services	May 1, 2010	July 1, 2010
Section 508.4.2 (formerly Section 508.4.3)	Home Health Aide Services	May 1, 2010	July 1, 2010
Section 508.4.3 (formerly Section 508.4.4)	Speech-Language Pathology	May 1, 2010	July 1, 2010
Section 508.4.4 (formerly Section 508.4.5)	Physical Therapy	May 1, 2010	July 1, 2010
Section 508.4.5 (formerly Section 508.4.6)	Occupational Therapy	May 1, 2010	July 1, 2010
Section 508.4.7	All Inclusive Visit	May 1, 2010	July 1, 2010
Section 508.4.6 (formerly Section 508.8)	Venipuncture Performed in the Home	May 1, 2010	July 1, 2010
Section 508.4.7 (new section)	Reimbursement Methodology	May 1, 2010	July 1, 2010
Section 508.8	Authorization	May 1, 2010	July 1, 2010
Section 508.9	Billing Procedure	May 1, 2010	July 1,2010
Section 508.8	Authorization	08/11/05	08/15/05
Section 508.8.1	Services Requiring Authorization	08/11/05	08/15/05
Section 508.8.2	Authorization Procedures	08/11/05	08/15/05

JULY 1, 2010

SECTION 508.4

Introduction: Section 508.4, Covered Services
Old Policy: Home health agencies must obtain authorization when the services are in excess of 124 visits in a calendar year. The total 124 visits includes any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), home health aide (HHA), medical social worker (MSW), and the procedures for all-inclusive services.
New Policy: Home health agencies must obtain authorization when the services are in excess of 60 visits in a calendar year. The total 60 visits include any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), and home health aide (HHA).

SECTION 508.4.1

Introduction: Section 508.4.1, Skilled Nursing Visit
Old Policy: REVENUE CODE: 0551(W2100)
New Policy: REVENUE CODE: 0551

SECTION 508.4.2

Introduction: Section 508.4.2, Medical Social Work Services
Old Policy: REVENUE CODE: 0561(W2105)SERVICE UNIT: Visit
DEFINITION: Service definitions and limitation are delineated in Attachment 1
New Policy: Delete Section

SECTION 508.4.2 (FORMERLY SECTION 508.4.3)

Introduction: Section 508.4.2, Home Health Aide Services
Old Policy: REVENUE CODE: 0571(W2110)
New Policy: REVENUE CODE: 0571

SECTION 508.4.3 (FORMERLY SECTION 508.4.4)

Introduction: Section 508.4.3, Speech-Language Pathology
Old Policy: REVENUE CODE: 0441(W2115)
New Policy: REVENUE CODE: 0441

SECTION 508.4.4 (FORMERLY SECTION 508.4.5)

Introduction: Section 508.4.4, Physical Therapy
Old Policy: REVENUE CODE: 0421(W2135)

New Policy: REVENUE CODE: 0421

SECTION 508.4.5 (FORMERLY SECTION 508.4.6)

Introduction: Section 508.4.5, Occupational Therapy
Old Policy: REVENUE CODE: 0431(W2140)
New Policy: REVENUE CODE: 0431

SECTION 508.4.6 (FORMERLY SECTION 508.4.8)

Introduction: Renumbering Section Venipuncture Performed in the Home

SECTION 508.4.7 (OLD)

Introduction: Section 508.4.7, All Inclusive Visit
Old Policy: Medicare has identified that certain home health agencies must bill an all inclusive code for any home health service visit. The actual visit may be done by any one of the home health disciplines approved for providing home health services for the specific agency. The disciplines are skilled nurse visit (SNV), physical therapy (PT), speech-language pathology (ST), occupational therapy (OT), and home health aide (HHA). The agencies using this code are usually county health departments and are known as The Family of Home Health Agencies. Service definitions and limitations for each home health discipline are delineated in **Attachment 1.**
New Policy: Delete section.

SECTION 508.4.7 (NEW)

Introduction: Section 508.4.9, Reimbursement Methodology
Old Policy: N/A
New Policy: Medicaid reimbursement of Medicare certified home health services shall be based on 90% of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge, whichever is less. The calculated LUPA rates will include an applicable Core-Base Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to beneficiaries outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full.

SECTION 508.8

Introduction: Section 508.8, Authorization

Old Policy: Authorizations for Home Health Services in excess of 124 visits per calendar year are no longer required; however, it is the responsibility of the provider to maintain the CMS-485, CMS-486, and OASIS assessments on file. Home Health visits are subject to post-payment audit.
New Policy: Authorizations for Home Health Services in excess of 60 visits per calendar year are no longer required; however, it is the responsibility of the provider to maintain the CMS-485, CMS-486, and OASIS assessments on file. Home Health visits are subject to post-payment audit.

SECTION 508.9

Introduction: Section 508.9, Billing Procedure
Old Policy: Home health claims may be billed using either the HCFA 1500 or the UB 92 until the date of change in the Bureau's fiscal agent. Following the implementation of the new fiscal agent for Medicaid, all claims must be billed using the UB 92 or the 837I electronic format. If the services were provided prior to the implementation date for the new fiscal agent, both the local W codes as well as the revenue codes must be noted on the claim. For services provided after implementation, only the revenue codes are required.
New Policy: All claims must be billed using the UB 04 or the 837I electronic format. If the services were provided prior to the implementation date for the new fiscal agent, only the revenue codes must be noted on the claim. For services provided after implementation, only the revenue codes are required.

AUGUST 15, 2005
SECTION 508.8

Introduction: Removal of Authorization Requirements for Home Health Services over 124 visits
Change: Removal of entire paragraph under "Authorization". Replace paragraph with statement "Authorizations for Home Health Services in excess of 124 visits per calendar year are no longer required; however, it is the responsibility of the provider to maintain the CMS-485, CMS-486, and the OASIS assessments on file. Home Health visits are subject to post-payment audit."
Directions: Replace this section

SECTION 508.8.1

Introduction: Removal of Authorization Requirements for Home Health Services over 124 visits
Change: Removal of entire paragraph under "Services Requiring Authorization".
Directions: Remove this section

SECTION 508.8.2

Introduction: Removal of Authorization Requirements for Home Health Services over 124 visits
Change: Removal of all paragraphs under “Authorization Procedures”.
Directions: Remove this section

CHAPTER 508—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR HOME HEALTH
TABLE OF CONTENTS

TOPIC **PAGE NO.**

Attachment 2: Covered Medical Supplies

CHAPTER 508–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS, FOR HOME HEALTH

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of services provided by certified home health agencies to eligible WV Medicaid members.

The policies and procedures set forth herein are regulations governing the provision of home health agency services in the Medicaid Program administered by the WV Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code.

508.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, Definitions, of the Provider Manual.

508.2 PROVIDER PARTICIPATION

In order to participate in the WV Medicaid Program and receive payment from the Bureau, home health agencies must meet the following conditions in addition to requirements set forth in Chapter 300:

- Certification for participation in Title XVIII, Medicare, by the appropriate certifying agency in the State where the agency is located. (In West Virginia, the Office of Health Facility Licensure and Certification in the Department of Health and Human Resources is the certifying agency.)
- A home health agency must be approved for Medicare participation before requesting an application from Medicaid for enrollment as a provider. The home health agency must send a copy of approval as a Medicare provider along with the rate of reimbursement set by Medicare for each service which has been approved by Medicare. A change in the Medicare rate and/or services provided must be submitted on the Medicare letterhead to the Medicaid agency.

508.3 MEMBER ELIGIBILITY

Payment for medically necessary and appropriate home health agency services is available on behalf of all WV eligible Medicaid members subject to the conditions and limitations that apply to

these services. The qualifying criteria are described in Attachment 1 and may be found at the CMS web site www.cms.hhs.gov/manuals.

- The member must meet the qualifying criteria for Medicare coverage as currently published or modified in the future. These criteria include having a need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or a need for occupational therapy subsequent to the initiation of physical therapy.

- The member may receive skilled nursing visits (SNV) if only a registered nurse or licensed practical nurse can provide the service as certified by a physician thus allowing the individual to be in the community rather than institutionalized.

- Home health services may be provided to a child who would be homebound if the services were not provided as certified by a physician. The home health services must not duplicate services received from other sources.

508.4 COVERED SERVICES

Except for the limitations and exclusions listed below and in attachment 1, the Bureau will pay for medically necessary and appropriate home health agency services provided to eligible Medicaid members by a Medicaid enrolled home health agency.

Home health agencies must obtain authorization when the services are in excess of 60 visits in a calendar year. The total 60 visits include any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), and home health aide (HHA).

508.4.1 SKILLED NURSING VISIT

REVENUE CODE: **0551**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.2 HOME HEALTH AIDE SERVICES

REVENUE CODE: **0571**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.3 SPEECH-LANGUAGE PATHOLOGY

REVENUE CODE: **0441**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.4 PHYSICAL THERAPY

REVENUE CODE: **0421**
SERVICE UNIT: **Visit**

DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.5 OCCUPATIONAL THERAPY
REVENUE CODE: **0431**
SERVICE UNIT: **Visit**
DEFINITION: Service definitions and limitations are delineated in **Attachment 1**

508.4.6 VENIPUNCTURE PERFORMED IN THE HOME
PROCEDURE CODE: **S9529**
SERVICE UNIT: **Visit**
SERVICE LIMIT: **None**
AUTHORIZATION: **None**
DEFINITION: Venipuncture performed in a member's home is a covered service. The member must meet the Medicare definition of home bound and have a physician's order for home based venipuncture. The member can not be receiving Home Health Services. This service includes transportation to the member's home and can not be provided at any other location.

508.4.7 REIMBURSEMENT METHODOLOGY

Medicaid reimbursement of Medicare certified home health services shall be based on 90% of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge, whichever is less. The calculated LUPA rates will include an applicable Core-Base Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to beneficiaries outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full.

508.5 MEDICAL SUPPLIES

A comprehensive list of covered medical supplies can be found in **Attachment 2**. Unless specified otherwise, Medicaid follows Medicare's guidelines for medical necessity review for medical supplies. Items not listed in **Attachment 2** are presumed non-covered.

Medicare guidelines for medical necessity can be found at www.ngs.medicare.com and/or palmettogba.com web sites. Questions regarding product classification should be directed to Palmetto GBA-SADMERC.

Physician orders and documentation supporting medical necessity for supplies must be present. Home health agencies must use reasonable quantities of the least costly product which will adequately meet the needs of the member. Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the member or other caregivers.

Medical supplies are separated into three categories:

- Routine (non-billable): Supplies that are customarily used in small quantities during the usual course of most home visits. They are usually included in the staff's supplies and not designated for a specific member. These supplies are included in the cost per visit of home health care services.
- Non-Routine (billable): Supplies that are needed to treat a member's specific illness or injury in accordance with the physician's plan of care. The item must be directly identifiable to an individual, the cost of the item can be identified and accumulated in a separate cost center, and the item is furnished at the direction of the member's physician and is specifically identified in the plan of care, i.e., the item is needed to treat a member's specific illness. The home health agency must also follow a consistent charging practice for Medicaid and non-Medicaid members receiving the item.
- Non-Covered: Supplies that are not covered under the Medicare home health benefit. Home health agencies can not bill for these supplies and the cost of the supplies can not be included as a part of the "cost of doing business". Comfort and convenience items are non-covered as well as program exclusions such as prescription drugs and biologicals.

508.6 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 100, General Information, of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of home health agency services described in this chapter.

- Home health agency services are covered when provided by Medicare certified/Medicaid enrolled home health agencies only for those services for which they have been approved by Medicare to provide.
- Services and supplies must be provided pursuant to a physician's written order which details the member-specific plan of care.
- Home health aide services will not be covered unless the member requires skilled nursing services, physical therapy services, speech-language pathology services, or occupational therapy services provided subsequent to physical therapy services.
- Newborn home health care will not be covered unless there is a diagnosis and/or condition that require intermittent skilled nursing services.
- Pre-filling of insulin syringes is a covered home health skilled service if there is no pharmacy or person in the home to provide the service.

508.7 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information, of the Provider Manual, the Bureau will not pay for the following services as a home health benefit:

- For a dually eligible member (Medicare/Medicaid), any services denied by the Medicare Program

- Services in excess of those deemed medically necessary by the Bureau to treat the member's condition
- Services not directly related to the member's diagnosis, symptoms, or medical history
- Duplicative services provided to members receiving benefits through the Home and Community-Based Aged/Disabled Waiver Program (ADW).
- Duplicative services provided to members receiving benefits through the Home and Community-Based Mental Retardation/Developmental Disability Waiver Program (MR/DDW)
- Services provided to members receiving benefits of the Hospice program
- Services provided to members receiving similar services from a behavioral health or community provider
- Homemaker services
- Respite care
- Custodial care
- Telephone consultations
- Failed appointments, including but not limited to, canceled appointments and appointments not kept
- Time spent in preparation of reports
- Experimental services or drugs

508.8 AUTHORIZATION

Prior authorizations for Home Health Services in excess of 60 visits per calendar year are required; it is the responsibility of the provider to maintain the CMS-485, CMS-486, and OASIS assessments on file. Home Health visits are subject to post-payment audit.

508.9 BILLING PROCEDURE

All claims must be billed using the UB 04 or the 837I electronic format; only revenue codes are required to be submitted on claim form.

508.10 COORDINATION OF CARE REQUIREMENTS AND PAYMENT LIMITS

Home health agency providers must determine whether Medicaid eligible member referred for home health agency services are authorized to receive similar services under other Medicaid programs or benefits. Home health agency providers must coordinate the provision of home health agency services with other Medicaid service providers in order to avoid duplication of similar services and subsequent disallowance of payments.

Requirements for coordination of care and payment limits for specific services are described in this section for the following benefits:

- Hospice
- Home and Community-Based Waiver Program for the Mentally Retarded/Developmentally Disabled
- Home and Community-Based Waiver Program for the Aged and Disabled

- Personal Care Services
- Children's Special Care

508.11 HOSPICE

Members who have elected to receive services through a hospice agency are not eligible to receive services through a home health agency. Medical care and case management of members receiving hospice services are the responsibility of the hospice agency.

508.12 MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED (MR/DD) WAIVER

Members who have been determined eligible for and are enrolled in the Home and Community-Based Waiver Program for the MR/DD may receive services from a home health agency that do not duplicate MR/DD Waiver services. An agreement between the MR/DD Waiver coordination agency and the home health agency must be on record. The need for home health agency services must be documented in the member's Individual Program Plan (IPP). Documentation of the referral must be maintained in the member's records of both the MR/DD Waiver Program coordination agency and the home health agency.

508.13 AGED AND DISABLED WAIVER (ADW)

Members who have been determined eligible for and are enrolled in the Home and Community Based Aged/Disabled Waiver Program may receive services from a home health agency that do not duplicate AD Waiver services. Home health agency services provided to ADW member must be coordinated by the ADW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for home health services must be documented in the member's Plan of Care (POC). Documentation of the referral must be maintained in the member's records of both the AD Waiver agency and the home health agency

508.14 PERSONAL CARE SERVICES

Members who are receiving personal care services provided through behavioral health or community care programs may also receive home health agency services. These services are limited to services which can only be performed by a licensed nurse and/or a licensed therapist. The home health agency must maintain documentation regarding the need for services as well as the plan of care for the member. No payment shall be made to home health agencies for home health aide services provided to members who are also receiving personal care services.

508.15 CHILREN'S SPECIALTY CARE

Staff of the Children's Specialty Care (CSC) program shall authorize all care, including home health services, for children receiving specialized medical services under the auspices of the CSC program. The CSC program evaluates requests for prior authorization of home health

services based on Medicaid policy requirements for such services, regardless of the child's eligibility for the Medicaid program.

Requests for prior authorization of home health services for CSC enrollees should be forwarded to the CSC program as follows:

Children Specialty Care Program
350 Capitol Street
Charleston, West Virginia 25301

508.16 MANAGED CARE

If the Medicaid member is enrolled in an MCO, coverage and prior authorization requirements of the health plan must be followed. If the member is enrolled in the PAAS Program, authorization or a referral must be given by the member's PCP. Medicaid will not reimburse for services if the HMO denies payment because their requirements were not followed.

CHAPTER 508
HOME HEALTH SERVICES
JULY 1, 2004

ATTACHMENT 1
GUIDELINES FOR COVERED SERVICES
PAGE 1 OF 3
REVISED JULY 1, 2010

GUIDELINES FOR COVERED SERVICES

The Medicaid Program uses the Medicare guidelines for covered Home Health services as currently published or amended in the future. These guidelines and future updates may be found at www.cms.gov/manuals.

Since the West Virginia Medicaid population does not always fit the picture of the elderly or disabled Medicare members, exceptions to the Medicare guidelines have been implemented for Medicaid members. These exceptions include, but are not limited to the definition of homebound status when certain skilled medical procedures are necessary and when skilled services for infants and children are necessary.

Skilled nursing visits (SNV) may be provided for Medicaid eligible individuals who do not meet the Medicare defined criteria for homebound if only a registered nurse or licensed practical nurse can provide the service, thus allowing the individual to be deinstitutionalized. Documentation must clearly indicate the need for the service, such as why the individual cannot go to a health care provider for the treatment. Examples of this type of SNV include but are not limited to IV infusions, central line dressing changes, and sterile dressing changes for wounds with the application of a prescribed medication.

Skilled nursing, physical therapy, occupational therapy, and speech-language pathology home health services must be reasonable and necessary for the diagnosis and treatment of the illness or injury within the context of the member's unique medical condition. To determine if the services are reasonable and necessary, the following items will be considered:

- The diagnosis is never to be the sole factor in determining medical necessity.
- The determination of medical necessity of the services should be based upon the member's unique condition, whether it is acute, chronic, terminal, or expected to continue over a long period of time, and in some cases if the condition is stable.
- The services are intermittent.
- Documentation must support the establishment of medical necessity and should clearly define the member's unique circumstance that justifies provision of these services.

Skilled nursing visits for observation are medically necessary when the likelihood of change in a member's condition requires the skills of a registered nurse to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures. When documentation indicates a reasonable potential for a complication or further acute episode, skilled registered nurse visits for observation and assessment will be covered for a maximum of three weeks from the start of care. Visits may be covered longer if there remains a reasonable potential for such a complication or acute episode. Documentation in the medical record must clearly indicate a change in the health status such as fluctuation of vital signs for observation and assessment to continue as a skilled service.

Teaching and training activities by a skilled nurse are covered when it is necessary to teach a member, family member or care giver how to manage the treatment regimen and the skill being taught is reasonable and necessary to the treatment of the illness, injury or functional loss. There is no requirement that the member, family member or other care giver be taught to provide a service if the member, family member or care giver cannot or chooses not to provide the care.

In all cases, documentation of the member's mental status must clearly indicate why the individual cannot be educated to provide the skilled care. Additionally, if there are others in the household who might be able to provide care, documentation must indicate why these individuals cannot provide the care or are unwilling.

Infants and toddlers are not automatically considered homebound. Infants discharged from a neonatal intensive care unit may receive skilled nurse visits for observation and education as appropriate. Documentation must clearly indicate the need for these visits. This documentation would include the mental status of the care giver as well as the reason the infant is homebound. Other conditions may warrant skilled nurse visits for infants include, but are not limited to, home IVs and infants identified as failure to thrive.

For children, the focus is to main stream the physically challenged individuals as much as possible. Home health services may be provided to a child who would be homebound if the services were not provided or the normal care giver is unavailable to provide the care for a short period of time. The home health visits must not duplicate services received from other sources.

A member with a psychiatric disorder is considered homebound if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended, even if he/she has no physical limitations. The diagnosis and rationale for homebound status must be made by a psychiatrist. The following conditions support the homebound determination:

- Agoraphobia, paranoia, or panic disorder;
- Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the member's judgment and decision making and therefore the member's safety;
- Acute depression with severe vegetative symptoms; and
- Psychiatric problems associated with medical problems that render the member homebound.

The services of a skilled psychiatric nurse must be required to provide the necessary care. Many members, who require the services of a skilled psychiatric nurse also require skilled nursing care related to a physical illness. Therefore, the psychiatric nurse must also have medical and surgical nursing experience to ensure that all the member's home care needs are met. Counseling services may be provided by either a trained psychiatric nurse. These services should not be duplicative, and concurrent counseling or psychotherapy services by multiple providers are not medically necessary.

For all home health services provided to Medicaid members, the documentation must clearly indicate that the services are reasonable and necessary. The documentation must be clear, specific and measurable. For homebound status, the medical record must indicate exactly why it is a considerable and taxing effort for the individual to leave the home. The lack of transportation is not evidence the individual is homebound. An individual who is physically and mentally capable of driving a car is not considered homebound.

CHAPTER 508
HOME HEALTH SERVICES
JULY 1, 2004

ATTACHMENT 2
COVERED MEDICAL SUPPLIES
PAGE 1 OF 19

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	SPECIALTY	NOT COVERED BY MEDICARE	SPECIAL INSTRUCTIONS
A4206	Syringe with needle; sterile 1 cc, each		100 per month	G3, T5, 58	X	
A4207	sterile 2 cc, each		100 per month	G3, T5, 58	X	
A4208	sterile, 3 cc, each		100 per month	G3, T5, 58	X	
A4209	sterile, 5cc or greater, each		100 per month	G3, T5, 58	X	
A4213	Syringe, sterile, 20cc or greater, each		60 per month	G3, T5, 58	X	
A4215	Needles only, sterile, any size, each		100 per month	G3, T5, 58	X	
A4216	Sterile water/saline, 10 ml		Cost Invoice	G3, T5, 58		
A4217	Sterile water/saline, 500 ml		Cost Invoice	G3, T5, 58		
A4244	Alcohol or peroxide, per pint		15 per month	G3, T5, 58	X	
A4245	Alcohol wipes, per box		2 boxes/month	G3, T5, 58	X	
A4246	Betadine or phisohex solution, per pint		12 per month	G3, T5, 58	X	
A4247	Betadine or iodine swabs/wipes, per box		2 boxes/month	G3, T5, 58	X	
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips		3 boxes/month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4253 KS	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (1 box)	W0708	2 boxes per month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4256	Normal, low and high calibrator solution/chips		1 per 3 months	G3, T5, 58		
A4258	Spring-powered device for lancet, each		1 per 2 years	G3, T5, 58		
A4259	Lancets, per box of 100		2 boxes/month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4259 KS	Lancets, per box of 100	W0709	1 box per month	G3, T5, 58		Requires diagnosis of 250.00 thru 250.93
A4265	Paraffin, per pound		12 per 3 months	G3, T5, 58		
A4310	Insertion tray without drainage bag; and without catheter (accessories only)		2 per month	G3, T5, 58		
A4311	Insertion tray without drainage bag; with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)		2 per month	G3, T5, 58		
A4312	with indwelling catheter, foley type, two-way, all silicone		2 per month	G3, T5, 58		

A4313	with indwelling catheter, foley type, three-way, for continuous irrigation	2 per month	G3, T5, 58		
A4314	Insertion tray with drainage bag; with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	2 per month	G3, T5, 58		
A4315	with indwelling catheter, foley type, two-way, all silicone	2 per month	G3, T5, 58		
A4316	with indwelling catheter, foley type, three-way, for continuous irrigation	2 per month	G3, T5, 58		
A4320	Irrigation tray with bulb or piston syringe, any purpose	2 per month	G3, T5, 58		
A4322	Irrigation syringe, bulb or piston, each	2 per month	G3, T5, 58		
A4324	Male external catheter, with adhesive coating, each	31 per month	G3, T5, 58		
A4325	Male external catheter, with adhesive strip, each	31 per month	G3, T5, 58		
A4326	Male external catheter specialty type with integral collection chamber, each	31 per month	G3, T5, 58		
A4327	Female external urinary collection device, meatal cup, each	2 per month	G3, T5, 58		
A4328	pouch, each	2 per month	G3, T5, 58		
A4330	Perianal fecal collection pouch with adhesive, each	31 per month	G3, T5, 58		
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each	5 per month	G3, T5, 58		
A4332	Lubricant, individual sterile packet, for insertion of urinary catheter, each	31 per month	G3, T5, 58		
A4333	Urinary catheter anchoring device, adhesive skin attached, each	12 per month	G3, T5, 58		
A4334	Urinary catheter anchoring device, leg strap, each	1 per month	G3, T5, 58		
A4335	Incontinence supply; miscellaneous	Prior Authorization	G3, T5, 58		
A4338	Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	2 per month	G3, T5, 58		
A4340	Indwelling catheter; specialty type, (e.g.; coude, mushroom, wing, etc.), each	2 per month	G3, T5, 58		

A4344	Indwelling catheter, foley type; two-way all silicone; each		2 per month	G3, T5, 58		
A4346	three-way for continuous irrigation, each		2 per month	G3, T5, 58		
A4347	Male external catheter, with or without adhesive, with or without anti-reflux device; per dozen		3 units per month	G3, T5, 58		
A4351	Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each		31 per month	G3, T5, 58		
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each		Prior Authorization	G3, T5, 58		
A4353	Intermittent urinary catheter, with insertion supplies		180 per month Sterile Technique **Only**	G3, T5, 58		Coverage limited to Sterile Technique **Only** when specifically prescribed in writing by physician
A4354	Insertion tray with drainage bag, but without catheter		2 per month	G3, T5, 58		
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each		10 per month	G3, T5, 58		
A4356	External urethral clamp or compression device (not to be used for catheter clamp), each		Prior Authorization	G3, T5, 58		
A4357	Bedside drainage bag, day or night with or without anti-reflux device, with or without tube, each		2 per month	G3, T5, 58		
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each		4 per month	G3, T5, 58		
A4359	Urinary suspensory without leg bag, each		1 per month	G3, T5, 58		
A4361	Ostomy faceplate, each		3 per 6 months	G3, T5, 58		Not reimbursable when billed with: A4375, A4376, A4377, A4378, A4379, A4380, A4381, A4382, A4383
A4364	Adhesive, liquid or equal, any type, per ounce		6 oz. per month	G3, T5, 58		
A4365	Adhesive remover wipes, any type, per 50		1 box per month	G3, T5, 58		
A4366	Ostomy vent, any type, each		15 per month	G3, T5, 58		Not reimbursable when billed with: A4416, A4417, A4418, A4419, A4423, A4424, A4425, and A4427

A4367	Ostomy belt, each		2 per 6 months	G3, T5, 58		
A4368	Ostomy filter, any type, each		1 per day	G3, T5, 58		
A4371	Ostomy skin barrier, powder, per oz		10 per 6 months	G3, T5, 58		
A4372	Ostomy skin barrier, solid 4 x 4 or equivalent, with built-in convexity, each		15 per month	G3, T5, 58		
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each		15 per month	G3, T5, 58		Not reimbursable with: A4361, A4377
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each		15 per month	G3, T5, 58		Not reimbursable with: A4361, A4378
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4375
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4376
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4381, and A4382
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each		20 per month	G3, T5, 58		Not reimbursable with: A4361, A4383
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each		30 per month	G3, T5, 58		Not reimbursable with: A4361, A4379, A4382
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each		30 per month	G3, T5, 58		Not reimbursable with: A4361, A4379, A4381
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each		30 per month	G3, T5, 58		Not reimbursable with: A4361, A4380
A4384	Ostomy faceplate equivalent, silicone ring, each		2 per month	G3, T5, 58		
A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each		15 per month	G3, T5, 58		
A4387	Ostomy pouch, closed with barrier attached, with built-in convexity (1 piece), each		60 per month	G3, T5, 58		
A4388	Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each		60 per month	G3, T5, 58		
A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each		60 per month	G3, T5, 58		
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each		60 per month	G3, T5, 58		
A4391	Ostomy pouch, urinary, with extended, wear barrier attached (1 piece), each		30 per month	G3, T5, 58		

A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each		30 per month	G3, T5, 58		
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each		30 per month	G3, T5, 58		
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce		16 oz. per month	G3, T5, 58		
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet		30 per month	G3, T5, 58		
A4397	Irrigation supply; sleeve, each		4 per month	G3, T5, 58		
A4398	Ostomy irrigation supply; bag, each		1 per 6 months	G3, T5, 58		
A4399	cone/catheter, including brush		1 per 6 months	G3, T5, 58		
A4400	Ostomy irrigation set		1 per year	G3, T5, 58		
A4402	Lubricant, per ounce		4 oz per month	G3, T5, 58		
A4404	Ostomy ring, each		2 per month	G3, T5, 58		
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce		4 oz per month	G3, T5, 58		
A4406	Ostomy skin barrier; pectin-based, paste, per ounce		4 oz per month	G3, T5, 58		
A4407	Ostomy skin barrier; with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4x4 inches or smaller, each		20 per month	G3, T5, 58		
A4408	Ostomy skin barrier; with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4x4 inches, each		20 per month	G3, T5, 58		
A4409	Ostomy skin barrier; with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each		20 per month	G3, T5, 58		
A4410	Ostomy skin barrier; with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4x4 inches, each		20 per month	G3, T5, 58		
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter; each		20 per month	G3, T5, 58		
A4414	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4x4 inches or smaller, each		20 per month	G3, T5, 58		

A4415	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each		20 per month	G3, T5, 58		
A4416	Ostomy pouch, closed; with barrier attached, with filter (1 piece), each	K0581	30 per month	G3, T5, 58		Not reimbursable with: A4366
A4417	Ostomy pouch, closed; with barrier attached, with built-in convexity, with filter (1 piece)	K0582	15 per month	G3, T5, 58		Not reimbursable with: A4366
A4418	Ostomy pouch, closed; without barrier attached, with filter (1 piece), each	K0583	60 per month	G3, T5, 58		Not reimbursable with: A4366
A4419	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each	K0584	15 per month	G3, T5, 58		
A4420	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each	K0585	15 per month	G3, T5, 58		
A4421	Ostomy supply; miscellaneous		Prior Authorization	G3, T5, 58		
A4422	Ostomy absorbent material (sheet/pad/cyrstal packet) for use in ostomy pouch to thicken liquid stomal output, each		1 per day	G3, T5, 58		
A4423	Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each	K0586	15 per month	G3, T5, 58		
A4424	Ostomy pouch, drainable; with barrier attached, with filter (1 piece) , each	K0587	15 per month	G3, T5, 58		
A4425	Ostomy pouch, drainable; for use n barrier with non-locking flange, with filter (2 piece system), each	K0588	15 per month	G3, T5, 58		
A4427	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each	K0590	15 per month	G3, T5, 58		
A4428	Ostomy pouch, urinary; with extended wear barrier, with faucet-type tap with valve (1 piece), each	K0591	15 per month	G3, T5, 58		
A4429	Ostomy pouch, urinary; with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	K0592	15 per month	G3, T5, 58		
A4430	Ostomy pouch, urinary; with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	K0593	15 per month	G3, T5, 58		
A4431	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each	K0594	15 per month	G3, T5, 58		

A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each	K0595	15 per month	G3, T5, 58		
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each	K0596	15 per month	G3, T5, 58		
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each	K0597	15 per month	G3, T5, 58		
A4450	Tape, non-waterproof, per 18 square inches		60 units per month	G3, T5, 58		
A4452	Tape, waterproof, per 18 square inches		30 units per month	G3, T5, 58		
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce		4 oz per month	G3, T5, 58		
A4521	Adult-sized incontinence product, diaper, small size; each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4522	Adult-sized incontinence product, diaper, medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4523	Adult-sized incontinence product, diaper, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4524	Adult-sized incontinence product, diaper, extra large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month

A4525	Adult-sized incontinence product, brief, small size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4526	Adult-sized incontinence product, brief, medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4527	Adult-sized incontinence product, brief, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4528	Adult-sized incontinence product, brief, extra large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4529	Child-sized incontinence product, diaper, small/medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month

A4530	Child-sized incontinence product, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4531	Child-sized incontinence product, brief, small/medium size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4532	Child-sized incontinence product, brief, large size, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4533	Youth-sized incontinence product, diaper, each	W0560	200 per month	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month
A4534	Youth-sized incontinence product, brief, each	W0560	200 per month	G3, T5, 58	X	
A4535	Disposable liner/shield for incontinence, each	W0564	150 per month	G3, T5, 58	X	
A4536	Protective underwear, washable, any size, each	W0562	8 per year	G3, T5, 58	X	
A4537	Under pad, reusable/washable, any size, each		2 per year	G3, T5, 58	X	Available only for members 3 years or older. When billing incontinent supplies (diapers, briefs, underpads, etc.) in combination, the total maximum is 250 items per month

A4550	Surgical supply, miscellaneous		15 per month	G3, T5, 58	X	
A4554	Disposable underpads, all sizes, (e.g., chux's)		150 per month	G3, T5, 58		
A4561	Pessary, rubber, any type		1 per lifetime	G3, T5, 58		
A4562	Pessary, non-rubber, any type		1 per lifetime	G3, T5, 58		
A4623	Tracheostomy, inner cannula		1 per month	G3, T5, 58		
A4625	Tracheostomy care kit for new tracheostomy		14 per lifetime	G3, T5, 58		
A4626	Tracheostomy cleaning brush, each		1 per 6 months	G3, T5, 58		
A4629	Tracheostomy care kit for established tracheostomy		1 daily	G3, T5, 58		
A4649	Surgical supply, miscellaneous		Prior Authorization Cost Invoice	G3, T5, 58		
A4927	Gloves, non-sterile, per 100		1 box monthly	G3, T5, 58	X	
A5102	Bedside drainage bottle with or without tubing, rigid or expandable,each		2 per month	G3, T5, 58		
A5105	Urinary suspensory; with leg bag, with or without tube		1 per month	G3, T5, 58		
A5112	Urinary leg bag; latex		1 per month	G3, T5, 58		
A5113	Leg strap; latex, replacement only, per set		2 per month	G3, T5, 58		
A5114	foam or fabric, replacement only, per set		2 per month	G3, T5, 58		
A4561	Pessary, rubber, any type		1 per lifetime	G3, T5, 58		
A4562	Pessary, non-rubber, any type		1 per lifetime	G3, T5, 58		
A5051	Ostomy pouch, closed; with barrier attached (1 piece), each		60 per month	G3, T5, 58		
A5052	Ostomy pouch, closed;without barrier attached (1 piece), each		60 per month	G3, T5, 58		
A5053	for use on faceplate, each		60 per month	G3, T5, 58		
A5054	for use on barrier with flange (2 piece), each		90 per month	G3, T5, 58		
A5055	Stoma cap		30 per month	G3, T5, 58		
A5061	Ostomy pouch, drainable; with barrier attached (1 piece), each		60 per month	G3, T5, 58		
A5062	without barrier attached (1 piece), each		20 per month	G3, T5, 58		
A5071	Ostomy pouch, urinary; with barrier attached (1 piece), each		20 per month	G3, T5, 58		
A5072	without barrier attached (1 piece), each		30 per month	G3, T5, 58		
A5073	for use on barrier with flange (2 piece), each		30 per month	G3, T5, 58		
A5082	catheter for continent stoma		2 per month	G3, T5, 58		

A5102	Bedside drainage bottle with or without tubing, rigid or expandable,each		2 per month	G3, T5, 58		
A5105	Urinary suspensory; with leg bag, with or without tube		1 per month	G3, T5, 58		
A5112	Urinary leg bag; latex		1 per month	G3, T5, 58		
A5113	Leg strap; latex, replacement only, per set		2 per month	G3, T5, 58		
A5114	foam or fabric, replacement only, per set		2 per month	G3, T5, 58		
A5119	Skin barrier; wipes, box per 50		1 per month	G3, T5, 58		
A5121	solid, 6x6 or equivalent, each		15 per month	G3, T5, 58		
A5122	solid, 8x8 or equivalent, each		15 per month	G3, T5, 58		
A5126	Adhesive or non-adhesive; disk or foam pad		36 per month	G3, T5, 58		
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		1 per month	G3, T5, 58		
A6154	Wound pouch, each		10 per month	G3, T5, 58		
A6196	Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing		31 per month	G3, T5, 58		
A6197	Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing		31 per month	G3, T5, 58		
A6198	Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing		31 per month	G3, T5, 58		
A6199	Alginate or other fiber gelling dressing, wound filler, per 6 inches		45 per month	G3, T5, 58		
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing		15 per month	G3, T5, 58		
A6201	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. inc., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6203	Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing		15 per month	G3, T5, 58		

A6204	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6205	Composite dressing, pad size more than 48 sq. in, with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6206	Contact layer, 16 sq. in. or less, each dressing		5 per month	G3, T5, 58		
A6207	Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing		5 per month	G3, T5, 58		
A6208	Contact layer, more than 48 sq. in., each dressing		5 per month	G3, T5, 58		
A6209	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing		15 per month	G3, T5, 58		
A6210	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6211	Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing		15 per month	G3, T5, 58		
A6212	Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6213	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6214	Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6215	Foam dressing, wound filler, per gram		Prior Authorization Cost Invoice	G3, T5, 58		
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing		95 per month	G3, T5, 58		

A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	95 per month	G3, T5, 58		
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing	95 per month	G3, T5, 58		
A6219	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	95 per month	G3, T5, 58		
A6220	Gauze, non-impregnated, pad size more 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	95 per month	G3, T5, 58		
A6221	Gauze, non-impregnated, pad size more than 48 sq. in. ., with any size adhesive border, each dressing	95 per month	G3, T5, 58		
A6222	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing	31 per month	G3, T5, 58		
A6223	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	31 per month	G3, T5, 58		
A6224	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing	31 per month	G3, T5, 58		
A6228	Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	250 per month	G3, T5, 58		
A6229	Gauze, impregnated, water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	150 per month	G3, T5, 58		
A6230	Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing	150 per month	G3, T5, 58		

A6231	Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing	12 per month	G3, T5, 58		
A6232	Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in., but or less than or equal to 48 sq. in., each dressing	12 per month	G3, T5, 58		
A6233	Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., each dressing	12 per month	G3, T5, 58		
A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	15 per month	G3, T5, 58		
A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	15 per month	G3, T5, 58		
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	15 per month	G3, T5, 58		
A6237	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	15 per month	G3, T5, 58		
A6238	Hydrocolloid dressing, wound cover, pad size ore than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	15 per month	G3, T5, 58		
A6239	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in, with any size adhesive border, each dressing	15 per month	G3, T5, 58		
A6240	Hydrocolloid dressing, wound filler, paste, per fluid ounce	15 per month	G3, T5, 58		
A6241	Hydrocolloid dressing, wound filler, dry form, per gram	15 per month	G3, T5, 58		
A6242	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	31 per month	G3, T5, 58		
A6243	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	31 per month	G3, T5, 58		

A6244	Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6245	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6246	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6247	Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing		15 per month	G3, T5, 58		
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce		15 per month	G3, T5, 58		
A6250	Skin sealants, protectants, moisturizers, ointments, any type,any size	Z7047	1 per month	G3, T5, 58		
A6251	Specialty absorptive dressing; wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing		31 per month	G3, T5, 58		
A6252	Specialty absorptive dressing; wound cover, pad size more than 16 sq. in. but less that or equal to 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6254	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing		31 per month	G3, T5, 58		
A6255	Specialty absorptive dressing, wound cover, pad size more than 16sq. In. but less than or equal to 48 sq. in., with any size adhesive border, each dressing.		31 per month	G3, T5, 58		
A6256	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing		31 per month	G3, T5, 58		
A6257	Transparent film, 16 sq. in. or less, each dressing		15 per month	G3, T5, 58		

A6258	Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing		15 per month	G3, T5, 58		
A6259	Transparent film, more than 48 sq. in., each dressing		15 per month	G3, T5, 58		
A6260	Wound cleansers, any type, any size		1 per month	G3, T5, 58		
A6261	Wound filler, gel/paste, per fluid ounce, not elsewhere classified		Prior Authorization Cost Invoice.	G3, T5, 58		
A6262	Wound filler, dry form, per gram, not elsewhere classified		Prior Authorization Cost Invoice	G3, T5, 58		
A6266	Gauze, impregnated, other than water, normal saline or zinc paste, any width, per linear yard		60 per month	G3, T5, 58		
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing		60 per month	G3, T5, 58		
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing		60 per month	G3, T5, 58		
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing		31 per month	G3, T5, 58		
A6407	Packing strips, non-impregnated, up to 2 inches in width, per linear yard		31 per month	G3, T5, 58		
A6441	Padding bandage, non-elastic; non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	A6421	4 per month	G3, T5, 58		
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard		4 per month	G3, T5, 58		
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	A6422	4 per month	G3, T5, 58		
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	A6424	4 per month	G3, T5, 58		

A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard		4 per month	G3, T5, 58		
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	A6426	4 per month	G3, T5, 58		
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches per yard	A6428	4 per month	G3, T5, 58		
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard		4 per month	G3, T5, 58		
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard.	A6430	4 per month	G3, T5, 58		
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	A6432	4 per month Cost Invoice	G3, T5, 58		
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than fives inches, per yard	A6434	4 per month	G3, T5, 58		
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	A6436	4 per month	G3, T5, 58		
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard		4 per month	G3, T5, 58		
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than 5 inches, per yard	A6438	4 per month	G3, T5, 58		
A6455	Self-adherent band, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard		4 per month	G3, T5, 58		

A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	A6440	4 per month	G3, T5, 58		
A7524	Tracheostoma stent/stud/button, each		Prior Authorization	G3, T5, 58		
A7525	Tracheostomy mask, each	A4621	4 per month	G3, T5, 58		
A7526	Tracheostomy tube collar/holder, each	A4621 S8181	4 per month	G3, T5, 58		
B4034	Enteral feeding supply kit; syringe, per day -		1 per day Prior Authorization	G3, T5, 58		
B4035	pump fed, per day		1 per day Prior Authorization	G3, T5, 58		
B4081	Nasogastric tubing; with stylet		4 per month	G3, T5, 58		
B4082	without stylet		4 per month	G3, T5, 58		
B4083	Stomach tube - levine type		4 per month	G3, T5, 58		
B4086	Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each		2 per 6 months	G3, T5, 58		
B9999	NOC for Parenteral supplies		Prior Authorization Cost Invoice	G3, T5, 58		
	****SPECIALTY**					
	G3 - Durable Medical Provider					
	T5 - Pharmacy					
	58 - Home Health Agency					

CHAPTER 509–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPICE SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	March 15, 2014	May 1, 2014

CHAPTER 509—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR HOSPICE SERVICES

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Attachment 1: Hospice Election Form HEF-01

CHAPTER 509–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPICE SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the chapter must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

Hospice is a continuum of care, directed by professionals, designed to optimize the comfort and functionality of terminally ill members for whom curative medicine has exhausted its possibilities. Hospice emphasizes relief from distress for the member without actively shortening or prolonging life. Relief from distress includes palliation of physical, psychological and psychosocial symptoms of distress and a regular regime for alleviation of physical pain. All efforts are directed to the enrichment of living during the final days of life and to the provision of ongoing opportunities for the member to be involved in life.

Hospice services are defined as reasonable and medically necessary services, palliative and supportive in nature, provided to the terminally ill for the management of the terminal illness and related conditions.

This chapter sets forth requirements of the Bureau for Medical Services regarding payment and processing for Hospice Services provided to eligible West Virginia Medicaid members.

509.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid Services will apply pursuant to **Common Chapter 200, Definitions and Acronyms**. In addition, the following definitions will apply for Hospice services.

Attending physician - ***In accordance with*** **42 CFR 418.3(1)(i),** a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or (ii) **Nurse Practitioner (NP) –** A nurse who meets the

training, education and experience requirements as described in **410.75(b)**. (2) Is identified by the member, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the member's medical care.

Bereavement Counseling - Emotional, psychosocial, and spiritual support and services provided before and after the death of the member to assist with issues related to grief, loss, and adjustment. ***(See* 42 CFR §418.3)**

Certificate-of Need (CON) - West Virginia issues a Certificate of Need (CON) to indicate a health service's compliance with **W.Va. Code §16-2D-1** ***et seq.***, and to fulfill a need in the community with no duplication of services. In West Virginia, all healthcare providers, unless exempt, must obtain a CON.

Employee (including contractors and volunteers**) -** A person who: (1) Works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice. ***(In accordance with* 42 CFR §418.3)**

Evaluation – An initial and ongoing process to determine service requirements and the effectiveness of plans of care.

Fiscal Agent - An agency contracted by the Bureau for Medical Services to verify coverage, prior authorization requirements, service limitations and practitioner information as well as pay claims.

Home Health Aide - A person specially trained to assist sick, disabled, infirm, or frail persons at home when no family member is fully able to assume this responsibility. Aides are supervised by health professionals, and provided as part of a continuing medical care plan ***in accordance with the West Virginia State Plan on Hospice Services.***

Homemaker Aide - A person specially trained to provide direct care and support services that are necessary in order to enable an individual/client to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. Homemaker services include assistance with personal hygiene, nutritional support, and environment maintenance. These aides are supervised by health professionals and provided as part of a continuing medical care plan ***in accordance with the West Virginia State Plan on Hospice Services.***

Hospice - A public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care. ***(See* 42 CFR §418.3)**

Hospice Care - A comprehensive set of services described in 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill member and/or family members, as delineated in a specific patient plan of care. ***(See* 42 CFR §418.3)**

Hospice Discharge – A hospice provider determines that the patient is no longer terminally ill, expires, moves out of the hospice's service area, transfers to another hospice, or the patient (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. ***(In accordance with* 42 CFR §418.26)**

Hospice Informed Consent - A written agreement to receive hospice care made by the member which specifies in writing the type of care and services to be provided. The informed consent form shall be signed by the member or their legal representative prior to service.

Hospice Interdisciplinary Team - An interdisciplinary team (IDT) of professionals comprised at minimum, of a physician, a social worker, and nurse who plan and direct the care of each hospice member, along with home health aides and counseling/clergy persons who provide additional services. ***(In accordance with* 42 CFR §418.56)**

Interdisciplinary Team Plan of Care - A group of interdisciplinary professionals (Physician, Nurse, Social worker, Counselor/Clergy) that collaborates continuously with the member's attending physician (if the member has an attending physician) to develop and maintain a member-directed, individualized plan of care. The plan is based on the interdisciplinary team assessments which recognize the member and family's physiological, social, religious, and cultural variables and values. ***(In accordance with* 42 CFR §418.56)**

Legal Representative - An individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill member who is mentally or physically incapacitated. This may include a legal guardian. ***(In accordance* with 42 CFR §418.3 *Definitions)***

Palliative Care - Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice. ***(See* 42 CFR §418.3)**

Physician - An individual who meets the qualification and conditions as defined ***in section 1861(r) of the Social Security Act and implemented at* 42 CFR §410.20 *of this chapter. (See* 42 CFR §418.3)**

Physician Designee - A doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available. ***(See* 42 CFR §418.3)**

Pre-Existing Conditions – The health status existing prior to the diagnosis of the terminal illness arising in organs that are not typically affected by the terminal illness.

Prior Authorization (PA) - A utilization review method used to control certain services which are limited in amount, duration, or scope. The prior approval necessary for specified services to

be delivered for an eligible member by a specified provider before services can be performed, billed, and payment made.

Registered Nurse - A person who has graduated from a college's nursing program or from a school of nursing, passed a national licensing exam, and is professionally licensed by the West Virginia State Board of Nursing as a Registered Nurse (RN). A registered nurse's scope of practice is determined by each state's Nurse Practice Act, which outlines what is legal practice for registered nurses and what tasks they may or may not perform.

Related Condition – A medical condition that arises as a direct logical consequence of the terminal illness.

Revocation - To cancel or withdraw the election of Hospice care. ***(In accordance with* 42 CFR §418.28)**

Social Worker - Must be a WV licensed social worker.

Terminally ill - A medical prognosis that the patient's life expectancy is 6 months or less if the illness runs its normal course. ***(See* 42 CFR §418.3)**

Transfer - Changing the hospice provider from which a member is receiving services to another hospice provider.

Utilization Management Contractor (UMC) - The contracted agent of the Bureau for Medical Services who receives requests for Hospice Services and issues prior authorizations to Hospice Providers.

509.2 PROVIDER PARTICIPATION REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from the Bureau for Medical Services (BMS), hospice providers must:

- Meet and maintain applicable licensures, accreditation, and certification requirements, including the Certificate of Need (CON);
- Meet and maintain all BMS enrollment requirements listed in **Chapter 300, Provider Participation Requirements*;***
- Be physically located within the state of WV;
- Meet and maintain Medicare enrollment conditions. ***In accordance with* 42 CFR §418 Hospice Care, West Virginia State Plan Supplement 2 to Attachment 3.1-A & 3.1-B page 6 on Hospice services, §1905 (o) of the Social Security Act.**

Contact the Molina Medicaid Solutions Provider Relations Department at 1-888-483-0793 for enrollment information or visit website at www.wvmmis.com.

509.2.1 Hospice Staff Criminal Investigation Background (CIB) Check Requirements, Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check, which includes fingerprints, must be conducted by the West Virginia State Police initially and again every three years for all Hospice provider staff providing direct care services to members including direct-care personnel If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted.

Prior to providing Hospice services, required fingerprint-based checks must be initiated. Hospice providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing direct care services by a Hospice provider cannot be considered to provide services if ever convicted of the following:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Child/adult abuse or neglect
D. Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult
E. Any type of felony battery
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed Hospice provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing Hospice services, the Hospice provider must take appropriate action, including notification to the BMS Hospice Program Manager.

The OIG Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. This list can be obtained at **http://exclusions.oig.hhs.gov**.

All payments for services provided by excluded providers or employees will be recovered by BMS.

509.2.2 Hospice Staffing Requirements

***In accordance with* 42 CFR §418.62 *and* §418.64, hospice staffing involves employing, contracting and otherwise obtaining the services of the individuals who provide core services, supplemental services and physician services.**

- Federal regulations require that core hospice functions and services be performed only by employees of the hospice or by volunteers under the supervision of hospice employees.

- Supplemental services may be provided by individuals who are either employed, or contracted by the hospice, or who are volunteers.

509.2.3 Hospice Interdisciplinary Team (IDT)

- Each hospice must have an Interdisciplinary Team (IDT) composed of individuals who provide or supervise the care and services offered by the hospice. Each IDT must include at least the following individuals: *(In accordance with* **42 CFR §418.56** *and* **§418.64**).

  1. A doctor of medicine or osteopathy,
  2. A registered nurse
  3. A licensed social worker and
  4. A pastoral or other counselor

- The registered nurse, the licensed social worker and the (pastoral or other) counselor must be employees of the hospice, or volunteers under the supervision of designated employees of the hospice.

- The physician of the IDT may be a volunteer or a hospice employee, or the hospice may contract with the physician.

- The hospice must designate a registered nurse that is a member of the IDT to provide coordination of care and to ensure continuous assessment of each member's and family's needs and implementation of the interdisciplinary plan of care.

- If the hospice has more than one IDT, it must identify a specifically designated IDT to establish policies governing the day-to-day provision of hospice care and services.

- There must be a continuous and identifiable relationship between each member and his or her IDT.

- Efforts must be made to provide consistent IDT membership and assignment of hospice members.

509.3 HOSPICE SERVICE REQUIREMENTS

Services that are covered by the hospice program are those that are reasonable and necessary for the palliation and management of the terminal illness and related conditions. An interdisciplinary plan of care must be established before care begins and must detail the type, scope and frequency of those services to address the needs of the member and the member's family. All care must be planned, delivered and coordinated ***in accordance with*** **42 CFR §418.56** ***and*** **§418.200*.***

Hospice Services Are of Two Types:

I. **Core Hospice Services** are to be provided directly by hospice employees/contractors/volunteers.
These include:

- **Nursing Care:** must be provided by a registered nurse (RN), or by a licensed practical nurse (LPN) under the supervision of a registered nurse.

- **Medical Social Services**: must be provided by a licensed social worker (LSW) working under the direction of a physician.

- **Physician Services**: must be provided by a professional who is acting within the scope of the physician's license, who is either a doctor of medicine (MD), of osteopathy (DO), of podiatry (DPM), of dentistry (DDS), of optometry (OD), or a chiropractor (DC). The medical director of the hospice or the physician member of the IDT must be a licensed doctor of medicine or of osteopathy.

- **Counseling Services**: must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for him or her to adjust to the member's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. **Bereavement counseling is a required hospice service, but it is not reimbursable**. ***(See*** **West Virginia State Plan Hospice Services attachment 3.1 – C).**

II. **Other Hospice Services:** the hospice provider must make available services that are not considered "core" services. These may be provided by the employees of the hospice provider or they may be arranged by contractual agreement. They include:

- **Drugs and Biologicals**: drugs and biologicals must be identified as those documented in the hospice plan of care and provided by the hospice while the member is under hospice care. Hospice covered drugs are those related to the

palliation and management of the terminal illness and related conditions necessary to meet the needs of the member***. In accordance with*** **West Virginia State Plan Attachment 3.1-A & 3.1-B** ***and*** **42 CFR §418.56(c)(4)*, §418.106*, *and* §418.202 (f)*.**

- Management, ordering, dispensing, administration, labeling, disposition, and storing of drugs and biologicals must follow the policies and procedures ***in accordance with*** **42 CFR §418 Hospice Care**;

- Home Health Program services, drugs and biologicals obtained through the West Virginia Medicaid Pharmacy Program for the palliation and management of symptoms related to the member's terminal illness;

- Coverage of medications to control pain and nausea must be provided by the hospice provider unless justified by pre-existing conditions;

- **Durable Medical Equipment and Supplies**: are to be available for comfort or self-help related to the palliation of the terminal illness and related conditions. ***(In accordance with West Virginia State Plan Attachment 3.1-A &3.1-B page 7 and*** **42 CFR §418.56*, §418.202 (f)***, *and* **§418.106*)***.

- **Short term inpatient care:** is to be provided either to provide respite for family or other persons caring for the member at home, or for control of pain or symptoms arising from the terminal illness and related conditions that are not possible in any other setting. ***(In accordance with*** **West Virginia State Plan Attachment 3.1-A** ***&*** **3.1-B page 7** ***and*** **42 CFR §418.202 (e)*)***

- **Home health and homemaker services:** must meet the specifications of **42 CFR 484.36**, and must be provided under the supervision of an RN. Home health aides and homemaker service providers may provide personal care services and household services for safety and sanitation of the member, appropriate for the plan of care.

- **Rehabilitation Services:** include physical and occupational therapies and speech pathology used for symptom control or to maintain activities of daily living and functional skills. ***(In accordance with*** **West Virginia State Plan Attachment 3.1-C pages 2 & 3 on Hospice Services** ***and*** **42 CFR §418.202*).***

When a hospice contracts or arranges for any service, the hospice must maintain professional, financial and administrative responsibility for the services and must ensure that all staff members meet the regulatory qualification requirements.

509.3.1 Hospice Service Exceptions

Hospice services may be provided to children under age 21 concurrently with curative treatment. ***(In accordance with the*** **Affordable Care Act 2302 Concurrent Care for Children*.)***

509.3.2 Hospice Physician Services Staffing

- The following functions may be performed by a physician designee including a physician employee, volunteer physician, or a contracted physician:

    1. Hospice medical director services (must be a doctor of medicine (MD) or osteopathy (DO);

    2. Physician services related to the palliation and management of the member's terminal illness and related conditions;

    3. Care for general medical needs when the attending physician is not available (if the member has an attending physician); and

    4. Physician participation in the IDT (must be a doctor of medicine (MD) or osteopathy (DO).

        The hospice or the physician of the Interdisciplinary Team (IDT) may designate another physician or other physicians to be "on call" during the hours the IDT assigned physician is not on duty.

            1. The on-call physician may assist with urgent, emergency or otherwise unscheduled plan of care revisions.

            2. The hospice or the IDT assigned physician of the IDT may not designate substitute physicians to routinely assist with initial plans of care and scheduled plan of care reviews and revisions.

            3. When the "on call" physician provides a service to a member, it must be documented in that member's health record.

509.3.3 Hospice Volunteers

- A hospice provider uses volunteers in defined roles and under the supervision of designated hospice employees. Volunteers may perform administrative functions or direct care services as outlined in the Federal Regulations. In the Hospice Program, "employee" also refers to a volunteer under the jurisdiction of the hospice. All use of volunteers must be *in accordance with* **42 CFR §418.78** *and* **§418.304 (b)**.

- Volunteer hours of service must equal at least five percent of the hours of direct member care furnished by paid personnel, employed or contracted.

- If a physician volunteers some services and is reimbursed by the hospice for other services, the terms and conditions of such must be described in a written agreement or contract between the physician and the hospice.

- Services provided by volunteers may not be billed to Medicaid when those services are provided at no charge for members who are not eligible for Medicaid.

Examples of equitable ways for a physician to donate or volunteer services may include:

a. A percentage of their time; or

b. A particular service (e.g., treatment of decubitus ulcers or psychotherapy) or a particular occurrence of a service (donate one visit per week/month, etc. to each member in their care).

509.3.4 Hospice Employee Training Requirements

- A hospice must provide orientation that includes the hospice philosophy to all employees, including contracted and volunteer staff that have member and family contact;

- A hospice must provide an initial orientation for each employee, including contracted and volunteer staff that addresses the employee's specific job duties;

- A hospice must assess the skills and competence of all employees furnishing care, including contracted and volunteers furnishing services, and, as necessary, provide in-service training and education programs where required;

- A hospice must provide ongoing educational opportunities for all employees, including contracted and volunteer staff; and

- The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months. *(In accordance with* **42 CFR §418.78(a)** *and* **§418.100(g) 1-3, p. 122**.

509.4 BENEFIT PERIODS

***(In accordance with* 42 CFR §418.21)** A member may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period;
(2) A subsequent 90-day period;
(3) An unlimited number of subsequent 60-day periods that will continue as long as the member lives unless he or she revokes hospice care or is discharged from hospice care.

The periods of care are available in the order listed and may be elected separately at different times Having once elected Hospice, it is not necessary for a member to elect hospice again after the initial election unless he or she revokes hospice care or is discharged from hospice care.

- Members enrolled in the West Virginia Medicaid Hospice Services may revoke hospice coverage. In that event, the remainder of that benefit period is forfeited. If the member then re-enrolls, coverage begins immediately under the next benefit period.

- If a member revokes West Virginia Medicaid Hospice Services four times, they are not eligible to enroll again.

Example: A member enrolls in hospice services on January 1. For whatever reason, he revokes his hospice coverage on February 15, after 46 days. The remainder of the 90 days of that first period is forfeited. Should circumstances lead him to enroll again even the next day, February 16, he is now in the second benefit period. If he revokes again before that 90-day period is concluded, he also forfeits the remainder of that second period. A third enrollment will be for the 60-day period. If that period is revoked, the remainder is forfeited and only the unlimited 60-day periods remain. If he elects again during an unlimited 60-day period, it will continue for as long as he lives unless he revokes the fourth time. The member who revokes West Virginia Medicaid Hospice Services four times is not eligible to enroll again.

509.5 HOSPICE ENROLLMENT

Enrollment in the West Virginia Medicaid Hospice Services Program requires the following from the three parties involved:

- **Physician** – must determine that the member has a life expectancy of 6 months or less if the illness runs its normal course and certifies that assessment in writing;

- **Hospice Provider -** must complete a plan of care, inform the enrolling member of what hospice services will be provided, document the member's informed consent, and complete a West Virginia Medicaid Hospice Election Form (HEF-01). ***(See Appendix 1).*** The provider must also inform the member how to dis-enroll from hospice care, change providers, and transfer services to another hospice;

- **Member/Legal Representative -** After explanation of hospice services, by the hospice provider, the member/legal representative must sign and date their consent on the completed HEF-01.

To complete the enrollment of the member in hospice services, the provider must furnish the member with the following:

- A copy of the completed and signed HEF-01;

- A copy of the Plan of Care upon member's and/or the member's legal representative's request, with descriptions of the nature and scope of the services to be provided, and a schedule for providing them. Also a telephone number for contacting the hospice;

- A copy of the conditions of enrollment in West Virginia Medicaid Hospice explained to the member/legal representative by the provider and signed by the member/legal representative;

- A copy of the terms of revocation explained to the member/legal representative by the provider and signed by the member/legal representative.

The member is responsible for reporting other insurance and obtaining health care that is not related to the terminal illness or disease.

509.5.1 Physician Certification

For the first 90-day election period of hospice coverage, the hospice medical director or IDT assigned physician and the attending physician (if the member has an attending physician) must certify and document that the member has a terminal illness which is defined as having a life expectancy of 6 months or less if the illness runs its normal course and their diagnosis. ***(In accordance with* 42 CFR §418.22).**

509.5.2 Physician Certification Timeline

- The hospice must obtain a copy of this written certification no later than 2 calendar days after hospice care is initiated.

  For the initial 90-day period, if the hospice cannot obtain a written certification within 2 calendar days, it must obtain oral certifications within 2 calendar days and written certification no later than 8 calendar days after the period begins *(See* **West Virginia State Plan Attachment 3.1-A** *&* **3.1-B***).*

- If these requirements are not met within the set timeline, the provider is not eligible for reimbursement of hospice services furnished before the date that written certification is obtained.

For Subsequent Recertification Periods:

A hospice physician or hospice nurse practitioner must conduct a face-to-face recertification visit for each hospice member whose total stay across all hospices is anticipated to reach 180 days. The visit must occur no more than 30 calendar days prior to the 180-day recertification. The physician/nurse practitioner must continue to visit that member no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care ***(In accordance with* 42 CFR §418.22).**

The written narrative associated with the 180-day recertification and every subsequent recertification must include:

- Date of the member's face-to-face visit with the hospice physician or hospice nurse practitioner;

- Clinical findings to determine whether the member continues to have a life expectancy of 6 months or less.

- The hospice nurse practitioner must document and provide all clinical findings to the certifying hospice physician, signed and dated on a separate and distinct section of, or an addendum to, the recertification form and must be clearly titled.

- All certifications and recertifications must be signed and dated by the hospice physician(s) and must include the benefit period dates to which the certification or recertification applies.

Authorization is required for all hospice certifications and recertifications. Appropriate documentation must be submitted to the Utilization Management Contractor (UMC) within 8 calendar days of the member election of hospice. It is understood that due to the nature of Hospice Services, services may need to commence before the initial authorization is finalized and, in these instances, retrospective authorization will be granted for members who meet the requirements of the program.

If the hospice is not able to complete the face-to-face visit according to the above specifications, the hospice must discharge the member and Medicaid will no longer reimburse the hospice for the member's hospice services. Medicaid is not responsible for reimbursement of hospice services during the period of discharge.

When the face-to-face evaluation is completed by the hospice physician or hospice nurse practitioner, the hospice provider will be able to bill the Medicaid program for services.

509.5.3 Enrolling the Member in Hospice Care

The hospice is responsible for enrolling the member who is certified as eligible for hospice care and who gives consent to enter the program.

The provider must develop a Plan of Care designed to meet the member's individual needs. Members must be informed that by electing West Virginia Hospice Services they must **waive** Medicaid coverage of the following services if they are related to the member's terminal condition:

- Hospice care provided by a hospice other than the hospice designated by the member, unless provided under arrangements made by the designated hospice.

- Any Medicaid services that are related to treatment of the terminal condition for which hospice care was elected or of a related condition; or that are equivalent to hospice care except for services:

    a. Provided (either directly or under arrangement) by the designated hospice;

    b. Provided as room and board by a nursing facility or ICF/IID if the individual is a resident;

    c. Provided by the member's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; and

d. When an election period ends, the hospice discharges a member according to reasons for discharge under 42 CFR §418.26 (a thru d), or the member's waiver of other Medicaid benefits expires. Also, regular Medicaid coverage is reinstated if the member revokes hospice care for the subsequent election period. ***(In accordance with* 42 CFR §418.24 *&* §418.28*)*.**

Hospice care does not include, but is not limited to the following:

- Services furnished before or after a hospice election period;
- Services of the member's attending physician, if the attending physician is not an employee of or working under the arrangement with the hospice; or
- Medicaid services received for the treatment of an illness or injury not related to the member's terminal condition. ***(See* 42 CFR §418.402*)*.**

Once a member elects to receive West Virginia Hospice services, Medicaid will not reimburse for other Medicaid services that treat the terminal condition. However, Medicaid may reimburse for services that are required to treat conditions that are unrelated to the terminal illness.

Hospice services may be provided to children under age 21 concurrently with curative treatment. ***(In accordance with the* Affordable Care Act 2302 Concurrent Care for Children*).***

509.5.4 Informed Consent of the Member

The hospice provider must assure that the consent to enroll in Hospice Services is informed consent. An informed consent form detailing the type and scope of the care is to be given to the member or the member's representative to be read and signed.

The hospice provider must complete the Hospice Election Form HEF-01 and have the member or the member's legal representative sign and date it.

509.6 NOTIFICATION OF ENROLLMENT

The completed, signed and dated physician certification, the signed and dated HEF-01, and the signed and dated plan of care must be received by the UM Contractor (UMC) within 8 calendar days of the initiation of hospice care.

Authorization by the UMC is required for the initial and subsequent certifications. Authorization will not be approved for hospice services without appropriate enrollment documentation.

509.7 TERMINATION OF HOSPICE SERVICES

In accordance with 42 CFR §418.26, 418.28, 418.30, hospice services may be terminated for any of the following reasons:

- The member chooses to revoke hospice care;
- The hospice chooses to terminate their provision of services;
- The member no longer meets enrollment criteria;
- The member moves out of the hospice's service area;
- The member transfers to another hospice provider;
- The member's environment becomes unsafe for hospice staff; or
- The member dies.

When a member revokes hospice services or is discharged by the hospice provider, the hospice provider must send a copy of the HEF-01, with original member signature and the date of the termination of services written in the box marked Revoked, to the UM Contractor. This must be received by the UM Contractor within 8 calendar days of revocation to allow the member to resume Medicaid benefits waived upon election of hospice care. When a member is being discharged and will be in need to medication and/or medical supplies upon discharge, then the Hospice Provider must expedite the discharge election form to the UM contractor.

Also, the hospice provider must send a copy of the HEF-01 to the UMC following the death of the member with the date of death noted in the appropriate box.

509.7.1 Transfer of Member to another Hospice Provider

A member or legal representative may change the hospice provider from which hospice care is received only once in each election period. A transfer does not constitute a revocation of the election period during which the change is made. Transfers must be conducted ***in accordance with*** 42 CFR § 418.30.

509.8 BILLING AND REIMBURSEMENT

Reimbursement by the West Virginia BMS for covered hospice services will be at rates set by the Centers for Medicare and Medicaid Services (CMS) for the following 4 categories of care:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

509.8.1 Routine Home Care

Revenue Code: 0651
Service Unit: Unit = 1 Day
Service Limit: 1 unit per day

Definition of Service:

- This level of care consists of providing hospice services as described under Section 509.3, Hospice Service Requirements, except for those referring to Inpatient Care, or when the member's needs are not so intensive as to require continuous care.

- The hospice is paid the Routine Home Care rate for each day the member is under the care of the hospice and not receiving one of the other three more specialized categories of hospice care (Continuous Home Care, Inpatient Respite Care, and General Inpatient Care).

- This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the member is receiving hospital care for a condition unrelated to the terminal condition.

509.8.2 Continuous Home Care

Revenue Code: 0652
Service Unit: Unit = 1 hour
Service Limit: Minimum of 8 hours, up to a maximum of 24 hours a day.

Definition of Service:

- This code is billable for a minimum of 8 hours on a given day, and up to 24 hours a day. Reimbursement is based on the number of hours provided for the service in a day. Continuous home care is provided to the member during brief periods of crisis.

- Continuous home care may be provided for up to 24 hours, but these services must be predominantly nursing services. Home health aide or homemaker services may be provided in addition to nursing care.

509.8.3 Inpatient Respite Care

Revenue Code 0655
Service Unit: Unit = 1 Day
Service Limit: Up to 5 consecutive days

Definition of Service:

- An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility (freestanding hospice, hospital or nursing

facility) on a short-term basis to provide respite to family or other persons who are involved in daily care of the member.

- Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. ***(In accordance with 42 CFR §418.204).***

509.8.4 General Inpatient Care

Revenue Code: 0656
Service Unit: Unit = 1 Day
Service Limit: 1 unit per day

Definition of Service:

General inpatient care may be provided in an approved freestanding hospice, hospital or nursing facility. This care is usually for pain control or for acute or chronic symptom management which cannot be successfully treated in another setting.

509.9 REIMBURSEMENT PROCEDURES

- Hospice services are billed using the UB-04 paper form or electronic form 837i.
- Only one level of care under one Medicaid Revenue Code may be billed for a given day.
- Reimbursement is made for each day an eligible Medicaid member is under hospice care.
- Inpatient rates for revenue codes 655 and 656 are paid for the date of admission and all subsequent inpatient days with the exception of the date of discharge. The date of discharge will be paid at the Routine Home Care rate.
- If the member dies as an inpatient, then the date of death will be reimbursed at the inpatient rate if the inpatient care was related to the terminal illness.
- Reimbursement will be based upon the county the hospice service is rendered.

509.10 INPATIENT CARE PROVIDED DIRECTLY BY THE HOSPICE

The participating hospice that provides inpatient care directly must comply with all of the following standards for nursing, for member care, and for disaster preparedness:

- Nursing services must be provided 24 hours a day
- Each shift must provide an RN who provides direct member care; and
- Nursing care must be sufficient to meet any Plan of Care

509.11 NURSING FACILITY RESIDENTS

- West Virginia Medicaid maintains a separate program of Hospice Services for members who are residents of nursing facilities.

- West Virginia requires a Pre Admission Screening (PAS) be completed on every individual who enters a Medicaid certified nursing facility (Refer to Chapter 514, Nursing Facility Services). If a member electing hospice care is a resident of a West Virginia Medicaid certified nursing facility, the nursing facility may contract with a Medicare/Medicaid certified hospice agency to provide room and board for dually eligible members and for members who are Medicaid–only who qualify medically for both the hospice benefit and Medicaid nursing facility benefits.

- Medicare certification of a nursing facility is not a requirement of this program.

- The hospice agency must enroll with the Medicaid agency to be a provider of this benefit in nursing facilities.

- The room and board component provided by the nursing facility shall include the provision of a living space, nutrition, and ancillary services normally provided for residents.

- Ancillary services may include, but are not limited to, the basic activities of daily living, social and activity programs, laundry and housekeeping.

- The hospice provider is responsible for specialized services covered by Medicare or Medicaid including, but not limited to, medications associated with the terminal illness, assistance with care planning, and emotional support for the member and the member's family.

- The hospice must bill Medicare/Medicaid for all covered services as well as nursing facility room and board. ***(In accordance with* 42 CFR §418.112*. See* Chapter 514, Nursing Facilities*).***

- A hospice physician or hospice nurse practitioner must visit each hospice member face to face whose total stay across all hospices is anticipated to reach 180 days, no more than 30 calendar days prior to the 180-day recertification, and must continue to visit that member no more than 30 calendar days prior to every recertification thereafter. The provision applies to recertification on and after January 1, 2011. ***(In accordance with* Affordable Care Act, section 3131(b)*).***

- If the hospice is not able to complete the face to face prior to the above specifications, the hospice must discharge the individual and Medicaid will no longer reimburse the hospice for the individual's treatment or room and board. The nursing facility will need to resume billing Medicaid for the care of the individual; and

- Once the face to face evaluation is completed by the hospice physician or hospice nurse practitioner, the hospice provider may bill the Medicaid program for services, including the pass-through payment to the nursing facility for room and board.

- ***In accordance with*** **42 CFR 418.22**, the written narrative associated with the 180-day recertification and every subsequent recertification must include:

    1. Date of the member's face-to-face visit with the hospice physician or hospice nurse practitioner.

    2. Clinical findings to determine whether the member continues to have a life expectancy of 6 months or less; and

    3. The hospice nurse practitioner must document and provide all clinical findings to the certifying hospice physician, signed and dated on a separate and distinct section of, or an addendum to, the recertification form and must be clearly titled.

    4. All certifications and re-certifications must be signed and dated by the hospice physician(s) and must include the benefit period dates to which the certification or recertification applies.

The nursing facility cannot charge Medicaid a bed hold if the resident/member is under the hospice benefit. The bed hold must be contracted between the nursing facility and the approved hospice provider.

509.12 DOCUMENTATION REQUIREMENTS FOR NURSING FACILITY AUTHORIZATION

For each individual who applies for hospice coverage in a nursing facility, election of services and physician certification documentation is required. ***(Refer to*** **Chapter 514, Nursing Facility Services 514.10.8*****).*** The hospice provider must submit the following information to the UM Contractor for review:

- An agreement between the specific nursing facility and the hospice provider specifying the appropriate services each will provide to qualified members;

- Documentation to support the individual's medical necessity for each covered service;

- Financial eligibility documentation for the specific individual regarding the Medicare and the Medicaid programs.

As with hospice services provided in other settings, those provided in nursing facilities apply only to the terminal illness and related conditions. For health needs not related to the terminal diagnosis, additional West Virginia Medicaid policies and procedures are to be followed.

The authorization information must be submitted with the first claim for payment.

509.13 BILLING AND REIMBURSEMENT FOR NURSING FACILITY HOSPICE

Revenue Code: 0658
Service Unit: Unit = 1 Day
Service Limit: 1 unit per day

- The West Virginia Medicaid Program will remit to the hospice provider 95 percent of the daily rate which would have been paid to the nursing facility for care of the member had they not elected hospice coverage.

- The hospice will in turn reimburse the nursing facility for the cost of room and board, as identified in their contract.

- The amount of reimbursement will be based on the nursing facility base per diem rate with the Medicaid adjustment for the acuity of the member.

- Services must be billed on a UB-04 paper form.

- A printout of the computerized report identifying the specific case mix class of the individual must be attached.

- The hospice must mail all of the claim information to the BMS Fiscal Agent.

Providers are responsible for verifying Medicaid eligibility prior to service delivery. Failure to properly verify eligibility may result in claim denial. Hospice providers are strongly encouraged to print electronic eligibility verifications and retain them until paid.

For information concerning procedure codes and diagnosis codes, refer to **Chapter 100, General Information**.

SERVICE	PERSON OR COMPANY	PHONE NUMBER	FAX NUMBER
Hospice Program Manager	Bureau for Medical Services 350 Capitol Street, Room 291 Charleston, WV 25301	304-356-4840	304-558-4398
Claims Processing	Fiscal Agent - Molina HealthCare P.O. Box 3766 Charleston, WV 25337	1-888-483-0793 (for Providers) 304-348-3380 (for Members)	304-348-3380
Prior Authorizations	Utilization Management Contractor (UMC) – APS HealthCare WVMI Hospice Unit 100 Capitol St.,Suite 600 Charleston, WV 25301	1-800-982-6334	1-888-298-5144 1-304-346-3669

CHAPTER 509
HOSPICE SERVICES
JULY 1, 2012

ATTACHMENT 1
HOSPICE ELECTION FORM
HEF-01
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HOSPICE ELECTION FORM

West Virginia Department of Health and Human Resources
Office of Home and Community-Based Services
The Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3707

I. HOSPICE

HOSPICE NAME:	**Place of Service: Home ___/Hospice House___/NF___**
ADDRESS:	
	PROV. NO.:
PERSON COMPLETING FORM:	
TELEPHONE:	**FAX:**

II. ACTION

ELECTION:	**FIRST**	**SECOND**	**THIRD**	**LATER**
EFFECTIVE DATE:				
DATE RECIPIENT EXPIRED:	**DATE RECIPIENT DISCHARGED:**		**DATE SERVICES REVOKED:**	

III. RECIPIENT

NAME:		**(Sex: M F)**
ADDRESS:		
	(County:)	
MEDICAID NUMBER:	**DATE OF BIRTH:**	**TELEPHONE:**
SOCIAL SECURITY NO:	**DIAGNOSIS NAME:**	**DIAGNOSIS CODE:**
AUTHORIZED REPRESENTATIVE:		
ADDRESS:		
TELEPHONE:		

IV. ATTENDING PHYSICIAN

NAME:	
ADDRESS:	
TELEPHONE:	**PROVIDER NO.:**
HOSPICE EMPLOYEE? YES_____ NO_____	

V. SIGNATURES

FOR ELECTION ONLY:

I certify that I have read (or had read to me) and understand the conditions of enrollment in West Virginia Medicaid Hospice. All questions I had about these provisions of my hospice care were answered by a hospice representative and I have received a written copy of the conditions of enrollment.

I hereby elect West Virginia Medicaid Hospice Program:

_____

RECIPIENT OR REPRESENTATIVE DATE

_____

HOSPICE REPRESENTATIVE DATE

FOR REVOCATION ONLY:

I certify that I have read (or had read to me) and understand the terms of revocation. I understand that if I revoke West Virginia Medicaid Hospice four times, I will not be eligible to enroll again. All questions I had about revocation of my hospice care were answered by a hospice representative and I have received a written copy of the terms of revocation.

I hereby revoke my participation in the West Virginia Medicaid Hospice Program:

_____

RECIPIENT OR REPRESENTATIVE DATE

_____

HOSPICE REPRESENTATIVE DATE

Completion of this form is required by Federal regulation. Failure to complete will result in non-payment of Medicaid Hospice benefits. Return completed form to address above or FAX to Policy Units at (304) 558-4398. Call (304) 558-5962 with any questions.

CHAPTER 510 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPITAL SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 510.8.1	Prior Authorization Requirements For Outpatient Services	01/12/06	02/15/06
Section 510.8.1	Prior Authorization Requirements For Outpatient Services	10/24/05	Postponed
Section 510.8.1	Prior Authorization Requirements For Outpatient Services (Surgeries-Place of Service 22 and 24)	09/28/05	11/01/05
Section 510.8.1	Prior Authorization Requirements For Outpatient Services	09/28/05	10/01/05 Policy clarification
Section 510.8.1	Prior Authorization Requirements for Outpatient Services	09/01/05	10/01/05
Section 510.8.1	Prior Authorization Requirements for Outpatient Services	02/14/05	05/01/05
Section 510.8.2	Non-covered Services - Outpatient	02/14/05	05/01/05
Attachment 1	Special Coverage Considerations and Billing Instructions	02/14/05	05/01/05

CHAPTER 510 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPITAL SERVICES

JANUARY 12, 2006

SECTION 510.8.1

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment 3.

Change: Number 4 should read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 3, along with the PA form that may be utilized.

Directions: Replace pages.

OCTOBER 24, 2005

SECTION 510.8.1

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

SEPTEMBER 28, 2005

Section 510.8.1

Introduction: Policy clarification for Critical Access Hospitals regarding diagnostic imaging PA requirements.

Introduction: Prior Authorization required for surgeries preformed in place of service 22 and 24.

Change: Critical Access Hospitals (CAHs) who have chosen encounter, as well as those who bill Fee For Service, must obtain a prior authorization for certain diagnostic imaging testing. Reimbursement for diagnostic imaging services are considered part of the encounter and cannot be billed separately. CAHs will be required to obtain a PA from WVMI and document this information in the patient's medical record for audit purposes.

Change: Effective November 1, 2005, all surgeries performed in place of services 22 (Out patient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization.

Directions: Replace pages.

SEPTEMBER 1, 2005

Section 510.8.1

Introduction: Implementing changes in policy for imaging procedures effective 10/01/05.

Change: Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Directions: Replace pages.

MAY 1, 2005

Section 510.8.1

Introduction: Corrected the number of physical therapy visits to 20 from 10.

Directions: Replace this section.

Change: Replace page

Section 510.8.2

Introduction: 5th bullet - Corrected the number of physical therapy visits to 20 from 10. Added Enhanced Extracorporeal Counterpulsation (EECP), Stretta, and Cosmetic Surgery to the list of noncovered services.

Directions: Replace this section.

Change: Page

Attachment 1

Introduction: Added section relating to new condition code which allows inpatient admission to be changed to outpatient.

Directions: Insert this section.

Change: Attachment 1

CHAPTER 510—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR HOSPITAL SERVICES

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CHAPTER 510–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPITAL SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive range of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in this manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth requirements of the BMS regarding coverage, payment and processing for Hospital Services provided to eligible WV Medicaid members by acute care, psychiatric and medical rehabilitation hospitals.

Inpatient and outpatient hospital services, including tests furnished by participating hospitals, are covered only when ordered by a licensed medical practitioner for the care and treatment indicated in the management of illness, injury, or maternity care, or for the purpose of determining existence of an illness or disease. All Medicaid covered items and services must be medically necessary. The physician's order and appropriate documentation of medical necessity must be on file in the patient's record. The fact that a provider has prescribed, recommended, or approved medical care, goods, or a service, does not in itself make such care, goods or services medically necessary or a covered service. For definition of medically necessary, refer to Chapter 200, Definitions.

There must be documentation in the patient's record for all services billed to the West Virginia Medicaid Program, which substantiates the medical necessity for covered items or services. For Medicaid covered services or items requiring prior authorizations, the physician's order and documentation must be submitted prior to the provision of the service.

This Chapter outlines or describes the allowable services which may be rendered within each of the three categories of hospital providers, acute care, psychiatric, and medical rehabilitation.

510.1 DEFINITIONS

Definitions governing the provision of WV Medicaid services will apply pursuant to Chapter 200, Definitions. In addition, the following definitions apply specifically to the requirements for payment of Hospital Services as described in this chapter.

Critical Access Hospital (CAH) – Critical Access Hospital is defined in the code of federal regulations at CFR 42, Chapter 4, Section 400.2.2, as "a facility designated by the Centers for Medicare and Medicaid Services as meeting the applicable requirements of Section 1820 of the Act and of Subpart F of Part 485 of this chapter. Characteristics of critical access hospitals include:

- Special reimbursement status, consisting of 100 percent cost reimbursement as determined by Medicare fiscal intermediary (for Medicaid reimbursement methodology see Attachment 1.)

- Number of beds: Except as permitted for CAHs having swing bed agreements (with Medicare) under Section 485.645 of this chapter, the CAH maintains no more than 15 inpatient beds.
- Length of stay. The CAH provides acute inpatient care for a period that does not exceed on an annual average basis 96 hours per patient.

Eligible Medicaid Patient – An individual with a valid identification card receiving financial and/or medical assistance from the DHHR and children in foster care under Department supervision.

Regulating Agency – The unit in the Department of Health that is responsible for Medicaid certification of all participating laboratory and radiology providers in accordance with the standards set forth in Title XIX laboratory and radiology services regulations.

510.2 PROVIDER PARTICIPATION

Refer to Chapter 300 for enrollment requirements for Hospital providers.

510.3 MEMBER ELIGIBILITY

Reimbursement for medically necessary Hospital Services is available on behalf of all WV Medicaid-eligible members, subject to the conditions and limitations applicable to these services. Additional information on member eligibility is located in Chapter 400.

510.4 HOSPITAL INPATIENT SERVICES

An inpatient admission is defined as a person who has been admitted to an inpatient facility for bed occupancy for purposes of receiving inpatient hospital facility services. Inpatient care is covered under the Medicaid Program when it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. The services must be consistent with the diagnosis or treatment of the patient's condition, and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury, or to improve the functioning of a malformed body part, is not covered. Nursing and other related services, such as use of hospital facilities, medical and social services, and transportation furnished by the hospital during an inpatient stay are included in the rate of reimbursement. Covered services are limited to those admissions which are certified by the Bureau's utilization management agency in accordance with the procedures and admission criteria utilized by the agency and approved by BMS. Refer to Attachment I for additional information. Additionally, admissions must be effected upon the written order of a physician who is licensed in the practice of medicine and surgery in the state in which he/she is located, and authorized to admit patients to the facility in which the service is rendered.

510.4.1 Acute Care Hospital – Inpatient Services (This category of hospital is intended to include both acute care general and critical access hospitals)

The WV Medicaid Program reimburses hospitals for medically necessary inpatient services provided to eligible members within coverage limitations in effect on the date of service. Coverage and benefit limitations may be revised periodically as necessary due to changes in Federal regulations, fiscal constraints, or WV Medicaid policies.

Covered inpatient services include general acute care admissions and critical access admissions, as well as admissions to Medicare certified distinct part psychiatric and medical

rehabilitation inpatient units. Services rendered in the distinct part psychiatric unit are covered for both children and adults. Coverage for services rendered in the distinct part rehabilitation inpatient unit is limited to children through age 20 or under age 21.

A member admitted to a psychiatric distinct part must have a mental health DSM IV diagnosis as the primary diagnosis. If during the distinct part inpatient stay, the treatment emphasis changes to, or shifts to a physical health diagnosis or condition, the hospital cannot bill the distinct part rate but must bill the appropriate DRG. In these instances the patient must be discharged from the distinct part unit and if medically necessary and appropriate and following medical necessity review and certification by the Bureau's utilization management agency, readmitted as an acute care medical admission.

Inpatient services are primarily for treatment indicated in the management of acute or chronic illness, injury, impairment, or for maternity care. The member's hospital records and the hospital's utilization review mechanism must document that the care and services rendered were medically necessary; that the services rendered could only be provided on an inpatient basis (i.e. could not be provided on an outpatient basis or in a lower level of care facility); and that the services rendered were necessary for each day of inpatient care billed to the program. Outpatient charges including observation services incurred with 24 hours of admission must be made a part of the inpatient claim.

510.4.2 Psychiatric Inpatient Facilities

Members who are admitted to distinct part psychiatric units must have an admission diagnosis of a mental illness. If however, during the course of the stay, treatment changes from psychiatric care to physical care, the hospital shall bill the appropriate DRG. These admissions will be subject to audit and cost settlement.

510.4.2.1 Inpatient Psych Facility Acute Psych Under 21

Services rendered in this setting include inpatient acute care psychiatric services for individuals under 21 (Professional services rendered to members who would be admitted to a psych under 21 facility must be billed separately under the practitioner's provider number. Those charges are not included in the facility's invoice). Such facilities may also render all of the outpatient services for which they meet applicable federal and state regulatory requirements (Outpatient services are reimbursed on a procedure specific fee for service utilizing appropriate HCPCS and CPT codes just as for outpatient services rendered in any other approved setting). Services rendered in the outpatient setting may also include partial hospitalization services in Medicaid approved Partial Hospitalization Programs, as further defined in Attachment 1. These facilities are reimbursed based on costs and are subject to audit and cost settlements.

Services rendered to Medicaid members enrolled in an HMO are not the responsibility of the HMO and must be billed to Medicaid. If the Medicaid recipient is a member of the PAAS Program, PAAS PCP referrals are not required.

510.4.2.2 Inpatient Psychiatric Residential Treatment Facility

Services rendered in this setting are available only to Medicaid eligible individuals under age 21. PRTFs may only render inpatient services, which are inclusive of any medical, pharmaceutical or psychiatric professional services rendered in the facility. PRTFs are not authorized to render

outpatient hospital services. These facilities are reimbursed based on costs and are subject to audit and cost settlements.

Services rendered to Medicaid members enrolled in an HMO are not the responsibility of the HMO and must be billed to Medicaid. If the Medicaid recipient is a member of the PAAS Program, PAAS PCP referrals are not required.

510.4.2.3 Adult Psychiatric Services

Medicaid program coverage for inpatient psychiatric services rendered to adults is limited as follows:

a. Medicaid covers such services when rendered to Medicaid eligible individuals in Medicare certified distinct part psychiatric units of acute care general hospitals when such individuals are admitted following medical necessity review and admission certification by the Bureau's utilization management contractor

b. For those individuals 65 and over who are both Medicare and Medicaid eligible, the Medicaid program provides coverage of coinsurance and deductible payments subject to Medicaid's upper payment limits for individuals admitted to facilities designated as institutes for mental disease (IMD). Psychiatric facilities classified as IMD are defined in federal regulation at CFR 42, Section 435.1009, IMD. In general, this designation includes all JACHO approved psychiatric inpatient facilities

510.4.3 Medical Inpatient Rehabilitation Facility

Services covered in this setting are medical inpatient rehabilitation services for Medicaid eligible individuals under 21, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification. These facilities are reimbursed based on costs and are subject to audit and cost settlements.

Medicaid covers inpatient rehabilitation services in facilities that are certified as rehabilitation hospitals or rehabilitation units of a general acute care hospital. The facility must also have a current provider agreement for rehabilitation services.

510.5 SERVICE LIMITS INPATIENT SERVICES

Medicaid Program coverage places limits on certain categories of facilities with regard to admission review procedures and characteristics of members they may serve. The following sections outline those limitations and program exclusions:

510.5.1 Prior Authorization Requirements For Inpatient Services

All inpatient admissions, with the exception of those related to labor and delivery, are subject to medical necessity review and certification of admission by the Bureau for Medical Services Utilization Management Agency. (See Attachment 2 for further information.)

General requirements by category of provider are as follows:

1. Acute Inpatient. Admissions to both general and critical access acute care facilities are subject to medical necessity review and preadmission certification. Retrospective review is available for admissions occurring on weekends and holidays, or at times when the utilization management agency review process is unavailable. Additionally, retrospective

review is permitted for admissions of Medicaid members whose eligibility has been determined retroactively. Retrospective review must be requested within 12 months of discharge date.

2. Admissions to Medicare certified distinct part psychiatric and rehabilitation units of acute care facilities are subject to both preadmission and continued stay review.
3. Psychiatric inpatient facility and PRTF admissions are subject to admission and continued stay review by the Bureau's utilization management contractor.
4. Inpatient Medical Rehabilitation Facility admissions are subject to both admission and continued stay review by the Bureau's utilization management contractor. Members who are inpatients, upon reaching the age of 21, may continue to receive services through age 21, as long as they continue to meet medical necessity criteria for continued stay.

510.5.2 Inpatient Non-Covered Services (Exclusions)

The following inpatient services are excluded from coverage by the West Virginia Medicaid Program:

1. Admissions which are not authorized by the Bureau's utilization management contractor in accordance with Medicaid Program Policy in effect as of the date of service.
2. Admissions other than emergency to out-of-state facilities for services which are available in-state or in border area facilities
3. Admissions for experimental or investigational procedures
4. Admissions and/or continued stays which are strictly for patient convenience and not related to the care and treatment of a patient
5. Inpatient psychiatric or medical rehabilitation facility admissions of individuals age 21 or over
6. Inpatient admission for services which could be performed in an outpatient setting

510.6 REIMBURSEMENT METHODOLOGY FOR INPATIENT SERVICES

Reimbursement methodologies for hospital services vary depending on the type of service at issue. The following describes various inpatient services and their corresponding reimbursement methodologies.

Service	Reimbursement Methodology
Inpatient Acute Care Services – General	Diagnosis related group (DRG)
Acute Care Hospital – Critical Access	Per diem rate established by Medicare fiscal intermediary
Distinct Part	Cost based
Inpatient Psych Facility – Acute Psych Under 21	Interim per diem for in-state facilities and border facilities. Must submit cost reports subject to audit and cost settlement

Inpatient Psychiatric Residential Treatment Facilities (PRTF)	Interim per diem for facilities in-state, out-of-state is percentage of charge. Must submit cost reports subject to audit and cost settlement.
Medical Inpatient Rehabilitation Facility	Per diem

510.7 ACUTE CARE HOSPITAL OUTPATIENT SERVICES

The following outlines those outpatient hospital services which are covered by the West Virginia Medicaid Program. These services are reimbursable for all Medicaid eligible members.

- **Lab, radiology, and other diagnostic procedures including pulmonary function testing**

  Medicaid coverage rules require that lab, radiology, and other diagnostic services rendered in the outpatient department of the hospital must be performed by facilities which meet all applicable professional and regulatory certification. Reimbursement may be made only for medically necessary tests ordered by a physician or other practitioner acting within the scope of his/her license for the care and treatment indicated in the management of illness, injury, impairment, maternity care, or for the purpose of determining the existence of an illness or disease process. Medicaid does not reimburse for clinical laboratory tests or radiology procedures performed for quality assurance, paternity determination, or routine drug screening. Refer to Medicaid Lab and Radiology Services Manual.

- **Emergency room services**

  Medicaid covers five levels of emergency room services. Those levels of service are further defined in Attachment 1. There are five CPT procedure codes available for billing emergency room services. The reimbursement is an all-inclusive fee, which is considered to include the following items:

  - Use of emergency room
  - Routine supplies (such as sterile dressings)
  - Minor supplies (bandages, slings, finger braces, etc.)
  - Pharmacy charges
  - Suture, catheter, and other trays
  - IV fluids and supplies
  - Routine EKG monitoring
  - Oxygen administration and O_2 saturation monitoring

Diagnostic procedures including lab and radiology may be billed separately and in addition to the emergency room services. See Attachment I for further information.

- **Outpatient surgery**

Outpatient surgery procedures are those which can safely be performed in the outpatient department of the hospital or freestanding ambulatory surgery center. Procedures in which both the surgery and recovery can be accomplished on a date of service, do not normally require the nursing services support and care of an inpatient hospital admission.

- **Radiation and cobalt therapy**
- **Chemotherapy**
- **Outpatient physical therapy**
- **Observation Services**

  Observation services are those furnished on a hospital's premises, including use of a bed and periodic monitoring by hospital nurses or other staff. The services must be reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered when provided by the order of a physician and within the limitations defined in Medicaid Program policy. (See Attachment 1)

- **Partial hospitalization**

  Partial hospitalization is an outpatient hospital service rendered in a treatment setting, where an interdisciplinary program of medical therapeutic services is provided for the treatment of psychiatric and substance abuse disorders. The interdisciplinary program of medical therapeutic services may be delivered through one of the two following program formats (services may not be provided under both formats concurrently):

  Medicaid Program policy defines partial hospitalization services to include a 4 hour structured treatment program, which may be offered either during the day or evening hours. The second covered service format is a short-term intensive program for those individuals whose needs can be met through an intensive outpatient program consisting of 6 to 10 hours of group therapy per week, delivered in 2 hour per day group therapy sessions. (See Attachment 1 for further details regarding treatment scheduling and reimbursement options.)

- **Infusion Therapy**
- **Transfusion**

510.8 OUTPATIENT SERVICE LIMITATIONS

Partial hospitalization services may only be rendered in settings authorized by the Bureau for Medical Services and subject to all prior authorization requirements and limitations. Physical and occupational therapy rendered in the hospital outpatient setting are also subject to prior authorization by the Bureau's utilization management contractor. All outpatient services must be medically necessary for the diagnosis and/or treatment of an illness or injury and ordered by a physician or other practitioner acting within their licensure and/or scope of practice as defined by state law.

510.8.1 Prior Authorization Requirements For Outpatient Services

Medicaid covered outpatient services which require medical necessity review and prior authorization are:

1. Partial hospitalization
2. Physical therapy exceeding twenty (20) sessions or units per year.

Refer to Medicaid Physical and Occupational Therapy Services Manual at www.wvdhhr.org.

3. Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

   Critical Access Hospitals (CAHs) who have chosen encounter, as well as those who bill Fee For Service, must obtain a prior authorization for certain diagnostic imaging testing. Reimbursement for diagnostic imaging services are considered part of the encounter and cannot be billed separately. CAHs will be required to obtain a PA from WVMI and document this information in the patient's medical record for audit purposes.

   Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

4. Certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 3 along with the PA form that may be utilized.

   (See **Attachment 2** for utilization management agency information.)

510.8.2 Non-Covered Services (Exclusions) Outpatient

The following are excluded from coverage in the outpatient service department:

- Any charges incurred by a Medicaid member who was not eligible on the date of service
- Charges related to use of hospital facilities by attending physician
- Services which are denied as not medically necessary

- Partial hospitalization services which are not authorized by the Bureau's utilization management contractor
- Physical or occupational therapy services exceeding twenty (20) sessions which are not authorized by the Bureau's utilization management contractor
- Services known as alternative therapies, including but not limited to acupressure, acupuncture, chelation therapy, massage therapy, naturopathy, reflexology, tai chi, and yoga
- Mass screenings for any condition whether for outpatients or inpatients
- Convenience items or services; items or service for the convenience of the patient or caregiver that are not related to medical care or treatment
- Infertility services
- Seat lift chairs and/or comparable items
- Prenatal sex determination services
- Maintenance services provided when a persons highest level of function has been reached and no progress is being made
- Experimental/investigational/research studies on medical or surgical procedures/services, treatment and/or therapies
- Free Service – Medicaid funds cannot be used to reimburse for services that are provided free of charge to other individuals, or groups of individuals
- Outpatient observation on the same date as discharge from inpatient facility
- Observation services billed in conjunction with therapeutic services such as chemotherapy, or labor and delivery
- Observation which extends into hospital admission
- Educational services or nutritional counseling
- Injections or visits solely for the administration of injections unrelated to a medical encounter in emergency room or observation area
- Preoperative testing performed on the same date as surgery in the hospital outpatient department, or preoperative monitoring during a normal recovery period
- Enhanced Extracorporeal Counterpulsion (EEC)
- Stretta
- Cosmetic Surgery

510.9 REIMBURSEMENT METHODOLOGY FOR OUTPATIENT SERVICES

With the exception of services rendered in a critical access hospital setting, outpatient hospital services are all reimbursed fee-for-service specific to the procedure. These services are listed below with the corresponding reimbursement method. (Additional information is in Attachment 1.)

- Lab, radiology, and other diagnostic procedures including pulmonary function testing. Reimbursement is fee-for-service/CPT code.
- Emergency room services – CPT codes, see Attachment 1

  Each of five levels of emergency room services is reimbursed using an all-inclusive fee.
- Day surgery procedures are reimbursed with CPT codes. These are surgical procedures that generally do not require admission. Payment includes usual supplies such as local anesthesia, dressing trays, and other surgical supplies.
- Radiation and cobalt therapy – Reimbursement is CPT codes.
- Chemotherapy use CPT codes
- Outpatient physical therapy – CPT codes – PA after 20 visits
- Observation services – CPT codes, see Attachment 1
- Partial hospitalization – CPT and HCPCS codes, see Attachment 1
- Infusion therapy – Reimbursed CPT codes
- Transfusion – Reimbursed CPT codes
- Casting – Reimbursed CPT codes

510.10 MANAGED CARE

If a Medicaid recipient is a member of an HMO, the HMO is responsible for the services in this manual, excluding the behavioral health services. Prior authorization requirements of the HMO must be followed prior to rendering the service. If the recipient is a member of the PAAS Program, a referral from the PCP must be obtained prior to rendering the service, excluding behavioral health services, and Medicaid prior authorization requirements must be followed. If the requirements of the MCO/PAAS are not followed, Medicaid will not reimburse for services rendered.

510.11 INTERFACILITY TRANSPORTS VIA AMBULANCE

Ambulance transportation from one hospital to a more distant hospital must be for specialized care that is not available at the sending facility. In addition, the patient's current medical condition must meet the medical necessity criteria established in Chapter 524 of the Transportation Services Provider Manual.

Reimbursement for same day, round trip transportation by ambulance for services not available at sending facility is the responsibility of the sending facility, not the Medicaid member or Program. The hospital or Medicaid member requesting ambulance transport is responsible for reimbursing the ambulance agency if the reason for transport does not meet the criteria listed above.

510.12 MATERNITY RELATED SERVICES

A newborn child whose mother is Medicaid eligible at the time of birth, and who resides with the mother, is eligible for Medicaid services up to 1 year from the date of birth. Whether or not the mother is on Medicaid, the service must be billed with the newborn's Medicaid identification number. Payment is determined by DRG for maternity related services.

For managed care members, the managed care entity is responsible for claims incurred by a newborn. The MCO responsible is the one the mother was enrolled in at the time of the birth. The MCO is responsible for the newborn up to 2 months after birth.

CHAPTER 510
HOSPITAL SERVICES
NOVEMBER 1, 2004

ATTACHMENT I
SPECIAL COVERAGE CONSIDERATIONS
AND BILLING INSTRUCTIONS
PAGE 1 OF 16

WEST VIRGINIA MEDICAID PROGRAM HOSPITAL REGULATIONS

MEDICAID COVERAGE FOR OUTPATIENT PARTIAL HOSPITALIZATION PROGRAMS

I. SERVICE DESCRIPTION

Partial hospitalization is an outpatient hospital service rendered in a treatment setting, where an interdisciplinary program of medical therapeutic services is provided for the treatment of psychiatric and substance abuse disorders. The interdisciplinary program of medical therapeutic services may be delivered through any one of the following program formats (services may not be provided under multiple program formats concurrently):

1. Day programming, which must provide at a minimum, twenty (20) hours of scheduled treatment, delivered in sessions of 4 hours duration and extending over a minimum of five (5) days per week; or

2. Evening hours programming must provide a minimum of sixteen (16) hours of scheduled programming, extending over a minimum of four (4) days per week; or

3. A short term intensive program for those individuals whose needs can be met through an intensive outpatient program consisting of six to ten hours of group therapy per week, delivered in two (2) hour per day group therapy sessions.

   Some flexibility in billing is made possible through the availability of an abbreviated treatment session procedure code. The abbreviated treatment session is a one (1) hour unit of service limited to a maximum of three (3) units per date of service. This one (1) hour service unit may be billed for individuals who have been approved for either a four (4) hour day or evening programming or the two (2) hour short term intensive program in instances when the patient is unable to complete the full four (4) hour or two (2) hour treatment session. This abbreviated treatment session is not intended to replace either the four (4) hour day or evening program, or the two (2) hour intensive outpatient modality. It is intended only for use in those instances when the patient is unable to complete either a four (4) hour evening or day program, or a two (2) hour intensive outpatient session. It may not be billed in addition to or with either the evening/day program or the intensive outpatient procedure code.

II. PROVIDER ELIGIBILITY

Partial hospitalization programs may be operated by psychiatric acute inpatient facilities and acute care general hospitals with a Medicare certified distinct part substance abuse and/or psychiatric unit, which is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Additionally, the partial hospitalization program must meet the standards and guidelines for such programs as defined by a national accreditation or standard setting organization recognized by the West Virginia Medicaid Agency.

III. PROGRAM COVERAGE AND LIMITATIONS

All partial hospitalization services require medical necessity review and prior authorization through the Bureau's utilization management contractor. Services may not exceed 40 units in a calendar year.

IV. REIMBURSEMENT RATES

Both the twenty (20) hour per week day program, and the sixteen (16) hour per week evening program, will be reimbursed on a per diem basis, at the rate of $125.00 per day, thirty (30) days per individual per calendar year. The intensive outpatient Partial Hospitalization Units Program, which consists of three (3) to five (5) two hour group sessions (units) per week, will be reimbursed at the rate of $50.00 per session.

The abbreviated treatment session one (1) hour service unit will be reimbursed at the rate of $25.00 per one (1) hour unit, to a maximum of three (3) units for a date of service. This procedure may not be billed in combination with any other treatment modality for that date of service.

Services must be reported using CPT codes as follows:

Partial Hospitalization, per diem (Minimum - 4 hours)	H0035
Partial Hosp. Intensive Group Therapy (two hour session)	90853
Partial Hosp. Treatment Session, per hour (maximum - 3 hours)	H0015

The Medicaid Program will not be responsible for reimbursement of any services provided prior to issuance of an authorization, nor for any dates of service which exceed the authorization.

WEST VIRGINIA MEDICAID PROGRAM

COVERAGE BARIATRIC SURGERY PROCEDURES

The West Virginia Medicaid Program covers bariatric surgery procedures subject to the following conditions:

- Medical Necessity Review and Prior Authorization

The patient's primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request, along with all the required information, to the West Virginia Medical Institute (WVMI), 3001 Chesterfield Place, Charleston, West Virginia 25304. The West Virginia Medical Institute (WVMI) will perform medical necessity review and prior authorization based upon the following criteria:

1. A Body Mass Index (BMI) greater than 40 must be present and documented for at least the past 5 years. Submitted documentation must include height and weight.

2. The obesity has incapacitated the patient from normal activity, or rendered the individual disabled. Physician submitted documentation must substantiate inability to perform activities of daily living without considerable taxing effort, as evidenced by needing to use a walker or wheelchair to leave residence.

3. Must be between the ages of 18 and 65. (Special considerations apply if the individual is not in this age group. If the individual is below the age of 18, submitted documentation must substantiate completion of bone growth.)

4. The patient must have a documented diagnosis of diabetes that is being actively treated with oral agents, insulin, or diet modification. The rationale for this criteria is taken from the Swedish Obese Subjects (SOS) study, *International Journal of Obesity and Related Metabolic Disorders*, May, 2001.

5. Patient must have documented failure at two attempts of physician supervised weight loss, attempts each lasting six months or longer. These attempts at weight loss must be within the past two years, as documented in the patient medical record, including a description of why the attempt failed.

6. Patient must have had a preoperative psychological and/or psychiatric evaluation within the six months prior to the surgery. This evaluation must be performed by a psychiatrist or psychologist, independent of any association with the bariatric surgery facility, and must be specifically targeted to address issues relative to the proposed surgery. A diagnosis of active psychosis; hypochondriasis; obvious inability to comply with a post operative regimen; bulimia; and active alcoholism or chemical abuse will preclude approval.

7. The patient must demonstrate ability to comply with dietary, behavioral and lifestyle changes necessary to facilitate successful weight loss and maintenance of weight loss. Evidence of adequate family participation to support the patient with the necessary lifelong lifestyle changes is required.

8. Patient must be tobacco free for a minimum of six months prior to the request.

9. Contraindications: Three (3) or more prior abdominal surgeries; history of failed bariatric surgery; current cancer treatment; Crohn's disease; End Stage Renal Disease (ESRD); prior bowel resection; ulcerative colitis; history of cancer within prior 5 years that is not in remission; prior history of non-compliance with medical or surgical treatments.

10. Documentation of a current evaluation for medical clearance of this surgery performed by a cardiologist or pulmonologist, must be submitted to ensure the patient can withstand the stress of the surgery from a medical standpoint.

PHYSICIAN CREDENTIALING REQUIREMENTS

In order to be eligible for reimbursement for bariatric surgery procedures, physicians must:

- Provide evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.
- Provide documentation that the physician is working within an integrated program for the care of the morbidly obese that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training and psychological/psychiatric assistance as needed.
- Provide assurances that surgeons performing these procedures will follow the guidelines established by the American Society for Bariatric Surgery including:
    - Credentials to perform open and laporoscopic bariatric surgery
    - Document at least 25 open and/or laporoscopic bariatric surgeries within the last three years

PHYSICIAN PROFESSIONAL SERVICES

Professional services which will be required of the physician performing bariatric surgery include the surgical procedure, the 90-day global post-operative follow-up, and a 12 month assessment period which includes the following: medical management of the patient's bariatric care, nutritional and personal lifestyle counseling, and a written report at the end of the 12 month period consisting of: an assessment of the patient's weight loss to date, current health status and prognosis, and recommendations for continuing treatment. That 12 month assessment report must be submitted to the patient's attending or primary care physician, as well as to the Bureau for Medical Services.

While the bariatric surgeon's association with the patient may end following the required 12 month follow-up, the patient's continuing care should be managed by the primary care or attending physician throughout the patient's lifetime.

REIMBURSEMENT:

Hospital

Participating hospitals will be reimbursed for approved admissions through the DRG reimbursement methodology.

The hospital must be a facility in which the procedures are performed on a regular basis, and that has the proper equipment and appropriately trained staff for this specialized surgery, as outlined by the American College of Surgeons for facilities performing bariatric surgery . WVMI reserves the right to deny the request based on the appropriateness of the facility involved.

Physicians

The physician performing the bariatric surgery procedure will be reimbursed through the existing RBRVS payment methodology for the surgical procedure. Reimbursement includes

a post-operative follow-up for the global period of 90 days. For the remainder of the required 12 month follow-up period and assessment, the bariatric surgeon may submit claims using the appropriate evaluation and management procedure code. After completion of the required 12 month evaluation period, the patient may be followed-up and medically managed either by the surgeon or primary care physician utilizing appropriate E & M procedure codes.

CPT Codes/Covered Procedures

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty.

43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty.

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy.

43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption.

43848 Revision of gastric restrictive procedure for morbid obesity (separate procedure). (This is only for correction of serious complications caused by the procedure within the first 6 months postoperatively, and is not meant to indicate that a patient can have a second procedure due to failure to lose weight from a prior procedure.)

Only one procedure will be covered per lifetime. Those failing to lose weight from a prior procedure will not be approved for a second one.

Non-Covered Procedures

The following procedures will not be covered by West Virginia Medicaid Program:

A. Mini-gastric bypass surgery

B. Gastric balloon for treatment of obesity

C. Laparoscopic adjustable gastric banding

INPATIENT ADMISSION CHANGED TO OUTPATIENT

I. General Information

A. Background

The Center for Medicare and Medicaid Services (CMS) has issued directions on how to bill when a physician orders a member to be admitted to an inpatient bed, but upon reviewing the case later, the hospital's utilization review committee determines that an inpatient level of care does not meet the hospital's or State Medicaid Utilization Management's admission criteria.

For these purposes, CMS implemented a condition code obtained from the National Uniform Billing Committee (NUBC):

> Condition Code 44 - - Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its or Medicaid's Utilization Management inpatient criteria.

B. Policy

1. In cases where a hospital utilization review committee determines that an inpatient admission does not meet inpatient criteria, the hospital may change the member's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicaid covered services that were furnished to the member, provided all of the following conditions are met:

   a. The hospital has not submitted a claim to Medicaid for the inpatient admission;

   b. A physician concurs with the utilization review committee's decision; and

   c. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

2. When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the <u>entire</u> episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

3. When the hospital submits a 13x or 85x bill for services furnished to a member whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 in one of Form Locators 24-30, or in the ANSIX12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim.

OUTPATIENT BILLING
SURGERY, RECOVERY, OBSERVATION,
AND EMERGENCY DEPARTMENT

The following information defines the billing methodology for hospital based outpatient surgery, recovery, observation, partial hospitalization and Emergency Department visits.

BACKGROUND:

Surgical procedures must be billed with the appropriate CPT or HCPCS code and revenue code. Surgical procedures previously reported using W1546, W1547 and W1548 must now be reported using the specific CPT Code for the service. Units are reported in fifteen (15) minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. If you wish to report multiple procedures, bill all additional lines with zero units and zero charges. The maximum number of payable units is 16, but several procedures, including those previously billed with W codes, allow fewer units. The maximum rate is one hundred ninety-six dollars ($196.00) per unit.

Appropriate Revenue codes for billing out patient surgical procedures (procedure codes 10021 through 69979) are:

- 036X Operating Room Services
- 0391 Blood Administration (36430 – 36460)
- 045X Emergency Room
- 049X Ambulatory Surgical Care
- 051X Clinic
- 072X Labor Room/Delivery (59400 – 59899)
- 075X Gastro – Intestinal Services (Endoscope Procedures)
- 079X Extra Corporeal Shock Therapy

Some procedures in the surgical range are divided into technical and professional components (e.g. 59025 Fetal non-stress test) and must be billed with the TC modifier.

Recovery must be billed with Revenue Code 710. Payment will be made based on the combination of Revenue Code and units billed. Units are reported in fifteen (15) minute time increments. The maximum units allowed are twenty-four (24). For minor procedures and those not requiring anesthesia the billing of recovery is not appropriate. The rate is sixty dollars and ninety cents ($60.90) per unit. No procedure code is required.

Observation

Observation is billed using Revenue Codes 760 and 762 and time units reported in one (1) hour increments. The maximum number of units allowed for an episode of care is 48. The rate is ten dollars ($10.00) per unit (hour).

Observation is defined as, “The use of a bed and periodic monitoring, by hospital nursing or other staff which are reasonable and necessary, to evaluate an outpatient’s condition to determine the need for inpatient admission.”

The criteria for observation services include the following basic provisions:

- Observation services are covered only upon written order of a physician. This order must document the medical necessity for the services and is retained as part of the patient’s medical record. Documentation requirements for admission to observation are essentially the same as for inpatient admission; however the medical necessity criteria are less stringent.
- Observation does not require prior authorization.
- Coverage of observation may not exceed 48 hours.
- Charges for observation services which result in an inpatient admission are deemed to be part of the admission and not separately billable.
- Ancillary services, laboratory, x-ray and other diagnostic procedures, performed during the observation period, may be billed separately.
- Observation services are appropriate for labor and delivery monitoring when the medical necessity criteria are met.

Emergency Department Services

Emergency Department services must be reported using CPT codes as follows:

Minimal ER Service	99281
Brief ER Service	99282
Intermediate ER Service	99283
Extended ER Service	99284
Emergent ER Service	99285

The following definitions and descriptions are representative of the treatment provided at various levels within the Emergency Department. The specific criteria are intended as guidelines for the determination of charges.

Minimal

General Description:

The individual’s chief complaint upon presentation is minimal. That is, the individual requires only the most minimal treatment or could go without treatment and present little affect to his/her general health.

Specific Requirements:

1. Multiple Trauma/Surgical

    A. Cleansing of the wound or band-aide therapy
    B. Sprains or strains requiring only advice or elastic wrap
    C. No instrument trays required

2. Medical

    A. Medication orders received by telephone prior to patient's arrival
    B. Minimal physician examination
    C. No instrument trays required

3. OB-GYN

    A. Individual arrives in the Emergency Department for a consultation with their private physician
    B. No instrument trays required

4. Behavioral Medicine

    A. Individual requires a simple interview only (no medication)

Brief

General Description:

This individual requires treatment; however, treatment could possibly be delayed 24 hours with little effect to his/her general condition. Individuals in this classification rarely require admission to the hospital.

Specific Requirements:

1. Multiple Trauma/Surgical

    A. Simple orthopedic injuries requiring splints, slings, crutches, etc.
    B. Simple lacerations not requiring sutures

C. First degree burns

D. Minor eye injuries, including corneal abrasions

E. Post operative complications not requiring hospital admission

2. Medical

A. Medical evaluation without intravenous therapy or medication

B. Urinary tract infections requiring catheterization

C. Evaluation of sore throat with medication dispensed

D. Evaluation of headache with medication

E. Evaluation of neck vein distention without intravenous therapy/medication administration

F. Allergic reaction requiring only oral or injectable medication

G. Evaluation of conjunctivitis

3. OB-GYN

A. Obstetrical evaluation which may include urinary catheterization or vaginal exam

B. Evaluation of simple pelvic inflammatory disease

4. Behavioral Medicine

A. Individual requires a simple interview with medication administration

Intermediate

General Description:

This individual requires medical intervention today in order to prevent an impact on his/her general well-being. Oxygen and/or intravenous therapy may be required; however, hospital admission is indeterminate. Extensive monitoring is not required.

Specific Requirements:

1. Multiple Trauma/Surgical:

A. Minor lacerations requiring suturing

B. Simple fractures reduced and cast within the confines of the Emergency Department

C. Orthopedic injuries requiring major splinting

D. Partial thickness burns less than 20% body surface are that do not require follow-up

E. Removal of foreign body requiring incision

2. Medical

A. Evaluation of renal calculus requiring intravenous therapy

B. Dehydration requiring fluid replacement

C. Evaluation of simple chest pain not requiring cardiac monitoring or intravenous therapy

D. General medical evaluation requiring medication administration and/or intravenous therapy

E. Evaluation of minor GI bleeding requiring aspiration of gastric contents

F. Evaluation and monitoring of potential seizure activity

3. OB-GYN

A. Evaluation of pelvic inflammatory disease requiring multiple vaginal examinations and/or intravenous therapy and medication administration

B. Incision and drainage of Bartholin cyst

C. Removal of foreign body

4. Behavioral Medicine

A. Drug overdosage requiring induced emesis and not more than one liter of intravenous fluid administration

B. Evaluation and uncomplicated admission to a state psychiatric or other similar facility

Extended

General Description:

The individual presents to the Emergency Department with an injury or illness/disease process requiring prompt medical evaluation and intervention, the result of which is usually admission to the hospital.

Specific Requirements:

1. Multiple Trauma/Surgical

A. Requires periodic vital signs, neurological evaluations, or cardiac monitoring

B. Lacerations requiring major suturing

C. Partial thickness burns greater than 20% body surface area

D. Motor vehicle crash requiring evaluation but on invasive diagnosis or therapeutic measures except intravenous fluid administration

2. Medical

A. G.I. Bleeding requiring fluid replacement

B. Medical evaluation requiring cardiac monitoring

C. Evaluation and treatment of epiglottitis

D. Lumbar puncture for diagnostics

E. Evaluation and treatment of altered states of consciousness without other injury

3. OB-GYN

A. Evaluation and treatment of the following:

1) Profuse vaginal bleeding

2) Ectopic pregnancy

3) Placenta previa

4) Septic shock

B. Delivery in the Emergency Room

C. Rape examination

4. Behavioral Medicine

A. Individuals requiring suicidal or homicidal precautions

B. Individuals presenting as disruptive enough to require physical restraint and/or observation by the security department

C. Drug overdose requiring gastric lavage and intravenous therapy

Emergent

General Description:

The individual presents with an injury or disease process significant enough as to require immediate evaluation and intervention in order to prevent continued deterioration.

Specific Requirements:

1. Multiple Trauma Surgery
   - A. Individuals presenting with moderate shock requiring intravenous fluid and/or blood replacement
   - B. Trauma team activations that require no invasive therapeutic and/or diagnostic procedures (excluding urinary catheterization)
   - C. Individuals presenting with significant neurologic insult or injury

2. Medical
   - A. G.I. Bleeding requiring blood replacement and/or endoscopy performed in the Emergency Department for evaluation
   - B. Evaluation of chest pain requiring cardiac monitoring and intravenous nitroglycerin therapy
   - C. Cardiac arrest requiring CPR of less than 30 minute duration
   - D. Individuals presenting with chronic obstructive pulmonary disease requiring endotracheal intubation and complex intravenous and medication therapy

3. Behavioral Medicine
   - A. Drug overdose or suicide attempt requiring resuscitation but without CPR

Payment for two (2) Emergency Department visits on the same day, to the same facility, for the same problem is not allowed. When more than one visit occurs in a day, the charges must be rolled to the highest level appropriate to the visits. To request special consideration, submit the claim on paper with documentation to support the uniqueness of the visits for review to:

BMS Exception Review

350 Capitol Street, Room 251

Charleston, WV 25301-3707

Charges for surgical procedures, diagnostic procedures, casting supplies and certain drugs may be billed separately. Unusual and/or high cost drugs and supplies may be covered by exception following review of documentation. Such requests should be addressed as above.

ORGAN TRANSPLANT SERVICES

WV Medicaid covers certain types of organ transplants performed in a Medicare-approved transplant facility.

Organ transplant services are covered when generally considered safe, effective, and medically necessary when no alternative medical treatment as recognized by the medical community is

available. The intended transplant must be performed to manage a disease consistent with recognized standards in the medical community Investigational, research, or experimental procedures are not covered.

Member selection criteria are based on critical medical need for transplantation and a maximum likelihood of successful clinical outcome. All other medical and surgical therapies that might be expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:

- Current medical therapy has failed and the member has failed to respond to appropriate therapeutic management
- The member is not in an irreversible terminal state
- The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living

Prior authorization is required for all transplants. BMS' contracted agent reviews requests for prior authorization.

The following types of transplants are covered with prior authorization:

- Heart Transplant
- Bone Marrow Transplant
- Adult Liver Transplant
- Pediatric Liver Transplant
- Kidney Transplant
- Pancreas/Kidney Transplant
- Lung Transplant – single and double
- Heart/Lung Transplant
- Small Intestine Transplant
- Cornea

Transplants are not covered when two of them are performed together, except under the following circumstances:

- If the primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process
- If the damage to the second organ will compromise the outcome of the transplant of the primary organ, multiple organ transplantation may be considered

Reimbursement for the hospital admission in which the transplant is performed is standard DRG reimbursement with a maximum or a cap of $75,000. Additionally, the hospital will be reimbursed the organ procurement cost at the CORE standard organ procurement cost for each category of organ plus any additional transportation cost associated with the organ acquisition. Donor cost, if not reimbursed by the donors insurance, may be reimbursed by the Medicaid Program under the Medicaid eligible members ID number.

CRITICAL ACCESS HOSPITAL OUTPATIENT REIMBURSEMENT

The outpatient component of critical access reimbursement is per diem as determined by Medicare fiscal intermediary. Claims must be filed on the UB-92 claim form or the ASC X12N 837 (004010X096A1) electronic claim format utilizing procedure code T1015, bill type 851, and appropriate revenue code.

CAH/Medicaid Reimbursement of Title XVIII Medicare Crossovers:

Medicare crossover claims must be submitted on paper with a copy of the Medicare EOB attached. It is necessary that CAHs submit claims to Medicaid, because the Medicare fiscal intermediaries which process CAH claims do not cross over those claims automatically to Medicaid.

Cost Reporting:

Critical Access Hospital (CAH) reimbursement is subject to audit and year-end reconciliation to cost. The reconciliation is performed by an accounting firm, employed by the Bureau for Medical Services. The information utilized in the calculation of cost settlements are the Medicare cost report and Medicaid Program encounter data from claims history.

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ATTACHMENT 2
PRIOR AUTHORIZATION
PAGE 1 OF 2

PRIOR AUTHORIZATION

The utilization management contractor which performs medical necessity review and prior authorization of services for the Bureau for Medical Services is the West Virginia Medical Institute (WVMI).

The West Virginia Medical Institute maintains a website, http://www.wvmi.org/Priorauthcriteria.asp, which contains information regarding procedures for requesting prior approval, as well as criteria for all the different services for which they perform review for the Bureau for Medical Services. It also includes contact names and telephone numbers for key individuals and functions performed for BMS by WVMI.

If you have problems accessing the website or for some reason are unable to obtain information needed electronically, you may contact WVMI by telephone at (304) 346-9167 or 1-800-982-6334.

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ATTACHMENT 3
OUTPATIENT SURGERY PA REQUIREMENTS
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Confidential

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____

A. **Member** Name: _____ Date of Birth: _____
Last First MI
Member Address: _____
Street City State Zip

B. **Surgical Procedure** Requested: _____
CPT Code **(Required)**: _____ ICD-9-CM Code **(Required)**: _____ Assistant surgeon? ☐ Yes ☐ No

Diagnosis Related to Surgical Procedure: _____

C. **Facility** Performing Surgical Procedure: _____
Facility ID # (10 digits): _____ Facility is: □ In WV □ Outside WV

Referring Physician Name: _____
Mailing Address: _____
Street City State Zip
Surgeon Name: _____
Mailing Address: _____
Street City State Zip

Contact Name: _____ Phone# (_____)_____-_____ Ext: _____
Fax # (_____)_____-_____

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): _____
_____
_____
_____ Date of Onset: _____

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):_____
_____
_____

F. **Related Medications, Treatments, and Therapies (include duration): _____**
_____
_____
_____

G. If procedure routinely performed in office, please document need for OP surgical setting: _____
_____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For <u>WVMI Use Only:</u>
Approved: ___ Authorization Number: _____ Date*: _____

***(Authorization expires 90 days from this date)**

Denied: ____ Detailed letter to follow

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X
11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X

11471	Removal, sweat gland lesion	X	X
11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X
12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	

14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	
14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	
19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	

19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	
19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	

21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	
21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	

22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	
22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	
25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	

26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	
26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	
27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	

28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	
28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	
29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	

29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	

42810	Excision of nect cyst	X	
42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	
43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	
49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	

54409	Removal of inflatable penile prosthesis	X	
54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	
57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	
58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	

64555	Implant neuroelectrodes	X	
64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	
64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervation of extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	

69632	Rebuild eardrum structures	X	
69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	
76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	
51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	

CHAPTER 511—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR ICF/MR SERVICES

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CHAPTER 511–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR ICF/MR SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible participants. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

The policies and procedures set forth herein are the regulations governing the provision of Intermediate Care Facility for the Mentally Retarded Services (ICF/MR) in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9, of the Public Welfare Law of WV.

This chapter sets forth the Bureau for Medical Services (BMS) requirements for payment of services provided by ICF's/MR to eligible West Virginia (WV) Medicaid members.

PROGRAM DESCRIPTION

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) are part of the long term care continuum that provides care for individuals with mental retardation and/or developmental disabilities. The services provided are based on each member's needs, which vary according to age and level of mental retardation and developmental disabilities. In order for a facility to participate in the program, it must meet federal and state standards in the areas of client protection, facility staffing, active treatment, client behavior, health care services, physical environment, and dietetic services. ICF's /MR services in West Virginia are provided in small facilities throughout the state. Commonly, four (4) to eight (8) members reside in each of the ICF's/MR.

511.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, Definitions of the Provider Manual. The following definitions also apply to the requirements for services described in this chapter.

Active Treatment - aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

Individual Program Plan (IPP) (DD-5) is an outline of proposed activities that primarily focus on establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons with developmental disabilities and their families. It is designed to ensure accessibility, accountability, and continuity

of support and services. This service also ensures that persons with developmental disabilities have opportunities to make meaningful choices with regard to their life, and inclusion in the community. The IPP (DD-5) is the critical document that combines all information from the evaluations to guide the service delivery process. The completion of the IPP must be a joint effort among all parties involved in the member's life.

Individual Service Plan (ISP) is a specific breakdown of the service plan based upon assessments and needs which have been outlined.

Individual Habilitation Plan (IHP) establishes goals and identifies the discrete, measurable, criteria-based objectives the individual is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques necessary to allow the individual to function with as much self-determination and independence as possible.

Interdisciplinary Team (IDT) is a group of professionals, paraprofessionals, and non-professionals who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs.

Inventory for Client & Agency Planning (ICAP) assesses adaptive and maladaptive behavior and gathers additional information to determine the type and amount of special assistance that people with disabilities may need. The level of care an individual needs is based upon the results of the ICAP assessment. The service level determines the rate of reimbursement for the member.

511.2 PROVIDER PARTICIPATION: GENERAL REQUIREMENTS

In order to participate in the WV Medicaid Program and receive payment from the Bureau for Medical Services, the ICF/MR must:

- Meet and maintain all applicable licensing, accreditation, and certification requirements
- Meet and maintain all Bureau for Medical Services enrollment requirements
- Maintain a valid provider agreement on file that is signed by the provider and BMS upon application for enrollment into the WV Medicaid Program

511.2.1 SPECIFIC REQUIREMENTS

In addition to the provider requirements as set forth in Chapter 300, Provider Participation Requirements, the ICF/MR provider agencies must:

- Meet and maintain the standards established by the Secretary of the U.S. Department of Health and Human Services (DHHS), and all applicable Federal laws governing the provision of these services. This includes but is not limited to the Code of Federal Regulations and Federal Survey Procedures and Interpretative Guidelines for ICF's/MR .
- Be in compliance with all applicable state and local laws and regulations affecting the health and safety of the individuals, including fire prevention, building codes,

sanitation, medical practice acts, nurse practice acts, laws governing the procurement, storage, packaging, administration and accounting for drugs and other supplies, laws licensing professional clinical staff; communicable and reportable diseases, postmortem procedures, and all other applicable laws and regulations.

- Be certified by the Office of Health Facilities Licensure and Certification, (OHFLAC) as meeting the requirement of an ICF/MR and in compliance with relevant State and Federal Regulations. The ICF/MR must maintain standards necessary for licensure and certification. Reviews will be conducted at a minimum annually by OHFLAC. After completion of a certification survey, OHFLAC will report any deficiencies found during the survey to the ICF/MR and to the Office of Behavior and Alternative Health Care. The facility shall be responsible for the development and implementation of a plan of correction of any identified deficiency.

511.2.2 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

An ICF/MR must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 800, General Administration of the Provider Manual. In addition to the documentation requirements described in this chapter, the following requirements also apply to payment of ICF/MR services:

- All required documentation must be maintained for at least five (5) years in the provider's file subject to review by authorized OHFLAC personnel, BMS personnel or contracted agents.
- Ensure that all required documentation is maintained by the provider on behalf of the State of West Virginia and is accessible for State and Federal audits
- Ensure that all documentation meets standards before the claim is submitted for payment

MEMBER RECORDS

- The ICF/MR must develop and implement policies and procedures governing the release of member information, including consents necessary from the member, or parents (if the member is a minor) or legal guardian.
- The ICF/MR must develop and maintain a record-keeping system that includes a separate record for each member and documents the member's health care, active treatment, social information, and protection of the member's rights.
- The ICF/MR must keep confidential all information contained in the members' records, regardless of the form or storage method of the records.
- Data relative to accomplishment of the criteria specified in the member's Individual Program Plan objectives must be documented in measurable terms. Data must be collected in the form and frequency required by the plan. Data must accurately reflect the member's actual individual performance.

- The ICF/MR must legibly document, date and sign significant events that are related to the member's Individual Program Plan and assessments that contribute to an overall understanding of the member's ongoing level and quality of functioning.
- Required documentation includes, but is not limited to, the member's functional status, health condition, accomplishments, activities or needs which affect the Comprehensive Functional Assessment, Individual Program Plan (Individual Service Plan – Individual Habilitation Plan). It also includes any occurrence(s) inside or outside the ICF/MR which provides information about the member's interactions, responses, progress, or problems beyond the specific parameters of the Individual Program Plan.
- The ICF/MR must provide a legend to explain any symbol or abbreviation used in a member's record.
- The ICF/MR must provide each identified residential living unit with appropriate aspects of each member's record.
- The ICF/MR must keep an up- to- date picture of the member in the record.
- Providers that wish to computerize any of the DD forms utilized by the ICF/MR program may do so, however, all basic components must be included and the name/number indicated on the form.
- Records must comply with HIPAA regulations.

PERSONNEL RECORDS

Written job descriptions shall be developed for each category of personnel, to include qualifications, line of authority, and specific duty assignments.

Current employee records shall be maintained and shall include:

- A resume of each employee's training and experience
- Evidence of required licensure, certification and/or registration.
- Evidence of education
- Records of in-service training and continuing education
- Documentation that staff has received the training outlined in Federal Code of Regulations and ICF Interpretive Guidelines.
- Documentation that the employee does not have a conviction of or prior employment history of child or adult abuse, neglect or mistreatment

511.3 SERVICE COVERAGE

The Bureau for Medical Services will pay an all-inclusive per diem rate. This rate represents an inclusive payment for all services and items that are required to be provided by the ICF/MR. This includes but is not limited to active treatment, individual program planning, health care services, dietetic service, routine adaptive equipment, routine durable medical equipment, etc.

Covered services that are part of the per diem rate include room and board, nursing services, non-covered drugs, medical supplies, accessories and equipment, rehabilitation services, such as

physical therapy and speech therapy, regular, special, or supplemental diets, day habilitation or day treatment, transportation and all other prescribed care necessary to meet the current health needs of the member**.**

Nursing Services include the handling of the individual by the nursing and attendant staff, the provision of restorative and/or rehabilitative services, medical supplies and treatment, personal hygiene, and the administration of medication and/or medical gases (such as oxygen) prescribed by the physician as part of the plan of care. The facility must provide such items as dressings, bandages, disposable diapers, catheters, bed pans, medicine chest supplies, wheelchairs (unless specialized), walkers, crutches, syringes, needles, etc. Supplies and equipment which are customarily provided by the ICF/MR facility for the care and treatment of members are covered services and are included in the facility costs for rate setting as part of the per diem rate.

No charges will be permitted by the facility to the ICF/MR member/patient or his family, guardian or to any other source over and above the established rate of payment to the facility for those services covered under the Medicaid program. Reimbursement by the program for the ICF/MR facility services determined to be medically necessary and appropriate constitutes payment in full for services.

511.3.1 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

511.3.2 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100 General Information of the Provider Manual, the Bureau for Medical Services will apply the following:

- Payment for services provided by an ICF/MR is available only on behalf of members who have been determined to be in need of ICF/MR services.
- Reimbursement will be based on the results of the ICAP.

511.3.3 CODES

The following revenue codes are to the utilized:

REVENUE CODE	CODE DESCRIPTION
0191	ICAP - Level 1
0192	ICAP - Level 2
0193	ICAP - Level 3
0194	ICAP - Level 4
0183	Leave of Absence - Therapeutic
0185	Leave of Absence - Hospitalization

511.3.4 SERVICES PROVIDED BY OUTSIDE SOURCES:

If an ICF/MR does not provide a required service, it may enter into a written agreement with an outside service, program, or resource to do so. The agreement must state clearly the following:

- The responsibilities, functions, objectives, and other terms agreed to by both parties
- Provide that the ICF/MR is responsible for assuring that the outside services meet the standards for quality of services
- The ICF/MR must assure that outside services meet the needs of each individual
- If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to the physical facility.

Required services provided by outside sources are included in the ICF/MR per diem, and cannot be billed separately.

511.4 BIILLING PROCEDURES

An ICF/MR must comply with the billing procedures and requirements described in Chapter 600, Reimbursement of the Provider Manual.

511.4.1 BILLING REQUIREMENTS

The ICF/MR must furnish the Bureau for Medical Services, Behavioral and Alternative Health Care Division with such information regarding any payments claimed for individuals under the program as the Bureau for Medical Services may request

Collect no more than the established rate of payment for the services rendered and billed to the program; i.e., the ICF/MR may not bill anyone for supplemental payments.

The ICF/MR must have a record-keeping capability sufficient for determining the cost of services.

511.4.2 PAYMENT LIMITATIONS

Reimbursement rates are based upon the cost report submitted by the ICF/MR provider and outcomes of the ICAP instrument. The ICAP must be administered by qualified staff with the competencies to administer the assessment.

511.4.3 MEDICAL LEAVES OF ABSENCE

Reimbursement will be paid for an ICF/MR resident who must be transferred to an inpatient hospital for care and treatment that can only be provided on an inpatient basis.

The maximum bed reservation for such authorized absences shall be limited to fourteen (14) consecutive days, provided the resident is scheduled to return to the ICF/MR facility following discharge from the hospital. If the bed is used during the member's absence for emergency or respite care, it will in no way jeopardize or delay the return of the hospitalized member to the facility. However, such short-term use of the bed is not encouraged and when utilized the bed in such a manner will count these days in addition to reservation days in reporting the total census.

511.4.4 NON-MEDICAL LEAVES OF ABSENCE

Reimbursement will be paid to an ICF/MR facility for a non-medical leave of absence for therapeutic home visits and for trial visits to other facilities. Such visits are encouraged, and the policies of the ICF/MR should facilitate rather than inhibit such absences. Non-medical absences shall be initiated as part of the member's individual plan of care at the request of the member, his parent(s), or his guardian with the approval of the QMRP. The Medicaid agency will pay to reserve a bed for up to twenty one (21) days per calendar year for a member residing in an ICF/MR when the resident is absent for therapeutic home visits or for trial visits to another community residential facility. If the member's bed is used during the member's absence for short-term emergency or respite care – which in no way would jeopardize or delay the member's return to the ICF/MR – no additional payment is allowed for such short-term use of the bed for emergency or respite care. The facility will count these days in addition to bed reservation days in reporting the total census.

511.5 MEMBER ELIGIBILITY

Medical Eligibility is determined by submitting an application packet to the Bureau for Medical Services, Office of Behavioral and Alternative Health Care for member consideration.

511.5.1 DOCUMENTS REQUIRED FOR DETERMINING MEDICAL ELIGIBILITY

The DD-1 (Identification and Demographic Information Face Sheet), DD-2A (Medical Evaluation), DD-3 (Psychological Evaluation), DD-4 (Social History) and DD-5 (Individual Program Plan) need to be submitted to the Bureau for Medical Services, Division of Behavioral and Alternative Health Care, for approval for each member for whom payment is requested. The DD-1, DD-2A, DD-3, DD-4, and DD-5 must be current and received by the Bureau for Medical Services, Division of Behavioral and Alternative Health within ninety (90) days of admission to the ICF/MR or authorization of payment.

511.5.2 ELIGIBILITY DETERMINATION OF MEMBERS PRIOR TO ADMITTANCE

Individuals seeking ICF/MR services may have their eligibility determined prior to their admittance to an ICF/MR facility.

To establish prior eligibility, a complete packet of required information must be submitted within thirty (30) days prior to placement in the ICF/MR facility. Packets may be submitted to the eligibility determination section of the Bureau for Medical Services. All submitted information must be clinically current.

The prior eligibility packet of information includes the DD-2A, DD-3, and DD-4 and must be submitted to the Bureau for Medical Services, Office of Behavioral and Alternative Health, to establish eligibility for each member for whom payment is requested.

Current is defined as

- DD-2A (Medical Evaluation) must be current within the past six months. Any Medical Evaluation dated in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date.

- DD-3 (Psychological Report) must have been completed within 90 days of the placement date. Any date of a psychological report in excess of 90 days upon recipient by the Bureau for Medical Services shall be considered out of date
- DD-4 (Social History) must have been completed within 180 days of the placement date. Any social history in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date,

When current information is received in its entirety an eligibility determination will be made as quickly as possible (maximum of 45 days) and the decision communicated to the recipient and to the provider that submitted the packet.

511.5.3 ELIGIBILITY DETERMINATION OF MEMBERS POST ADMISSION

Individuals seeking ICF's/MR services can have their eligibility determined after their admittance to an ICF/MR. To establish eligibility, a complete packet of required information must be submitted within thirty (30) days after placement in the ICF/MR facility. Packets must be submitted to the eligibility determination section of the Bureau for Medical Services. All submitted information must be clinically current. The post eligibility packet of information includes the DD-2A, DD-3, DD-4, and DD-5. Documents must be submitted to the Office of Behavior and Alternative Health Care of the WV Bureau for Medical Services.

Current is defined as

- DD-2A (Medical Evaluation) must be current within the past six months. Any Medical Evaluation dated in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date.
- DD-3 (Psychological Report) must have been completed within 90 days of the placement date. Any date of a psychological report in excess of 90 days upon recipient by the Bureau for Medical Services shall be considered out of date
- DD-4 (Social History) must have been completed within 180 days of the placement date. Any social history in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date,

When current information is received in its entirety an eligibility determination will be made as quickly as possible (maximum of 45 days) and the decision communicated to the recipient and to the provider that submitted the packet.

The initial DD-5 (IPP) must be developed within seven (7) days of intake (initial DD-5), and completed within thirty 30 days after the intake and submitted to the Bureau for Medical Services, Office of Behavioral and Alternative Health. Payment shall be delayed until the receipt of the DD- 5 (IPP).

The provider will assume the financial risk of providing services during the period that eligibility is being considered. In the event an individual is determined not to meet ICF's/MR eligibility there is no mechanism to reimburse the provider.

511.5.4 MEDICAL ELIGIBILITY CRITERIA

BMS through its contracted agent determines the medical eligibility for an applicant in the MR/DD Waiver Program. In order to be eligible to receive MR/DD Waiver Program Services, an applicant must have both a diagnosis of mental retardation or a related condition and also manifest concurrent substantial adaptive deficits.

1. Persons with **related conditions** means individuals who have a severe, chronic disability which is attributable to:

- cerebral palsy or epilepsy: or
- any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and the severe chronic disability
  - the mental retardation or related condition is manifested (both diagnosis and substantial deficits) before a person reaches twenty two (22) years of age and
  - the mental retardation or related condition is likely to continue indefinitely

2. The applicant must have substantial limits in three (3) or more of the following major life areas:
   - self care,
   - receptive and/or expressive language, (communication)
   - learning, (functional academics)
   - mobility,
   - self direction,
   - capacity for independent living, (home living, social skills, employment, health and safety, community use, leisure)
     - Substantial adaptive deficits is defined as scores on standardized measures of adaptive behavior three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or below the seventy fifth (75^{th}) percentile when derived from MR normative populations.
     - The presence of substantial deficits must be supported by the additional documentation submitted for review (e.g. IEP, OT evaluations, narrative descriptions, etc.).

3. The applicant must have a need for an ICF/MR level of care that:
   - is certified by a physician (DD-2A) and,
   - is recommended by the evaluating psychologist (DD-3) and,

- Is identified by a licensed social worker (DD-4)

The applicant requires and would benefit from active treatment. Evaluations of the applicant must demonstrate a need for intensive instruction, services, assistance, and supervision in order to learn new skills and increase independence in activities of daily living.

511.6 OTHER ADMISSION REQUIREMENTS

An initial Inventory for Client and Agency Planning (ICAP) must be administered to a member within ninety (90) days of admission to an ICF/MR.

If a referred member already has an existing, clinically-current ICAP from another facility, the admitting ICF/MR has the option to use the current ICAP or complete one of its own.

The admitting ICF/MR provider must submit ICAP scores to the Bureau for Medical Services.

The rate of payment for the first 90 days will be the lowest of the currently used rates until the ICAP score is received. If the ICAP score results in a higher rate, payments will be adjusted.

511.7 ANNUAL RE-CERTIFICATION OF ELIGIBILITY

All members residing in an ICF/MR must be recertified for continued need. Recertification of the need for continued services must be made every twelve (12) months after certification. The ICF/MR is responsible for obtaining recertification documentation by the physician for each member for whom payment is requested under the Medicaid Program.

The ICF/MR must submit a copy of the current Annual DD-2A that provides the physician's certification of the continued need for ICF/MR level of care. The DD-2A must be current within the past 12 months. The subsequent DD-2A must be completed by the anniversary date of the previous DD-2A and be submitted within 30 days of completion. For example, if the submitted copy of the DD-2A is dated 09/15/03, then a new DD-2A will have to be completed no later than 09/15/04 and submitted by 10/15/04 for annual recertification.

Additional information may be requested as necessary which may include the DD-3, DD-4, DD-5 or other pertinent information .

This procedure is required annually. After review by the Office of Behavior and Alternative Care of the WV Bureau for Medical Services, notification of recertification will be submitted to the ICF/MR provider. The recertification date will be based on the actual date the DD-2A was completed by the physician and will extend for a period not to exceed one calendar year.

The ICF/MR provider will be responsible for maintaining the documentation of recertification in the member's chart.

511.8 ANNUAL SUBMISSION OF THE ICAP

From the admission date forward, an annual re-administration of the ICAP is required. The anniversary date for an annual re-administration of the ICAP will be (1) one year after the first submission of an ICAP. Providers may also administer an ICAP at a significant life change or juncture. The significant change shall not be acute in nature and if the condition will likely ameliorate in fewer than 6 months, then a resubmission of the ICAP would not be appropriate.

Any rate change would become effective the first day of the next calendar month after the administration of the ICAP.

511.9 TRANSFERS OF MEMBERS TO OTHER SITES

Transfers of members to other places are to be for good cause and completed in a time frame that allows the member and the member's family or guardian ample time to prepare for the transfer, unless there is an emergency.

Transfers should only occur when the ICF/MR cannot meet the member's needs, the member no longer requires an active treatment program in an ICF/MR setting, the member/guardian chooses to reside elsewhere, or when a determination is made that another level of service or living situation, either internal or external would be more beneficial.

Transfer between facilities within the same provider agency must be reported to the Bureau for Medical Services, Office of Behavior and Alternative Health Care Policy Units on the ICF/MR Discharge/Transfer Tracking Form (refer to form in Attachment) within 10 working days of the date of discharge/transfer from the facility.

511.10 DISCHARGE REQUIREMENTS FOR THE MEMBER

Upon discharging a member, an ICF/MR must:

- Prepare a final summary of the member's health, nutritional, social, behavioral, and functional status. This summary is to become a part of the member's permanent record.

  The summary can be presented to authorized agencies and persons with the consent of the member, the member's guardian or parent if the member is minor.

- Provide a post-discharge plan of care that will help the member adjust to the new living environment. Information must be sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement.

The Office of Behavior and Alternative Health Care of the WV Bureau for Medical Services must be notified within ten (10) working days of discharge by utilizing the ICF/MR Discharge/Transfer Tracking Form.

511.11 HOW TO OBTAIN INFORMATION: CPT, HCPCS, ICD-9, ETC.

For information on how to obtain information concerning procedure codes and diagnosis codes, please refer to Chapter 100, General Information of the Provider Manual. Additional information on the use of forms required by the ICF/MR program of services are found in the Attachments, as follows:

- DD-1 Identification and Demographic Information Fact Sheet
- DD-2A Medical Evaluation
- DD-3 Psychological Evaluation
- DD-4 Social History
- DD-5 Individual Program Plan

- ICF/MR Admittance/Discharge/Transfer Tracking Form

511.20 MANAGED CARE

West Virginia ICF/MR Program participants are exempt from managed care coverage. All services covered must follow guidelines set forth by Medicaid for reimbursement.

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ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT I
DD-1
IDENTIFICATION AND DEMOGRAPHIC INFORMATION FACT SHEET
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ICF/MR PROGRAM

Identification and Demographic Information Fact Sheet

☞This form is being submitted: ☐ As part of an **full application**

Participants Name_____ Date:_____
First Last Middle Initial

Service Coordination Agency_____ SS#_____

Medicaid #_____ DOB_____ Sex: □Male □Female

Residential Provider_____ Phone_____

Address_____ County DHHR_____

Type of Residence: □NF □SFCH □GH □ISS □Other _____

Date of Residential Placement_____Prior Institutionalization □Yes □No

Name of Last Facility _____

Legal Representative_____

Address _____

Phone_____ Relationship to Participant_____

Monthly Average Income $_____

Financial Resources: □Trust □Medicaid □Medicare □Private Pay Insurance □SSI
□SSDI □SSA □Handicapped Children Services □Other

Service Coordinator_____Phone_____

Regional Advocate_____Phone_____

Representative Payee_____Phone_____

Client Needs Summary for ICF/MR Waiver

____ DD-1 (**Identification and Demographic Information Fact Sheet)**

____ DD2A **(Annual Medical Evaluation)**

____ DD3 **(Comprehensive Psychological Evaluation (Triennial)**

____ DD4 **(Social History)**

____ DD5 **(IPP)**

_____ **ICF/MR ADMITTANCE / DISCHARGE / TRANSFER TRACKING INFORMATION**

CHAPTER 511
ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT II
DD-2A
ANNUAL MEDICAL EVALUATION
PAGE 1 OF 7

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

ANNUAL MEDICAL EVALUATION

County of Residence_____

Participant Name: _____ Birthdate:_____

Name of Behavioral Health Center: _____ Date: _____

Address of BHC: _____ SS#: _____

Location of Physical Exam: _____Medicaid #: _____

* **Illness/Accidents since Last Examination (Give dates and summarize):**

* **Allergies:**

* **CURRENT MEDICATIONS:**

Name of Medication	Date Started	Dosage	Frequency

* **LIST ANY PREVIOUS MEDICATIONS THAT COULD MOCK SYMPTOMS OR MIMIC MENTAL ILLNESS:**

Name of Medication	Date Started	Date Stopped	Dosage	Frequency

Participants Name _____Name of Behavioral Health Center _____ Date _____

*** LIST ANY OTHER MEDICATIONS THE PARTICIPANT IS USING OR USES FREQUENTLY (OVER THE COUNTER AND PRESCRIPTION):**

Name of Medication	Reason for Taking

*** NUTRITIONAL STATUS SUMMARY:**

LABORATORY PROCEDURES

TYPE OF TEST	DATE DONE	RESULTS - DATE REC.	TYPE OF TEST	DATE DONE	RESULTS - DATE REC.
URINALYSIS					
CBC					
SYPHILIS SEROLOGY					
HEPATITIS B (UNLESS IMMUNE)					
BLOOD SUGAR (AS INDICATED)					
MEDICATION BLOOD LEVELS (AS INDICATED)					

DENTAL EXAMINATION

DATE:

CONDITION OF MOUTH/GUMS:

CARIES:

DESCRIBE PROPHYLAXIS AND/OR REPAIR WORK COMPLETED:

_____ _____

SIGNATURE DATE

***This page may be mailed separately room the other pages of this medical report**

TEMERATURE:	HEIGHT	WEIGHT	B/P	PULSE	RESPIRATION

CODE: √ =NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL & DESCRIBE

SKIN		
SCALP		
EYES		
NOSE		
THROAT		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMITIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MAN. VAGINAL		
LYMPH		
ENDOCRINE		

N E U R O L O G I C A L		
ALERTNESS		
COHERENCE		
ATTENTION SPAN		
VISION		
HEARING		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		
OTHER		

PROBLEMS REQUIRING SPECIAL CARE (Check appropriate blanks)

MOBILITY:		**CONTINENCE STATUS:**		**FEEDING:**	
Ambulatory	_____	Continent	_____	Feeds Self	_____
Ambulatory w/Human Help	_____	Incontinent	_____	Needs To Be Fed	_____
Ambul. w/Mechanical Help	_____	Not Toilet Trained	_____	Gastric Tube	_____
Wheelchair	_____	Catheter	_____	Special Diet	_____
Wheelchair/Self Propelled	_____	Ileostomy	_____		
Wheelchair w/Assistance	_____	Colostomy	_____		
Lifted Bed To Chair	_____				
Bedfast	_____				

PERSONAL HYGIENE:		**MENTAL AND BEHAVIORAL DIFFICULTIES:**		**OTHER:**
Self-Care	_____	Alert	_____	Unable to Communicate
			_____	
Independent	_____	Confused/Disoriented	_____	
Needs Assistance	_____	Irrational Behavior	_____	
Needs Total Care	_____	Needs Close Supervision	_____	

ADDITIONAL RECOMMENDATIONS:

SPEECH THERAPY	____	PHYSICAL THERAPY	____	OCCUPATIONAL THERAPY	____
TRACHEOSTOMY	____	OXYGEN THERAPY	____	IV FLUIDS	____
DIAGNOSTIC SERVICES	____	SOAKS, DRESSINGS,			
TRACTION, CASTS	____	OTHER:			

---------- Please Complete All Sections Below To Ensure Certification For The Program ----------

DIAGNOSTIC SECTION:

MENTAL: (List All Cognitive, Developmental, Behavioral, Emotional and/or Psychiatric Conditions)

PHYSICAL: (List Chronic and Handicapping Conditions As Well As Current, Acute and/or Communicable Conditions)

PROGNOSIS:

I certify that this Patient's Developmental Disability, Medical Condition and Related Health Needs Are As Documented Above and Patient Requires the Level of Care and Services Provided in an *Intermediate Care Facility for Individuals with Mental Retardation and/or Related Conditions ***Yes*** _____ ***No***_____

(Note: ICF/MR level of care means the individual needs a high level of habilitation training and supervision. This level of care does not have to occur in an institution and can be provided in a community setting.)

_____ _____ _____

Date **Physician's Signature Required** **License #**

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for ICF/MR Level of Care _____ Yes _____ No

Approved for Community Support Services _____ Yes _____ No

Name of Reviewer: _____ Date_____

DD – 2A ICF/MR

CHAPTER 511
ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT III
DD-3
COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)
PAGE 1 OF 6

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)

NAME:_____EVALUATION DATE:____/____/___

BIRTHDATE: ___/____/____AGENCY/FACILITY: _____

REASON FOR EVALUATION:_____

I. RELEVANT HISTORY:

A. Prior Hospitalization/Institutionalization

B. Prior Psychological Testing

C. Behavioral History

II. CURRENT STATUS:

A. Physical/Sensory Deficits

B. Medications (Type, frequency and dosage)

C. Current Behaviors

1. Psychomotor

2. Self-help

3. Language

4. Affective

5. Mental Status

6. Others (Social interaction, use of time, leisure activities)

III. CURRENT EVALUATION

A. Intellectual/Cognitive:

1. Instruments used:

2. Results:

3. Discussion:

B. Adaptive Behavior:

1. Instruments used: ABS I & II Others (list)

2. Results:

3. Discussion:

C. Other:

1. Instruments used:

2. Results:

3. Discussion:

D.. Indicate the individual's level of acquisition of these skills commonly associated with need for active treatment.

1.	Able to take care of most personal care needs.	yes ☐ no ☐
2.	Able to understand simple commands.	yes ☐ no ☐
3.	Able to communicate basic needs and wants.	yes ☐ no ☐
4.	Able to be employed at a productive wage level without systematic long term supervision or support.	yes ☐ no ☐
5.	Able to learn new skills without aggressive and consistent training.	yes ☐ no ☐
6.	Able to apply skills learned in a training situation to other environments or settings without aggressive and consistent training.	yes ☐ no ☐
7.	Able to demonstrate behavior appropriate to the time, situation or place without direct supervision.	yes ☐ no ☐
8.	Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety.	yes ☐ no ☐
9.	Able to make decisions requiring informed consent without extreme difficulty.	yes ☐ no ☐
10.	Identify other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person to learn functional skills._____	

E. Developmental Findings/Conclusions

IV. <u>RECOMMENDATIONS:</u>

A. Training

B. Activities

C. Therapy/Counseling/Behavioral Intervention

.

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

_____	_____
Signature of Supervised Psychologist	Signature of Licensed Psychologist
_____	_____
Title	License #/Title
_____	_____
Date	Date

DD-3 – ICF/MR

CHAPTER 511
ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT IV
DD-4
SOCIAL HISTORY
PAGE 1 OF 4

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SOCIAL HISTORY

PARTICIPANT NAME:_____ DATE:_____

I. DEVELOPMENTAL HISTORY: Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman Numeral and Letter.

a) Physical

b) Social

c) Emotional

II. FAMILY: List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. EDUCATION/TRAINING: Describe education and training experiences, identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. FUNCTIONAL STATUS: Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now, or ever been gainfully employed? Indicate level of care recommendation.

V. RECREATION/LEISURE ACTIVITIES: Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.

VI. HOSPITALIZATIONS: List medical and psychiatric hospital dates and reason for admissions.

_____MR/DD_____Heart Disease_____Cerebral Palsy

_____Autism_____Diabetes_____Tuberculosis

_____Hepatitis_____Mental Illness_____Kidney Disease

_____Cancer_____Hypertension_____Metabolic Disease

_____Allergies_____Thyroid Disease_____Muscular Dystrophy

_____Epilepsy_____Other_____Other

Deceased Siblings (Cause of Death) _____

VIII. LEGAL STATUS: (Guardianship, committee, custody).

DD-4 New - July, 1985

Revised June 2001

IX. OTHER RELEVANT INFORMATION: (Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

DATE	DATE
SIGNATURE OF TEMPORARY LSW	SIGNATURE/CO-SIGN OF DEGREED/LSW
LICENSE #/DEGREE	LICENSE #/DEGREE

DD-4 New - July, 1985

Revised June 2001

CHAPTER 511
ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT V
DD-5
INDIVIDUAL PROGRAM PLAN
PAGE 1 OF 15

C O N F I D E N T I A L

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INDIVIDUAL PROGRAM PLAN

_____ _____ ___/___/

PARTICIPANT AGENCY/FACILITY DATE

I. Evaluations and Assessments Performed: List the Dates Assessments Completed

Medical/ Nursing	Initial Medical Examination ____/____/____ Dental Exam ____/____/ Neurological Exam ____/____/____ Nutrition ____/____/____ Motor ____/____/ Speech ____/____/____ Nursing ____/____/____ Hearing ____/____/ Vision ____/____/____ Language ____/____/____ Other
Psychological	ABS ____/____/____ WAIS ____/____/____ CIIS ____/____/ WISC-R ____/____/____ Other _____ ____/____/
Habilitative/ Social	Social History ____/____/____ Training/Education ____/____/ Recreation/Leisure ____/____/____ Other _____ ____/____/ Habilitation - WVATTS ____/____/____ Brigance ____/____/ L.A.P. ____/____/

II Evaluation and Assessment Summary: (List Strengths/Needs in all Areas)

A. Medical/Health:	
Strengths	Needs

DD-5

New - July, 1985

Current - September,1993

C O N F I D E N T I A L

NAME _____ DATE ____/____/

II. (cont'd)

B. Psychological Strengths	Needs
C. Social Strengths	Needs

B. Psychological Strengths	Needs

C O N F I D E N T I A L

NAME _____ DATE ____/____/

II. (cont'd)

D. Habilitation Strengths	Needs
C. Other Strengths	Needs

D. Habilitation Strengths	Needs

F. Projected Date of Community Placement: _____/_____/

DD-5

C O N F I D E N T I A L

DATE ___/_____/

NAME _____

of _____ Page

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

DD-5

C O N F I D E N T I A L

DATE ____/____/

NAME _____ ____ of

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

REEVALUATION DATE _____ □ 3 MOS. □ 6 MOS. □ 9 MOS. □ 12 MOS.

_____ ____/____/____ _____ ____/____/____

PARTICIPANT DATE SERVICECOORDINATOR DATE

_____ ____/____/____ _____ ____/____/____

PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR DATE

DD-5

C O N F I D E N T I A L

DATE ___/___/

NAME _____

of

IV. Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

DD-5

C O N F I D E N T I A L

DATE ____/____/

NAME _____

of

IV Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

REEVALUATION DATE _____ 90 DAYS_____ 180 DAYS_____ ANNUAL

_____ ____/____/____ _____ ____/____/____

PARTICIPANT DATE SERVICE COORDINATOR DATE

_____ ____/____/____ _____ ____/____/____

PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR SUPERVISOR DATE

DD-5

CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

V. Signatures:

Participant's Printed Name/Role	**Signature**	**Agency**	**Agree**	**Disagree ***	**Time Spent**
Individual					
Parent/Legal Rep.					
Service Coordinator					
Physician/RN					
Psychologist					
Social Worker					
Advocate					
Day Program Supervisor					
QMRP					

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

V. Signatures:

Participant's Printed Name/Role	Signature	Agency	Agree	Disagree*	Time Spent

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

VI. RATIONALE FOR DISAGREEMENT WITH IPP:

CHAPTER 511
ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT VI
DD-7
ICF/MR ADMITTANCE/DISCHARGE/TRANSFER
TRACKING INFORMATION
PAGE 1 OF 2

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

OFFICE OF BEHAVIORAL AND ALTERNATIVE HEALTH CARE

ICF/MR ADMITTANCE / DISCHARGE / TRANSFER TRACKING INFORMATION

MEMBER'S NAME_____ D.O.B._____

MEDICAID NUMBER _____SSN_____

CURRENT ADDRESS_____

_____COUNTY_____

CASE MANAGER _____ _____

DATE OF ADMITTANCE / DISCHARGE / TRANSFER **(please circle)** _____

NEW ADDRESS _____

_____COUNTY_____

NEW PROVIDER AGENCY _____

TELEPHONE NUMBER _____

NEW CASE MANAGER _____

REASON FOR TRANSFER / DISCHARGE _____

Signature of Person Completing Form Title

Printed Name Printed Title

Date Completed: _____

INSTRUCTIONS FOR DISCHARGE/TRANSDER: THIS FORM IS TO BE COMPLETED BY THE PROVIDER WHICH DISCARGES OR TRANSFERS THE INDIVIDUAL. IT MUST BE SUBMITTED TO THE BUREAU FOR MEDIAL SERIVCES, POLICY UNITS, 350 CAPITOL STREET – ROOM 251, CHARLESTON, WEST VIRGINIA 25301-3707, PHONE NUMBER 304-558-1708. FAX NUMBER 304-558 -4398 WITHIN 7 DAYS OF DISCHARGE/TRANSFER

B&AHC-ICF/MR -07

REVISED JANUARY 2002

CHAPTER 512–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRAUMATIC BRAIN INJURY (TBI) WAIVER SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 512.8.1.2(B)(3)	Initial Medical Evaluation	February 1, 2013	February 1, 2013
Section 512.8(F)	Member Eligibility	February 1, 2013	February 1, 2013
Section 512.3.8	Criminal Investigation Background Check and Restrictions and Medicaid Exclusion List	February 1, 2013	February 1, 2013
Section 512.2	Program Description	February 1, 2013	February 1, 2013
Entire Chapter	Entire Chapter	XXXX	February 1, 2012

Old Policy

512.2 PROGRAM DESCRIPTION

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

The TBI Waiver Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program. Members must be at least 22 years of age and be inpatient in a licensed nursing facility, inpatient hospital, or in a licensed rehabilitation facility to treat TBI at the time of application. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with APS Healthcare to implement the administrative functions of the Program.

TBI Waiver services, eligible for reimbursement by Medicaid, are to be provided exclusively to the member, for necessary activities as listed in the Service Plan. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the TBI Waiver Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.

TBI Waiver services include Case Management, Personal Attendant Services, Cognitive Rehabilitation Therapy, and Participant-Directed Goods and Services.

TBI Waiver members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency or an independent professional qualified to provide Cognitive Rehabilitation Therapy. In Personal Options, members are able to hire, supervise and terminate their own employees.

New Policy

512.2 PROGRAM DESCRIPTION

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

The TBI Waiver Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program. Members must be at least 22 years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with APS Healthcare to implement the administrative functions of the program.

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Old Policy

512.3.8 Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check, which includes fingerprints, must be conducted by the West Virginia State Police initially and again every three years for all TBI Waiver provider staff with direct access to members including direct-care personnel (agency and Personal Options), Case Managers, and Cognitive Rehabilitation Therapists. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted.

Prior to providing TBI Waiver services, required fingerprint-based checks must be initiated. TBI Waiver providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider agency cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

If aware of a recent conviction or change in status, appropriate action must be taken by the agency (or PPL for Personal Options direct-care workers) and BMS notified about the change.

The OIG Exclusion List must be checked for every agency employee and Personal Options direct-care worker who provides Medicaid services prior to employment and monthly thereafter.

Persons on the OIG Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All payments for services provided by excluded providers or employees will be recovered by BMS.

New Policy

512.3.8 Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check, which includes fingerprints, must be conducted by the West Virginia State Police initially and again every three years for all TBI Waiver provider staff providing direct care services to members including direct-care personnel (agency and Personal Options), Case Managers, and Cognitive Rehabilitation Therapists. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted.

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A. Abduction
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F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed TBI Waiver provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing TBI Waiver services, the TBI Waiver provider (or PPL for Personal Options direct-care workers) must take appropriate action, including notification to BMS TBI Program Manager.

The OIG Exclusion List must be checked for every agency employee and Personal Options direct-care worker who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All payments for services provided by excluded providers or employees will be recovered by BMS.

Old Policy

512.8 MEMBER ELIGIBILITY

Applicants for the TBI Waiver Program must meet all of the following criteria to be eligible for the program:

A. Be 22 years of age or older.
B. Be a permanent resident of West Virginia.
C. Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.
D. Be approved as medically eligible for nursing facility level of care.
E. Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
F. Be inpatient in a licensed nursing facility, inpatient hospital, or in a licensed rehabilitation facility to treat TBI at the time of application.
G. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
H. Choose to participate in the TBI Waiver Program as an alternative to nursing facility care.

If an individual meets eligibility requirements, a slot must be available for him/her to participate in the program. If no slots are available, applicants determined medically eligible for the Program will be placed on the Managed Enrollment List. As slots become available, applicants on the Managed Enrollment List will be notified and provided detailed instructions on continuing the application process.

New Policy

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C. Have a traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.
D. Be approved as medically eligible for nursing facility level of care.
E. Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
F. Be inpatient in a licensed nursing facility, inpatient hospital, or in a licensed rehabilitation facility to treat TBI or living in a community setting at the time of application.
G. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
H. Choose to participate in the TBI Waiver Program as an alternative to nursing facility care.

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Old Policy

512.8.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

A. An applicant shall initially apply for the TBI Waiver by having his/her treating physician (M.D. or D.O.) or specially trained neuropsychologist submit a Medical Necessity Evaluation Request form to APS Healthcare. The physician's/neuropsychologist's signature is valid for sixty (60) days. The referral source for the request may be from the applicant/applicant's representative, hospital or nursing facility, DHHR, the physician, social services agencies, or others.

B. The Medical Eligibility Evaluation Request form asks that the physician/neuropsychologist submit the applicant's identifying information including, but not limited to, the following:

    1. A statement that the individual's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment;
    2. A description of the functional deficits directly attributable to the TBI,
    3. The applicant is currently inpatient in a licensed nursing facility, inpatient hospital, or licensed rehabilitation facility for TBI, and;
    4. other pertinent medical diagnoses.

C. Once a referral is received, APS Healthcare will send a letter of verification of its receipt to the applicant and/or their legal representative and the referring physician or neuropsychologist. If the Medical Eligibility Evaluation Request form is incomplete it will

be returned to the referring physician or neuropsychologist for completion and resubmission, and the applicant will be notified. APS Healthcare will attempt to contact the applicant and/or their legal representative to schedule an assessment. APS Healthcare will make up to three attempts to contact the applicant. If it is determined that the applicant is not available, the referring physician or neuropsychologist and applicant and/or their legal representative will be notified that no contact could be made. If the referral is closed because of an inability to contact the applicant, a new referral will be required to re-initiate the process.

D. If contact is made, a letter will be sent to the applicant and contact person noting the contact was made and the date of the scheduled evaluation. If the applicant has identified a guardian or legal representative, no assessment shall be scheduled without presence of the guardian, legal representative or contact person. If the Medical Eligibility Evaluation Request form indicates that the applicant has severe dementia, no visit will be scheduled without the guardian, legal representative or contact person present to assist the applicant during the evaluation.

E. APS Healthcare completes the Pre-Admission Screening (PAS) and the Ranchos Los Amigos Scale. APS Healthcare staff will record observations and findings regarding the applicant's level of function. In those cases where there is a medical diagnosis question, APS Healthcare will attempt to clarify the information with the referring physician. In the event that APS Healthcare cannot obtain the information, it will be documented, and noted that supporting documentation from the referring physician was not received.

F. If it is determined that the applicant does not meet medical eligibility, the applicant, the referring physician or neuropsychologist, and applicant's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the "Potential Denial" letter. The applicant will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

G. If the review of the supplemental information by APS Healthcare determines that there is still no medical eligibility, the applicant and/or their legal representative (if applicable), and the referring physician or neuropsychologist will be notified by a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision.

H. If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, the date of eligibility can be no earlier than the effective date of the hearing decision.

I. If the applicant is determined medically eligible and a TBI Waiver slot is available, a notice of approved medical eligibility is sent to the applicant, the referring physician or neuropsychologist, and the applicant's legal representative, if applicable. Copies of the applicant's PAS and Rancho Los Amigos Scale are also sent at this time to the applicant and/or their legal representative (if applicable).

J. If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant and/or their legal representative (if applicable) and the referring entity informing them that a slot is not currently available. The applicant will be notified that they have been placed on the Managed Enrollment List.

K. When a TBI Waiver slot is available, APS Healthcare sends a Service Delivery Model Selection form advising the applicant to choose either Traditional or Personal Options. If the member chooses the Traditional Model, a Freedom of Choice Case Management Selection Form and a Freedom of Choice Personal Attendant Selection Form are also provided to the applicant and/or their legal representative (if applicable), advising him/her to choose a Case Management Agency and a Personal Attendant Service Agency. The forms are to be returned to APS Healthcare once selections are made.

L. APS Healthcare will notify both of the agencies selected, and provide them with a copy of the applicant's PAS and Ranchos Los Amigos Scale. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Section* **512.8.2**), Member Enrollment (Refer to Section 512.9) and the required seven day contact (Refer to *Section 512.10* **MEMBER ASSESSMENT**). If Personal Options has been selected APS Healthcare will notify PPL and provide them with a copy of the PAS and Ranchos Los Amigos Scale.

New Policy

512.8.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

A. An applicant shall initially apply for the TBI Waiver by having his/her treating physician(M.D. or D.O.) or specially trained neuropsychologist submit a Medical Necessity Evaluation Request form to APS Healthcare. The physician's/neuropsychologist's signature is valid for sixty (60) days. The referral source for the request may be from the applicant/applicant's representative, hospital or nursing facility, DHHR, the physician, social services agencies, or others.

B. The Medical Eligibility Evaluation Request form asks that the physician/neuropsychologist submit the applicant's identifying information including, but not limited to, the following:

1. A statement that the individual's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment;
2. A description of the functional deficits directly attributable to the TBI,
3. If the applicant is currently inpatient in a licensed nursing facility, inpatient hospital, or licensed rehabilitation facility for TBI,(does not apply if living in the community), and;
4. other pertinent medical diagnoses.

C. Once a referral is received, APS Healthcare will send a letter of verification of its receipt to the applicant and/or their legal representative and the referring physician or neuropsychologist. If the Medical Eligibility Evaluation Request form is incomplete it will be returned to the referring physician or neuropsychologist for completion and resubmission, and the applicant will be notified. APS Healthcare will attempt to contact the applicant and/or their legal representative to schedule an assessment. APS Healthcare will make up to three attempts to contact the applicant. If it is determined that the applicant is not available, the referring physician or neuropsychologist and applicant and/or their legal representative will be notified that no contact could be made. If the referral is closed because of an inability to contact the applicant, a new referral will be required to re-initiate the process.

D. If contact is made, a letter will be sent to the applicant and contact person noting the contact was made and the date of the scheduled evaluation. If the applicant has identified a guardian or legal representative, no assessment shall be scheduled without presence of the guardian, legal representative or contact person. If the Medical Eligibility Evaluation Request form indicated that the applicant has severe dementia, no visit will be scheduled without the guardian, legal representative or contact person present to assist the applicant during the evaluation.

E. APS Healthcare completes the Pre-Admission Screening (PAS) and the Ranchos Los Amigos Scale. APS Healthcare staff will record observations and findings regarding the applicant's level of function. In those cases where there is a medical diagnosis question, APS Healthcare will attempt to clarify the information with the referring physician. In the event that APS Healthcare cannot obtain the information, it will be documented, and noted that the supporting documentation from the referring physician was not received.

F. If it is determined that the applicant does not meet medical eligibility, the applicant, the referring physician or neuropsychologist, and applicant's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the "Potential Denial" letter. The applicant will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

G. If the review of the supplemental information by APS Healthcare determines that there is still no medical eligibility, the applicant and/or their legal representative (if applicable),

and the referring physician or neuropsychologist will be notified by a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision.

H. If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, the date of eligibility can be no earlier than the effective date of the hearing decision.

I. If the applicant is determined medically eligible and a TBI Waiver slot is available, a notice of approved medical eligibility is sent to the applicant, the referring physician or neuropsychologist, and the applicant's legal representative, if applicable. Copies of the applicant's PAS and Rancho Los Amigos Scale are also sent at this time to the applicant and/or their legal representative (if applicable).

J. If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant and/or their legal representative(if applicable) and the referring entity informing them that a slot is not currently available. The applicant will be notified that they have been placed on the Managed Enrollment List.

K. When a TBI Waiver slot is available, APS Healthcare sends a Service Delivery Model Selection Form advising the applicant to choose either Traditional or Personal Options. If the member chooses the Traditional Model, a Freedom of Choice Case Management Selection Form and a Freedom of Choice Personal Attendant Selection Form are also provided to the applicant and/or their legal representative if applicable), advising him/her to choose a Case Management Agency and a Personal Attendant Service Agency. The forms are to be returned to APS Healthcare once selections are made.

L. APS Healthcare will notify both of the agencies selected, and provide them with a copy of the applicant's PAS and Ranchos Los Amigos Scale. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Section* **512.8.2**), Member Enrollment (Refer to Section 512.9) and the required seven day contact (Refer to *Section 512.10* **MEMBER ASSESSMENT**). If Personal Options has been selected APS Healthcare will notify PPL and provide them with a copy of the PAS and Ranchos Los Amigos Scale.

CHAPTER 512–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRAUMATIC BRAIN INJURY (TBI) WAIVER SERVICES

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CHAPTER 512–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRAUMATIC BRAIN INJURY WAIVER SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for the Traumatic Brain Injury (TBI) Waiver Program provided to eligible West Virginia Medicaid members. Requirements and details for other West Virginia Medicaid covered services can be found in other chapters of the provider manual.

All forms for this program can be found at http://www.dhhr.wv.gov/bms

512.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Acronyms and Definitions*, of the Provider Manual. In addition, the following definitions apply to the TBI Waiver Program described in this chapter.

Abuse: the infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Activities of Daily Living (ADL): activities that a person ordinarily performs during the ordinary course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

Administrative Services Organization (ASO): the contract vendor, currently APS Healthcare, responsible for day-to-day operations and oversight of the TBI Waiver Program including conducting the medical evaluations and determining medical eligibility for applicants and members of the program

Community Integration: the opportunity to live in the community, and participate in a meaningful way to obtain valued social roles as other citizens without disabilities.

Competency Based Curriculum: a training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum must have goals, objectives and an evaluation system to demonstrate competency in training areas.

Emergency Plan: a written plan which details who is responsible for specific activities in the event of an emergency, whether it is a natural or man-made incident.

Environmental Maintenance: activities such as light housecleaning, making and changing the member's bed, dishwashing, and member's laundry.

Felony: a serious criminal offense punishable by imprisonment in a penitentiary for a period of at least one year.

Financial Exploitation: illegal or improper use of an elder's or incapacitated adult's resources. Examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other legal document.

Fiscal Agent: the contract vendor, currently Molina Medicaid Solutions, responsible for claims processing and provider relations/enrollment.

Fiscal Employer/ Agent (FE/A): the contract agent, currently Public Partnerships, LLC (PPL), under Personal Options, which receives, disburses, and tracks funds based on participants' approved service plans and budgets; assists participants with completing participant enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies workers' information (i.e., social security numbers, citizenship or legal alien verification documentation). The FE/A also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes; processes and pays vendor invoices for approved goods and services, as applicable; generates reports for state program agencies, and participants; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

Home and Community Based Services (HCBS): services which enable individuals to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

Informal Supports (Informals): Family, friends, neighbors or anyone who provides support and assistance to a member but is not reimbursed.

Instrumental Activities of Daily Living (IADL): skills necessary to live independently, such as abilities used to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

Legal Representative: a personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Misdemeanor: a less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail for less than a year

Neglect: "Failure to provide the necessities of life to an incapacitated adult" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult"(See WV Code §9-6-1). Neglect would include inadequate medical care by the service provider or inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Participant-Direction: the member, or his/her representative, has decision-making authority over certain services and takes direct responsibility to manage their services with the assistance of a system of available supports. Participant-Direction promotes personal choice and control over the delivery of services, including who provides the services and how services are provided.

Person-Centered Planning: a process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available.

Quality Management Plan: a written document which defines the acceptable level of quality, for a waiver agency and describes how plan implementation will ensure this level of quality through documented deliverables and work processes.

Remediation: act of correcting an error or a fault.

Representative Sample: a small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Resource Consultant: an employee of PPL who assists members who choose Personal Options with the responsibilities of self-direction, such as developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; developing and maintaining a directory of eligible employees; providing information and resources to help purchase goods and services; connecting with a network of peer supports; helping to complete required paperwork for Personal Options; and helping the member select a representative to assist them, as needed.

Scope of Services: the range of services deemed appropriate and necessary for an individual member. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

Sexual Abuse: any of the following acts toward an incapacitated adult in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

1) Sexual intercourse/intrusion/contact; and
2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

512.2 PROGRAM DESCRIPTION

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

The TBI Waiver Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program. Members must be at least 22 years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in a total or partial functional disability and/or psychosocial impairment. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with APS Healthcare to implement the administrative functions of the Program.

TBI Waiver services, eligible for reimbursement by Medicaid, are to be provided exclusively to the member, for necessary activities as listed in the Service Plan. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the TBI Waiver Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.

TBI Waiver services include Case Management, Personal Attendant Services, Cognitive Rehabilitation Therapy, and Participant-Directed Goods and Services.

TBI Waiver members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency or an independent professional qualified to provide Cognitive Rehabilitation Therapy. In Personal Options, members are able to hire, supervise, and terminate their own employees.

512.3 PROVIDER AGENCY CERTIFICATION

TBI Waiver provider agencies must be certified by APS Healthcare. A Certification Application must be completed and submitted to:

APS Healthcare, Inc.
100 Capitol Street, Suite 600
Charleston, WV 25301

An agency may provide Case Management, Personal Attendant Services and/or Cognitive Rehabilitation Therapy provided they maintain:

A. A separate certification and WV Medicaid provider number for each service;
B. Separate staffing; and,
C. Separate member files for Case Management, Personal Attendant and Cognitive Rehabilitation Therapy Services.

Conflicts of interest and self-referral are prohibited.

Certified TBI Waiver Case Management and Personal Attendant Service provider agencies must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
C. A competency based curriculum for required training areas for Personal Attendant direct care staff.
D. An organizational chart
E. A list of the Board of Directors (if applicable)
F. A list of all agency staff, which includes their qualifications.
G. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid Services' (CMS) quality framework and assurances.
(Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf).
H. A physical office that meets ADA standards.
I. Written policies and procedures for processing member grievances.
J. Written policies and procedures for processing member and staff complaints.
K. Written policies and procedures for member transfers.
L. Written policies and procedures for the discontinuation of member services.
M. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Attendant Services).
N. Office space that allows for member confidentiality.
O. An Agency Emergency Plan (for members and office operations).
P. Policy for maintaining 24 hour contact availability. (Personal Attendant Agencies Only)

Provider agencies will be reviewed by APS Healthcare within six months of initial agency certification, and annually thereafter. (Refer to *Section 512.3.2* **Initial/Continuing Certification of Provider Agencies**).

Agencies wishing to provide Cognitive Rehabilitation Therapy services to TBI Waiver members must maintain a current behavioral health provider license by the Office of Health Facilities and Certification (OHFLAC).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

512.3.1 Office Criteria

TBI Waiver Case Management and Personal Attendant Service provider agencies must designate and staff at least one physical office within West Virginia. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. An agency office site can serve no more than eight contiguous counties in WV as designated in the application. (TBI Waiver providers wishing to make changes in the approved counties they serve **must** make the request in writing to APS Healthcare. APS Healthcare will make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by APS Healthcare).
B. Meet ADA requirements for physical accessibility. (Refer to 28 CFR 36, as amended)
C. Be readily identifiable to the public.
D. Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)
E. Maintain an agency secure (HIPAA compliant) e-mail address for communication with BMS and APS Healthcare.
F. Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
G. Contain space for securely maintaining member and personnel records. (Refer to *Common Chapter 800*, *General Administration*, and *Common Chapter 300*, *Provider Participation Requirements*, for more information on maintenance of records).
H. Maintain a 24-hour contact method (Personal Attendant Agencies only).

512.3.2 Initial/Continuing Certification of Provider Agencies

Following the receipt of a completed Certification Application, APS Healthcare will conduct an onsite review, if required, to verify that the applicant meets certification requirements. This requirement may be waived if the prospective provider is a current Licensed Behavioral Health Center or is enrolled as an Aged and Disabled Waiver, Personal Care, or Intellectual/Developmental Disabilities (I/DD) Waiver provider at the time of application. APS Healthcare will notify Molina, BMS' fiscal agent, upon satisfactory completion of the onsite review or verification of LBHC, Aged and Disabled Waiver, Personal Care or I/DD waiver status.

Molina will provide the applicant with an enrollment packet which includes the TBI Provider Agreement. Once this process has been completed, Molina will assign a provider number. A letter informing the agency that it may begin providing and billing for TBI Waiver services will be sent to the agency and to APS Healthcare.

Persons employed by Medicaid members choosing Personal Options enter into a simplified provider agreement facilitated and signed by Public Partnerships, LLC (PPL) which acts as BMS' Fiscal Employer/Agent.

When a Case Management or Personal Attendant Service provider agency is physically going to move to a new location or open a satellite office, they must notify APS Healthcare **prior** to the move. APS Healthcare will schedule an on-site review of the new location to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified by APS Healthcare.

Once certified and enrolled as a Medicaid provider, TBI Waiver Case Management and Personal Attendant Service provider agencies must continue to meet the requirements listed in this chapter as well as the following:

A. Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the TBI Waiver Program.
B. Provide services based on each member's individual assessed needs, including evenings and weekends.
C. Maintain records that fully document and support the services provided.
D. Furnish information to BMS, or its designee, as requested. (Refer to *Common Chapter 800, General Administration*, and *Common Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
E. Maintain a current list of members receiving TBI Waiver services.

Licensed Behavioral Health Centers providing Cognitive Rehabilitation Therapy must maintain a current licensure with OHFLAC.

512.3.3 Record Requirements

TBI Waiver providers must meet the following record requirements:

Member records:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original documentation for services provided to the member by the provider responsible for development of the document (for example the Case Management Agency should have the original Service Plan, the complete Member Assessment, Contact Notes, Member Enrollment Confirmation, etc.)
C. Original documentation on each member must be kept by the Medicaid provider for five years, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

Personnel Records:

A. Original or legible copies of personnel documentation including training records, licensure, confidentiality agreements, criminal investigation background checks (CIB) etc. must be maintained on file by the provider.
B. Minimum credentials for professional staff must be verified upon hire and thereafter based upon their individual professional license requirements.
C. All documentation on each staff member must be kept by the provider in the designated office that represents the county where services were provided.
D. Verification that federal and state Exclusion Lists were checked as appropriate for the position.

TBI Waiver providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the Waiver program. Providers must also agree to make themselves, Board Members, their staff, and any and all records pertaining to member services available to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

512.3.4 Provider Certification Reviews

TBI Waiver provider agencies are required to submit designated evidence to APS Healthcare every 12 months to document continuing compliance with all Certification requirements as specified in this Chapter. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not provided within 30 days of expiration of current certification, a Provisional Certification may apply. Provider agencies who receive a Provisional Certification will be required to have an onsite review by APS Healthcare prior to full re-certification. If deficiencies are found by APS Healthcare during document review, the provider must submit a corrective action plan within 30 days of notice of deficiency. If an approved corrective action plan and required documentation is not submitted within the required time frame, BMS may hold provider reimbursement until an approved corrective action plan is in place.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation. Record selection will include a statewide representative sample of member records. The monitoring tools used by APS Healthcare to review member charts will be made available at www.apshealthcare.com The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers must respond to any corrective action within 30 calendar days after receipt of the completed report.

512.3.5 Personal Attendant Service Staff Requirements

Medicaid prohibits the spouse of a TBI Waiver member from providing Waiver services for purposes of reimbursement.

Personal Attendant Service staff and Personal Options direct care staff must be at least 18 years of age and must have completed the following competency based training before providing services to TBI Waiver members:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by an agency nurse, or a certified trainer from the American Heart Association, American Red Cross, or other organizations approved by BMS. First Aid – must be provided by an agency nurse, a certified trainer or an approved internet provider.
B. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
C. Personal Attendant Skills – training focused on assisting individuals with Traumatic Brain Injuries with ADL's – must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
D. Abuse, Neglect and Exploitation - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
E. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
F. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
G. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member with special needs must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
H. Crisis Intervention Training.

Prior to using an internet provider for training purposes TBI Waiver providers must submit the name, web address, and course name(s) to APS Healthcare for review. APS Healthcare will respond in writing whether this internet training meets the training criteria.

Personal Options members may access their PPL Resource Consultant for training materials and assistance.

512.3.5.1 Annual Direct Care Staff Training

CPR, First Aid, OSHA, Abuse, Neglect, Exploitation and HIPAA training must be kept current.

A. CPR is current as defined by the terms of the certifying entity.

B. First Aid, if provided by an agency RN, must be renewed within 12 months or less. If provided by a nationally recognized organization, current is defined by the terms of the certifying agency. Training will be determined current in the month it initially occurred. (Example: if First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.
C. OSHA, Abuse, Neglect and Exploitation, and HIPAA must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)
D. 4 hours of training focusing on enhancing direct care service delivery knowledge and skills for people with traumatic brain injuries must be provided annually. Member specific on-the-job-training may be counted toward this requirement.

512.3.5.2 Training Documentation

Documentation for training conducted by an agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee or for Personal Options, the member and/or their legal representative (if applicable). Training documentation for internet based training must include the employee's name, the name of the internet provider/trainer and either a certificate or other documentation proving successful completion of the training.

512.3.6 Case Manager Qualifications

A Case Manager must be licensed in West Virginia as a Social Worker, Counselor, or Registered Nurse and employed by a TBI Waiver Case Management Agency enrolled with Medicaid. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present (Example - if an employee has been with your agency for three years – documentation of licensure must be present for all three years).

512.3.7 Cognitive Rehabilitation Therapist Qualifications

Cognitive Rehabilitation Therapy (CRT) must be provided by Licensed Behavioral Health Centers (LBHCs) or independent Physicians, Neuropsychologists, Psychologists, Occupational Therapist, Speech Therapists, or Physical Therapists licensed to practice in the State of West Virginia. LBHC staff providing CRT can be licensed professionals from a wide range of disciplines including, but not limited to, counseling, education, medicine, neuropsychology, occupational therapy, physical therapy, psychology, recreation therapy, social work, special education and speech-language pathology. LBHC staff and independent professionals providing CRT to members must be certified or be in the process of attaining necessary credentials and/or experience for certification by the Society for Cognitive Rehabilitation (SCR). Staff in the process of attaining certification will have up to three years to finalize the certification process.

All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information*,), and

references shall be maintained on file by the provider. Provider agencies shall have an internal review process to ensure that employees providing TBI Waiver services meet the minimum qualifications.

512.3.8 Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check (CIB), which includes fingerprints, must be conducted by the West Virginia State Police initially and again every three years for all TBI Waiver provider staff providing direct-care services to members including direct-care personnel (agency and Personal Options), Case Managers, and Cognitive Rehabilitation Therapists. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted.

Prior to providing TBI Waiver services, required fingerprint-based checks must be initiated. TBI Waiver providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing direct-care services by a TBI Waiver provider cannot be considered to provide services if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse, must be considered by the licensed TBI Waiver provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing TBI Waiver services, the TBI Waiver provider (or PPL for Personal Options direct-care workers) must take appropriate action, including notification to the BMS TBI Program Manager.

The OIG Exclusion List must be checked for every agency employee and Personal Options direct-care worker who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All payments for services provided by excluded providers or employees will be recovered by BMS.

512.4 Voluntary Agency Closure

A provider agency may terminate participation in the TBI Waiver Program with 30 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS claims agent and to APS Healthcare. The provider must provide APS Healthcare with a complete list of all current TBI Waiver members that will need to be transferred.

APS Healthcare will provide selection forms to each of the agency's members, along with a cover letter explaining the reason a new selection must be made.

If at all possible, a joint visit with the member will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by APS Healthcare.

The agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible.

Personal Options members must notify PPL within 24 hours when an employee terminates their employment.

512.5 Involuntary Agency Closure

BMS may administratively terminate a provider agency from participation in the TBI Waiver program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the TBI Waiver program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to *Common Chapter 800, General Administration,* for more information on this procedure.

Prior to closure, the provider will be required to provide APS Healthcare with a complete list of all current TBI Waiver members that will need to be transferred. APS Healthcare will provide selection forms to each of the agency's members, along with a cover letter explaining the

reason a new selection must be made. APS HealthCare will ensure that the transfer of all members is accomplished as safely, orderly and expeditiously as possible.

512.6 Additional Sanctions

If BMS or APS Healthcare receives information that clearly indicates a provider is unable to serve new members due to staffing issues, member health and safety risk, etc. or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the Provider Selection Forms and from the provider information on the APS Healthcare website until the issues/concerns are addressed to the satisfaction of BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

512.7 INCIDENT MANAGEMENT

TBI Waiver providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. Incidents shall be classified by the provider as one of the following:

Abuse, Neglect, or Exploitation:

Anyone providing services to a TBI Waiver member who suspects an incidence of abuse or neglect, as defined in Section 512.1 of this Chapter, must report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-352-6513, 7 days a week, 24 hours a day. This initial report must then be followed by a written report, submitted to the local Department of Health and Human Resources, within forty-eight (48) hours following the verbal report. An Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

Critical Incidents:

Critical incidents are incidents with a high likelihood of producing real or potential harm to the health and welfare of the TBI Waiver member. These incidents might include, but are not limited to, the following:

- Attempted suicide, or suicidal threats or gestures.
- Criminal activity that is suspected or observed by members themselves, members' families, health care providers, concerned citizens, or public agencies that does not compromise the health or safety of the member.
- An unusual event such as a fall or injury of unknown origin requiring medical intervention if abuse and neglect is not suspected.
- A significant interruption of a major utility, such as electricity or heat in the member's residence, but does not compromise the health or safety of the member.
- Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that does not compromise the health or safety of the member.

- Fire in the home resulting in relocation or property loss that does not compromise the health or safety of the member.
- Unsafe physical environment in which the Personal Attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- Disruption of the delivery of TBI Waiver services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home that does not compromise the health or safety of the member.
- Medication errors by a member or his/her family caregiver that do not compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that does not compromise the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, but does not compromise the health or safety of the member.
- Any incident attributable to the failure of TBI Waiver provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services (APS).

Simple Incidents:

Simple incidents are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

- Minor injuries of unknown origin with no detectable pattern
- Dietary errors with minimal or no negative outcome

512.7.1 Incident Management Documentation and Investigation Procedures

Any incident involving a TBI Waiver member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section 512.7, all incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services, but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file.

Personal Attendant Service provider agencies must report to WVIMS monthly the number of hospitalizations which occurred during the month. In addition, providers are to report if there were no incidents.

For Personal Options, PPL must report any incidents in the WVIMS within 24 hours of learning of the incident. As noted in Section 512.7, all incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services, but also must be noted in WVIMS. APS Healthcare reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to Adult Protective Services. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider, or APS HealthCare investigating Personal Options related incidents, shall immediately notify Adult Protective Service (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to Adult Protective Service. If requested by Adult Protective Service, a provider shall delay its own investigation and document such request in the online WVIMS.

512.7.2 Incident Management Tracking and Reporting

Provider agencies must review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the agency Quality Management Plan. The Quality Management Plan must be made available to APS Healthcare monitoring staff at the time of the provider monitoring review or upon request.

PPL has a tracking/reporting responsibility defined in their contract with BMS

512.8 MEMBER ELIGIBILITY

Applicants for the TBI Waiver Program must meet all of the following criteria to be eligible for the program:

A. Be 22 years of age or older.
B. Be a permanent resident of West Virginia.
C. Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.
D. Be approved as medically eligible for nursing facility level of care.
E. Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
F. Be inpatient in a licensed nursing facility, an inpatient hospital, a licensed rehabilitation facility to treat TBI, or living in a community setting at the time of application.
G. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
H. Choose to participate in the TBI Waiver Program as an alternative to nursing facility care.

If an individual meets eligibility requirements, a slot must be available for him/her to participate in the program. If no slots are available, applicants determined medically eligible for the Program will be placed on the Managed Enrollment List. As slots become available, applicants on the Managed Enrollment List will be notified and provided detailed instructions on continuing the application process.

512.8.1 Medical Eligibility

APS Healthcare is responsible for evaluating medical eligibility, conducting assessments and determining if medical eligibility requirements for the TBI waiver program are met.

The purpose of the medical eligibility review is to ensure the following:

A. New applicants and existing members are medically eligible based on current and accurate evaluations.
B. The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

512.8.1.1 Medical Eligibility Criteria

An individual must have five deficits as described on the Pre-Admission Screening Form (PAS) to qualify for nursing facility level of care. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, bowel Continence, Bladder	Level 3 or higher; must be incontinent.
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.	
#28	Individual is not capable of administering his/her own medications.	

Applicants must also score at a Level VII or lower on the Ranchos Los Amigos Scale. Information on the Ranchos Scale can be found on the APS HealthCare web site at http://apshealthcare.com/publicprograms/west_virginia/WV_Participating_Providers.htm.

512.8.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

A. An applicant shall initially apply for the TBI Waiver by having his/her treating physician(M.D. or D.O.) or specially trained neuropsychologist submit a Medical Necessity Evaluation Request form to APS Healthcare. The physician's/neuropsychologist's signature is valid for sixty (60) days. The referral source for the request may be from the applicant/applicant's representative, hospital or nursing facility, DHHR, the physician, social services agencies, or others.

B. The Medical Eligibility Evaluation Request form asks that the physician/neuropsychologist submit the applicant's identifying information including, but not limited to, the following:

1. A statement that the individual's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment;
2. A description of the functional deficits directly attributable to the TBI;
3. If the applicant is currently inpatient in a licensed nursing facility, inpatient hospital, or licensed rehabilitation facility for TBI, (does not apply if residing in the community) and;
4. other pertinent medical diagnoses.

C. Once a referral is received, APS Healthcare will send a letter of verification of its receipt to the applicant and/or their legal representative and the referring physician or neuropsychologist. If the Medical Eligibility Evaluation Request form is incomplete it will be returned to the referring physician or neuropsychologist for completion and resubmission, and the applicant will be notified. APS Healthcare will attempt to contact the applicant and/or their legal representative to schedule an assessment. APS Healthcare will make up to three attempts to contact the applicant. If it is determined that the applicant is not available, the referring physician or neuropsychologist and applicant and/or their legal representative will be notified that no contact could be made. If the referral is closed because of an inability to contact the applicant, a new referral will be required to re-initiate the process.

D. If contact is made, a letter will be sent to the applicant and contact person noting the contact was made and the date of the scheduled evaluation. If the applicant has identified a guardian or legal representative, no assessment shall be scheduled without presence of the guardian, legal representative or contact person. If the Medical Eligibility Evaluation Request form indicates that the applicant has severe dementia, no visit will be scheduled without the guardian, legal representative or contact person present to assist the applicant during the evaluation.

E. APS Healthcare completes the Pre-Admission Screening (PAS) and the Ranchos Los Amigos Scale. APS Healthcare staff will record observations and findings regarding the applicant's level of function. In those cases where there is a medical diagnosis question, APS Healthcare will attempt to clarify the information with the referring physician. In the event that APS Healthcare cannot obtain the information, it will be documented, and noted that supporting documentation from the referring physician was not received.

F. If it is determined that the applicant does not meet medical eligibility, the applicant, the referring physician or neuropsychologist, and applicant's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the "Potential Denial" letter. The applicant will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

G. If the review of the supplemental information by APS Healthcare determines that there is still no medical eligibility, the applicant and/or their legal representative (if applicable), and the referring physician or neuropsychologist will be notified by a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision.

H. If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, the date of eligibility can be no earlier than the effective date of the hearing decision.

I. If the applicant is determined medically eligible and a TBI Waiver slot is available, a notice of approved medical eligibility is sent to the applicant, the referring physician or neuropsychologist, and the applicant's legal representative, if applicable. Copies of the applicant's PAS and Rancho Los Amigos Scale are also sent at this time to the applicant and/or their legal representative (if applicable).

J. If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant and/or their legal representative (if applicable) and the referring entity informing them that a slot is not currently available. The applicant will be notified that they have been placed on the Managed Enrollment List.

K. When a TBI Waiver slot is available, APS Healthcare sends a Service Delivery Model Selection Form advising the applicant to choose either Traditional or Personal Options. If the member chooses the Traditional Model, a Freedom of Choice Case Management

Selection Form and a Freedom of Choice Personal Attendant Selection Form are also provided to the applicant and/or their legal representative if applicable), advising him/her to choose a Case Management Agency and a Personal Attendant Service Agency. The forms are to be returned to APS Healthcare once selections are made.

L. APS Healthcare will notify both of the agencies selected, and provide them with a copy of the applicant's PAS and Ranchos Los Amigos Scale. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Section* **512.8.2**), Member Enrollment (Refer to Section 512.9) and the required seven day contact (Refer to *Section 512.10* **MEMBER ASSESSMENT**). If Personal Options has been selected APS Healthcare will notify PPL and provide them with a copy of the PAS and Ranchos Los Amigos Scale.

512.8.1.3 Medical Re-evaluation

Annual re-evaluations for medical eligibility for each TBI Waiver member must be conducted. The process is as follows:

A. APS Healthcare will schedule an annual re-evaluation of the member's medical eligibility screening 12 months after initiation of services.
B. APS Healthcare will visit the member in his/her home or at an agreed location in order to complete the evaluation. C.APS Healthcare will evaluate the findings of the annual functional assessment to determine whether the member continues to meet medical eligibility for the TBI Waiver.
D. If the member has identified a guardian or legal representative, no visit shall be scheduled without presence of the guardian, legal representative or contact person.
E. Once an evaluation time is arranged, APS Healthcare shall send a letter to the member and/or their legal representative (if applicable), Case Management Agency and PPL (if applicable), noting the contact and date of the visit.
F. If APS Healthcare is unable to contact the member, a letter will be sent to the member and/or their legal representative (if applicable), Case Management Agency, and referring physician or neuropsychologist stating that the member's eligibility is in jeopardy if the evaluation cannot be performed and requesting that the member and/or their legal representative or Case Manager contact APS Healthcare to schedule an evaluation.
G. If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member and/or their legal representative (if applicable), the Case Management Agency and PPL (if applicable). This notice includes the approved budget, a notice of resources for free legal services, and a Request for Hearing form.
H. If it is determined that the member does not meet medical eligibility, the member and/or their legal representative (if applicable), the referring physician or neuropsychologist, the Case Manager and PPL (if applicable) will be notified by a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the functional assessment and TBI Waiver policy will also be included with the "Potential Denial" Letter. The member will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

I. If the review of the supplemental information determines that there is still no medical eligibility, the member and/or their legal representative (if applicable) and Case Manager will be notified with a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable policy manual section(s), a copy of the functional assessment, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Hearing to be completed if the member wishes to contest the decision. If the member elects to appeal any adverse decision, services shall continue at the current level only if the appeal is submitted within thirteen (13) days of the receipt of the notice, and only until a final decision is rendered by the administrative Hearing Officer.

The Case Management Agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Attendant provider agency.

Medicaid will not pay for services provided to a medically ineligible member.

512.8.2 Financial Eligibility

The financial eligibility process starts once an applicant is determined to be medically eligible for TBI Waiver services and has returned the Service Delivery Model Selection Form to APS Healthcare. If the applicant selects the Traditional Model they must also return the Freedom of Choice Provider Selection Forms to APS Healthcare.

If the applicant has chosen the Traditional Model, the Case Management Agency that has been selected by the applicant will be notified, and a copy of the PAS and Ranchos Los Amigos Scale will be provided. Within three business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant. The applicant and/or Case Manager must submit a DHS-2 form to the county DHHR office to determine financial eligibility based on TBI Waiver criteria. A copy of the TBI Waiver Medical Eligibility Letter must be attached to the DHS-2 form. Financial eligibility cannot be initiated without this documentation.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant/member's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the TBI Waiver Program. Some assets of a couple are protected for the spouse who does not need nursing facility or home and community based care and these assets are not counted to determine eligibility for the individual who needs care in the home.

The financial eligibility process must be initiated within 60 calendar days from the date the Case Management Agency receives the notification of selection letter. Case Managers must notify APS Healthcare when the financial eligibility process has been initiated. If the financial eligibility process is not initiated within the 60 calendar days, APS Healthcare will close the referral. If the applicant wants TBI Waiver services after the closure, a new Medical Eligibility Evaluation Request Form must be submitted to APS Healthcare. TBI Waiver services cannot be paid until an applicant's financial eligibility is established (or verified) and the enrollment process has been completed with APS Healthcare. (Refer to *Section* **512.9 MEMBER ENROLLMENT**).

If the member has been a member of another waiver program, no services can be reimbursed prior to an applicant's closure from the other waiver program. The only exception is Case Management which may be provided 30 days prior to closure.

Termination of the Medicaid benefit itself (e.g., the medical card) always requires a 13 calendar day advance notice prior to the first of the month Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples: 1) Advance notice for termination is dated January 27, Medicaid would end February 28. 2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when TBI Waiver services end.

512.9 MEMBER ENROLLMENT

Once an applicant has been found medically and financially eligible, the Case Manager must request Member Enrollment from APS Healthcare by completing a Member Enrollment Request Form. APS Healthcare will complete the Member Enrollment and provide a Confirmation Notice to the Case Management Agency and the Personal Attendant Service provider agency. The member's Waiver case will be closed if services are not provided within 180 days of the date of enrollment in the Program.

No Medicaid reimbursed TBI Waiver services can be provided until the Case Management Agency is in receipt of the Member Confirmation Notice.

The Case Management Agency is responsible for maintaining a copy of the Member Enrollment Request Form and the Member Enrollment Confirmation Notice in the member file. The Personal Attendant Service provider agency (and LBHC if providing Cognitive Rehabilitation Therapy) is responsible for maintaining a copy of the Member Enrollment Confirmation Notice in the member file.

512.10 MEMBER ASSESSMENT

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan. A secondary purpose of the assessment is to provide the member a good understanding of the program, services, and expectations. Once Member Enrollment has been completed, the Case Manager will schedule a home visit within (7) seven calendar days to complete the Member Assessment.

The Case Manager must work with all service providers to ensure that the program meets the member's needs.

A new Member Assessment must be completed when a member's needs change. Changes in a member's needs are to be incorporated into the Service Plan. Case Managers are to share any changes in a member's assessment with all service providers listed on the members Service Plan. The Personal Attendant Service provider agency (and LBHC if providing Cognitive Rehabilitation Therapy) is to share any changes observed in the member with the case manager. A copy of all Member Assessments must be provided to the member and/or their legal representative (if applicable).

512.11 SERVICE PLAN DEVELOPMENT

The Case Manager is responsible for development of the person-centered Service Plan in collaboration with the member and/or their legal representative (if applicable). Participation in the development of the Initial Service Plan is mandatory for the member and/or their legal representative if applicable) and Case Manager. The member and/or their legal representative (if applicable) may choose to have whomever else they wish to participate in the process (Personal Attendant Service provider agency staff, other service providers, informal supports, etc.).

The Service Plan meeting must be scheduled within seven (7) calendar days of the Member Assessment.

The Service Plan must detail all services (service type, provider of service, frequency) the member is receiving, including any informal supports that provide assistance (family, friends, etc.) and address all needs identified in the PAS, the Member Assessment, etc. The Service Plan must also address the member's preferences and goals. It is the Case Manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Service Plan.

A copy of all Service Plans must be provided to the member and/or their legal representative if applicable) and the Personal Attendant Service provider agency. The Case Management Agency must have the original document in the member's file.

The member's Service Plan must contain reference to any other service(s) received by the member, regardless of the source of payment. A TBI Waiver provider agency that provides private-pay services to a member must ensure that documentation is maintained separately.

512.11.1 Six-Month and On-Going Service Plan Development

Participation in the six (6) month Service Plan and Annual Service Plan development is mandatory for the member and/or their legal representative if applicable), the Case Manager, and the Personal Attendant Service provider agency. The member and/or their legal representative (if applicable) may choose to have whomever else they wish to participate in the process (Cognitive Rehabilitation Therapist, direct care staff, family members, other service providers, informal supports, etc.).

512.11.2 Interim Service Plan Development

In order to begin services immediately to address any health and safety concerns, an Interim Service Plan may be developed and implemented upon the completion of Member Enrollment. The Interim Service Plan can be in effect up to 21 calendar days from the date of Member Enrollment Confirmation to allow time for assessments to be completed, the Service Plan meeting to be scheduled and the Service Plan to be developed.

If the Case Management Agency develops an Interim Service Plan, the Personal Attendant Service provider agency must initiate direct care services within three (3) business days.

512.12 COVERED SERVICES

The following services are available to TBI Waiver members if they are deemed necessary and appropriate during the development of their Service Plan:

A. Case Management
B. Personal Attendant Services
   i. Direct Care support
   ii. Transportation
C. Cognitive Rehabilitation Therapy
D. Participant-Directed Goods and Services

512.12.1 CASE MANAGEMENT

Case management activities are indirect services that assist the member in obtaining access to needed TBI Waiver services, other State Plan services, as well as medical, social, educational and other services, regardless of the funding source. Case management responsibilities also include the development of the member's Service Plan, the ongoing monitoring of the provision of services included in the member's Service Plan, monitoring member's continuing eligibility, member health and welfare, and advocacy.

Case management includes the coordination of services that are individually planned and arranged for members whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The Case Manager takes an active role in service delivery; although services are not provided directly by the Case Management Agency, the Case Manager serves as an advocate and coordinator of care for the member. This involves collaboration with the TBI Waiver member, family members, friends, informal supports, and health care and social service providers. Case Managers are to:

A. Evaluate social, environmental, service, and support needs of the individual.
B. In collaboration with the member and/or their legal representative (if applicable), develop and write an individualized Service Plan which details all services that are to be provided including both formal and informal (if available) services that will assist the member to achieve optimum function.
C. Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
D. Proactively identify problems and coordinate services that provide appropriate high quality care to meet the individualized and often complex needs of the member.
E. Provide advocacy on behalf of the member to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services.
F. Ensure that a member's wishes and preferences are reflected in the development of the Service Plan by working directly with the member and/or their legal representative if applicable) and all service providers.

G. Inform members and/or their legal representatives (if applicable) of their rights, including information about grievance and Fair Hearing processes.
H. Assure that a member's legal and human rights are protected.

Case Management activities specific to Participant Direction include, but are not limited to:

A. Informing members of the availability of the Participant-Directed option.
B. Explaining general rights, risks, responsibilities and the member's right to choose the Participant-Directed Model.
C. Assist in determining if a legal/non-legal representative is desired and/or needed by the member.
D. Providing or linking members with program materials in a format that they can use and understand.
E. Explaining person-centered planning and philosophy to members.
F. Linking members with PPL for completion of the necessary paper work for Participant-Direction.
G. Explaining to the member the roles and supports that will be available.
H. Reviewing and discussing the member's budget, including the budget available for Participant-Direction.
I. Ensuring that members know how and when to notify the Case Manager about any operational or support concerns or questions.
J. Monitoring the members risk management activities.
K. Ensuring a seamless transition into the Participant-Directed Model if chosen.
L. Coordinating services provided by traditional provider agencies.
M. Notifying APS Healthcare and PPL of concerns regarding potential issues which could lead to member disenrollment.
N. Notifying APS Healthcare of concerns about the status of the health and welfare of participants.
O. Follow-up with the member regarding the submission of critical incidents.

512.12.1.1 Case Management Code, Unit, Limit and Documentation Requirements

Procedure Code: T1016 UB

Service Unit: **15 minutes**

Service Limit: **192 15 minute units annually**

Prior Authorization Required: **Yes**

Documentation Requirements: All contacts with, or on behalf of a member, must be documented within the member's record, including date and time of contact, a description of the contact, and the signature of the Case Manager. At a minimum, the Case Manager must make contact with the member and/or their legal representative if applicable) once per month and document the contact on the Case Management Monthly Contact Form. Case Management Agencies may not bill for transportation services.

All documented evidence of Case Management staff qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file by the provider agency. The agency must have an internal review process to ensure that Case Management staff providing TBI Waiver services meets the minimum qualifications as required by policy (Refer to Section **512.3.6 Case Manager Qualifications**).

512.12.1.2 Ongoing Case Management Services

The Case Manager is responsible for follow-up with the member to ensure that services are being provided as described in the Service Plan. Initial contact, via telephone or face-to-face, must be made within seven (7) calendar days after direct care services have begun by the Personal Attendant Service provider agency. At a minimum, a monthly telephone contact with the member and/or their legal representative (if applicable) and a home visit every six (6) months must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the member. If a member and/or their legal representative (if applicable) cannot be reached by telephone for the monthly contact, a home visit must be made. At a minimum, the Case Manager must complete a six (6) month Member Assessment and Service Plan. This must be a face-to-face home visit with the member.

Specific activities to assure that needs are being met also include:

A. Assure financial eligibility remains current.
B. Assure the health and welfare of the member.
C. Address changing member needs as reported by the member and/or their legal representative (if applicable), Personal Attendant direct care staff, or informal support.
D. Address changing needs determined by the monthly member contact.
E. Refer and procure any additional services the member may need that are not services the Personal Attendant Service provider agency can provide.
F. Coordinate with all current service providers to develop the six (6) month Service Plan and the Annual Service Plan (or more often as necessary). It is mandatory that the member and/or their legal representative (if applicable), the Case Manager and the Personal Attendant Service provider agency be present at the six (6) month Service Plan meeting and the Annual Service Plan meeting.
G. Provide the Service Plan to all applicable service providers that are providing services to the member.
H. Provide copies of all necessary documents to the Personal Attendant Service provider agency such as Member Enrollment, PAS, Assessments, etc.
I. Annually submit a Medical Necessity Evaluation Request to APS Healthcare.

512.12.1.3 Reporting

The Case Management Agency will complete and submit required administrative and program reports as requested by either BMS or APS Healthcare. Monthly reports must be submitted by Case Management Agencies to APS Healthcare by the sixth (6^{th}) business day of every month.

512.12.2 PERSONAL ATTENDANT SERVICES

Personal Attendant Services are defined as long-term direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. The components of the Personal Attendant Service include Personal Attendant Direct Care Services and Transportation.

The functions of the Personal Attendant Service direct care staff include providing direct care services as defined by the member's Service Plan or the Spending Plan for Personal Options members, recording services and time spent with the member, communicating any member changes and completing all TBI Waiver training requirements.

Personal Attendant Service direct care staff duties and responsibilities as described in the Service Plan may include:

A. Assist member with ADLs.
B. Assist member with environmental tasks necessary to maintain the member in the home.
C. Assist member with completion of errands that are essential for the member to remain in the home (IADLs) — Examples: grocery shopping, medical appointments, Laundromat, and trips to the pharmacy. The member may accompany the Personal Attendant Service direct care staff on these errands.
D. Assist member in community activities. Activities provided in the community are limited to 30 hours per month. (Examples of community activities--visiting friends/relatives, going to a local community activity, etc.) Community activities must be documented on the Service Plan or Personal Options Spending Plan.
E. Report significant changes in members' condition to the Personal Attendant Service agency (or PPL if member is enrolled in Personal Options) and member's Case Manager.
F. Report any incidents to the Personal Attendant Service agency (or PPL if member is enrolled in Personal Options) and the member's Case Manager. (Examples: member falls (whether direct care staff was present or not), bruises (whether direct staff knows origin or not), etc.)
G. Report any environmental hazards to the Personal Attendant Service agency (or PPL if member is enrolled in Personal Options) and the member's case Manager. (Examples: no heat, no water, pest infestation or home structural damage).
H. Prompt for self-administration of medications.
I. Maintain records as instructed by the Personal Attendant Service agency (or PPL if member is. enrolled in Personal Options).
J. Perform other duties as assigned by the Personal Attendant Service agency (or member if enrolled in Personal Options) within program guidelines.
K. Accurately complete Personal Attendant Service worksheet and other records as instructed by the Personal Attendant Service agency.

Personal Attendant Service agency staff and employees of Personal Options participants cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's Service Plan or for members enrolled in Personal Options the member's approved Spending Plan. Functions/tasks that cannot be performed include, but are not limited to, the following:

A. Care or change of sterile dressings.
B. Colostomy irrigation.
C. Gastric lavage or gavage.
D. Care of tracheostomy tube.
E. Suctioning.
F. Vaginal irrigation.
G. Give injections, including insulin.
H. Administer any medications, prescribed or over-the-counter.
I. Perform catheterizations, apply external (condom type) catheter.
J. Tube feedings of any kind.
K. Make judgments or give advice on medical or nursing questions.
L. Application of heat.

If at any time a Personal Attendant is witnessed to be, or suspected of, performing any prohibited tasks, the Personal Attendant Service agency or PPL must be notified immediately.

More than one Personal Attendant Service provider agency can provide direct care services to a member. The agency the member selected on their Freedom of Choice Personal Attendant Service Selection Form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. There cannot be a duplication of services.

512.12.2.1 Personal Attendant Service (Direct Care support) Code, Unit, Limit and Documentation Requirements

Procedure Code: S5125 UB

Service Unit: 15 minutes

Service Limits: **Personal Attendant Services are limited by the member's budget.**

Prior Authorization Required: Yes

Documentation Requirements: All services provided to a member must be documented on the Personal Attendant Worksheet and maintained within the member's record.

All documented evidence of Personal Attendant Service direct care staff qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file by the provider agency. The agency must have an internal review process to ensure that Personal Attendant Service direct care staff providing TBI Waiver services meets the minimum qualifications as required by policy (Refer to *Section* **512.3 Personal Attendant Service Staff Requirements**).

In Personal Options, all documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality statements, and references shall be maintained on file by PPL.

512.12.2.2 Transportation

Transportation is a component of the Personal Attendant Service and provides reimbursement for Personal Attendant direct care staff that performs essential errands for or with a member or community activities with a member.

The member may be transported by Personal Attendant Service agency direct-care staff in order to gain access to services and activities as specified in the Service Plan. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. However, if free transportation is not readily available and/or reliable, services must not be delayed and the provider must provide the transportation as specified in the member's Service Plan. Mileage can be charged for essential errands, activities related to the Service Plan and community activities (Refer to *Section* **512.12.2.2Transportation)**.

512.12.2.3 Transportation Code, Unit, Limit and Documentation Requirements

Procedure Code: A0160 UB

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: Yes

Documentation Requirements: All transportation with, or on behalf of, a member must be included on the member's Service Plan and documented by the Personal Attendant Service agency and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).

512.12.3 COGNITIVE REHABILITATION THERAPY

Cognitive Rehabilitation Therapy is therapy utilized for the development of cognitive skills to improve functional attention, memory, and problem solving including compensatory training in a context of direct one-to-one participant contact with the therapist.

512.12.3.1 Cognitive Rehabilitation Therapy Code, Unit, Limit and Documentation Requirements

Procedure Code: 97532 UB

Service Unit: **15 minutes**

Service Limit: **192 15 minute units annually**

Prior Authorization Required: **Yes**

Documentation Requirements: All contacts with, or on behalf of a member, must be documented within the member's record, including date and time of contact, a description of the

contact, and the signature of the Cognitive Rehabilitation Therapist. Cognitive Rehabilitation Therapists may not bill for transportation services.

All documented evidence of Cognitive Rehabilitation Therapists qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file. Provider agencies must have an internal review process to ensure that staff providing TBI Waiver services meets the minimum qualifications as required by policy (Refer to *Section* **512.3.7 Cognitive Rehabilitation Therapist Qualifications**).

512.12.4 PARTICIPANT-DIRECTED GOODS AND SERVICES

Participant-Directed Goods and Services are equipment, services or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the Service Plan. The member must budget for their approved good or service within their allocated budget.

The following are non-allowable services, equipment or supplies: gifts for staff/family/friends, payments to someone to serve as a representative, clothing, food and beverages, electronic entertainment equipment, utility payments, swimming pools and spas, costs associated with travel, comforters, linens, drapes, furniture, vehicle expenses including routine maintenance and repairs, insurance and gas money, medications, vitamins, herbal supplements, monthly internet service, yard work, illegal drugs or alcohol, household cleaning supplies, home maintenance and repair, pet care, respite services, spa services, experimental or prohibited treatments, education, personal hygiene, discretionary cash, and any other good or service that does not address an identified need in the Service Plan, decrease the need for other Medicaid services, and/or increase the person's safety in the home and /or improve and maintain the member's opportunities for full membership in the community.

512.12.4.1 Participant-Directed Goods and Services Code, Unit, Limit and Documentation Requirements

Procedure Code: T2028 UB

Service Unit: As specified on member's Service Plan

Service Limit: $1000 Annually

Prior Authorization Required: **No**

Documentation Requirement: Participant Directed Goods and Services receipts and other approved documentation per the PPL contract with BMS must be maintained on file with PPL. Must be in the member's Spending Plan.

512.13 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, Case Management Agencies must communicate in writing to each member and/or their legal representative (if applicable)

Their right to:

A. Transfer to a different provider agency, from traditional services to Personal Options, or from Personal Options to traditional services.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Freedom from abuse, neglect, and exploitation.
F. Take part in decisions about their services.
G. Confidentiality regarding TBI Waiver services.
H. Access to all of their files maintained by agency providers.

And their responsibility to:

I. Notify the TBI Waiver Personal Attendant Service Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
J. Notify providers or PPL promptly of changes in Medicaid coverage.
K. Comply with their Service Plan and their Personal Options Spending Plan (if applicable).
L. Cooperate with all scheduled in-home visits
M. Notify their Case Management Agency and PPL (if applicable) of a change in residence or an admission to a hospital, nursing facility or other facility.
N. Notify their Case Management Agency and PPL (if applicable) of any change of medical status or direct care need.
O. Maintain a safe home environment.
P. Verify services were provided.
Q. Communicate any problems with services to the provider agency or PPL (if applicable).
R. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
S. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL (if applicable) or the APS hotline at 1-800-352-6513.
T. Report any suspected illegal activity to their local police department or appropriate authority.

512.14 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance. All TBI Waiver provider agencies will have a written member grievance procedure. APS Healthcare will explain the grievance process to all applicants/members at the time of initial application/re-evaluation. Applicants/members and/or their legal representative If applicable) will be provided with a Member Grievance Form at that time. Service providers will only afford members a grievance procedure for services that fall under the particular service provider's authority; for example, a Case Management Agency will not conduct a grievance procedure for Personal Attendant Service Agency activities, nor will a Personal Attendant Service Agency conduct a grievance procedure for Case Management Agency activities.

A member may by-pass the level one grievance and file a level two grievance with APS Healthcare if he/she chooses. The grievance process is not utilized to address decisions regarding medical or financial eligibility, a reduction in services or case closure. These issues must be addressed through the fair hearing process.

The grievance procedure consists of two levels:

A. Level One: TBI Waiver Provider

A TBI Waiver provider has 10 business days from the date they receive a Member Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency director or their designee with the member and/or their legal representative (if applicable). The agency has five days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to APS Healthcare for a Level Two review and decision.

B. Level Two: APS Healthcare

If a TBI Waiver provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, APS Healthcare will, within 10 business days of the receipt of the Member Grievance Form, contact the member and/or their legal representative (if applicable) and the TBI Waiver provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

512.15 TRANSFERS

A TBI Waiver member may request a transfer to another agency at any time. If a member wishes to transfer to a different agency a Member Request to Transfer form must be completed and signed by the member and/or their legal representative (if applicable). The form may be obtained from the current provider, the new provider, APS Healthcare or other interested parties. Once completed and signed by the member, the form must be submitted to APS Healthcare. APS Healthcare will then coordinate the transfer and set the effective date based on when required transfer documents are received.

At no time should the transfer take more than 45 calendar days from the date that the member signed transfer request is received at APS Healthcare, unless there is an extended delay caused by the member in returning necessary documents.

Transferring Agency Responsibilities:

A. To continue providing services until APS Healthcare notifies them that the transfer has been completed.
B. If it is a Case Management transfer, to provide the receiving agency, on the day of the transfer, a copy of the current PAS, the Service Plan, a copy of the Member Enrollment Confirmation and any other pertinent documentation.
C. If it is a Personal Attendant Service transfer, to provide the receiving agency, on the day of the transfer, with a copy of the current PAS, the member's Service Plan and any other pertinent documentation.

D. To maintain all original documents for monitoring purposes.

Receiving Agency Responsibilities:

A. Personal Attendant Service Agencies must meet with the member and/or their legal representative (if applicable) within 7 business days to review the Service Plan.
B. If it is a Case Management transfer, a Member Assessment must be conducted within seven (7) business days of the transfer effective date.
C. Develop the Service Plan within seven (7) business days of the transfer effective date.

The Service Plan from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new plan to prevent a gap in services.

Member transfers from traditional services to Personal Options, as well as, from Personal Options to traditional services are processed by APS Healthcare and will include both the Case Manager and Resource Consultant from PPL to ensure that all necessary documentation is shared and that there is no gap in the delivery of service.

512.15.1 Emergency Transfers

A request to transfer that is considered an emergency, such as when a member suffers abuse, neglect, or harm, will be reviewed by APS Healthcare and APS Healthcare will take appropriate action. The Case Management Agency, the Personal Attendant Service Agency that the member is transferring from or the Personal Options member and/or their legal representative (if applicable) must submit supporting documentation that explains why the member is in emergency status. APS Healthcare will expedite the request as necessary, coordinating with the member and agencies involved.

512.16 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by APS Healthcare:

A. No services have been provided for 180 continuous days – example, an extended placement in long-term care or rehabilitation facility.
B. Unsafe Environment – an unsafe environment is one in which the personal Attendant Service and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
    1) The member or other household members demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal Attendant Service Agency staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
    2) The member or other household members display an abusive use of alcohol and/or drugs.

When APS Healthcare receives an unsafe closure request, they will obtain documentation from the provider to support the request. If documentation supports the request, APS Healthcare will first attempt to process the request as a transfer. To do so, APS Healthcare will require the member and/or their legal representative (if applicable) to sign a Consent for Release of

Information Form. This will permit all information regarding the alleged unsafe circumstances to be disclosed to any agency the member wishes to transfer to. If the agency selected by the member is not willing to accept the member due to unsafe circumstances, the case will be closed. If at any time, the member removes the perceived threat from the service environment, services may continue. Referrals to Adult Protective Service will be made as required.

C. Member no longer desires services

The Request for Discontinuation of Services Form must be submitted to APS Healthcare for review. If APS Healthcare approves the discontinuation, APS Healthcare will send notification of discontinuation of services to the member and/or their legal representative (if applicable) with a copy to the Case Management Agency and PPL (if applicable). The notice shall include the reason and justification for the discontinuation of services. Fair hearing rights will also be provided except if the member no longer desires services. The effective date for the discontinuation of services is 13 calendar days from the receipt of the notification letter, if the member (or legal representative) does not request a hearing. If it is an unsafe environment services may be discontinued immediately.

All discontinuation of services (closures) must be reported on the Case Management Monthly Report.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Case Management Monthly Report:

A. Death
B. Moved Out of State
C. Medically Ineligible
D. Financially Ineligible

512.17 DUAL PROVISION OF TBI WAIVER AND PERSONAL CARE (PC) SERVICES

Approval of the provision of both TBI and PC services to the same person will be considered if the following criteria are met:

A. Any PC services provided to an active TBI Waiver member must be approved by the reviewing agencies (Refer to H below), including the initial 60 hours. The Dual Service Provision Request must be completed.

B. The reviewing agency must document that the member has direct-care needs that cannot be met by the TBI Waiver.
C. All policy set forth in *Chapter 517, Personal Care Services*, must be followed. PC policy supersedes TBI Waiver policy for this request.
D. There must be a PC Plan of Care that reflects the TBI Waiver services provided and the additional Personal Care services to be provided. Personal Care services must also be

reflected on the member's TBI Waiver Service Plan. These plans must be coordinated to ensure that services are not duplicated. PC and Personal Attendant services cannot be provided during the same hours on the same day. A service planning meeting between the Case Manager and Personal Care provider must be held with the member and/or their legal representative (if applicable) in the member's residence and documented on the Request for Dual Service Provision. For members participating in Personal Options, the meeting must include PPL and the member.

E. There must be a valid PAS and a valid PC Medical Eligibility Assessment (PCMEA) that documents the need for both services.
F. The Case Manager is responsible for the coordination of the two services.
G. Dual Service Provision Request Forms must be signed by the Case Manager, PC RN and the member and/or their legal representative (if applicable). Original signatures are required; i.e., "signature of member on file" is not acceptable.
H. All PC providers should submit requests to:

APS Healthcare
100 Capitol Street
Suite 600
Charleston, WV 25301

Documentation submitted must include a copy of the PAS and the PCMEA, TBI Waiver Service Plan and PC RN Plan of Care, and any documentation that supports the request. Additionally, a narrative describing how services will be utilized and verification that TBI Waiver and PC services will not be duplicated must be submitted. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member and/or their legal representative (if applicable), Personal Care and Personal Attendant Service providers, and the member's Case Manager will receive notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

I. BMS will conduct post-payment review of these combined services for duplication or inappropriate services. APS Healthcare and BMS will review compliance during the agency monitoring process.

512.18 EXCLUDED SERVICES AND NON-REIMBURSABLE SITUATIONS

Medicaid will only reimburse for TBI Waiver services that are defined as required services on the member's Service Plan (Refer to *Common Chapter 300, Provider Participation Requirements*, for more information about reimbursement.) The following services are not reimbursable:

A. Services provided for other member(s) of the TBI Waiver member's household or to anyone who is not a TBI Waiver Program member.
B. Services provided by a Case Management Agency, Personal Attendant Service Agency or Cognitive Rehabilitation Therapy provider that are not included in the Service Plan.
C. Services provided to an individual who is not medically and financially eligible on the date(s) that service is provided.

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR I/DD WAIVER SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 513.2.1	Bureau for Medical Services Contractual Relationships	August 1, 2012	January 1, 2013
Section 513.2.2	Traditional and Agency with Choice Provider Enrollment and Responsibilities	August 1, 2012	January 1, 2013
Section 513.2.2.1	Additional Qualifications for Traditional Option Agency Staff and Participant-Directed Options Agency with Choice Model Staff	August 1, 2012	January 1, 2013
Section 513.2.2.1.1	Criminal Investigation Background Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff	August 1, 2012	January 1, 2013
513.2.2.1.3	Office of the Inspector General (OIG) Medicaid Exclusion List Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model	August 1, 2012	January 1, 2013
513.2.4.7	Utilization Guidelines for I/DD Waiver Providers	August 1, 2012	January 1, 2013
513.3.2.2	Functionality	August 1, 2012	January 1, 2013
513.3.4	Slot Allocation Referral and Selection Process	August 1, 2012	January 1, 2013

513.4	Member Annual Re-determination of Eligibility Process	August 1, 2012	January 1, 2013
513.4.1	Annual Re-determination of Medical Eligibility	August 1, 2012	January 1, 2013
513.8	Individual Program Plan (IPP)	August 1, 2012	January 1, 2013
513.8.2.4	Critical Juncture IDT Meeting	August 1, 2012	January 1, 2013
513.9.1.1	Behavior Support Professional: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.2	Crisis Services : Traditional Option	August 1, 2012	January 1, 2013
513.9.1.5.1	Environmental Accessibility Adaptations: Home: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.5.2	Environmental Accessibility Adaptations: Vehicle: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.6	Facility-Based Day Habilitation: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.8.1	Person-Centered Support: Agency: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.8.2	Person-Centered Support: Family: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.10.1	Respite: Agency: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.10.2	Respite: Crisis Site: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.14	Supported Employment: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.11	Service Coordination : Traditional Option	August 1, 2012	January 1, 2013

513.9.1.12.1	Skilled Nursing: Licensed Practical Nurse: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.12.1.2	Skilled Nursing: Licensed Registered Nurse: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.12.2.1	Skilled Nursing: Licensed Registered Nurse: Individual Program Planning: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.15	Therapeutic Consultant: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.16.1	Transportation: Miles: Traditional Option	August 1, 2012	January 1, 2013
513.9.1.16.2	Transportation: Trips: Traditional Option	August 1, 2012	January 1, 2013
513.9.1	Participant-Directed Services	August 1, 2012	January 1, 2013
513.9.2.1.1.2	Goods and Services: Participant-Directed Option: Agency with Choice Model	August 1, 2012	January 1, 2013
513.9.2.1.1.4	Respite: Participant-Directed Option: Agency with Choice	August 1, 2012	January 1, 2013
513.9.2.1.5	Transportation: Miles: Participant-Directed Option: Agency with Choice	August 1, 2012	January 1, 2013
513.9.2.2	Participant-Directed Services: *Personal Options* Financial Management Service Option	August 1, 2012	January 1, 2013
513.9.2.2.1	Qualifications for Qualified Support Workers: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013

513.9.2.2.1.2	Criminal Investigation Background (CIB) Check Requirements for Qualified Support Workers: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
523.9.2.2.1.3	Office of the Inspector General (OIG) Medicaid Exclusion List Requirements for Qualified Support Workers: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
513.9.2.2.1.4	Protective Services Record Check for Qualified Support Workers: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
513.9.2.3.1	Goods and Services: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
513.9.2.3.2	Person-Centered Support: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
513.9.2.3.3	Respite: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
513.9.2.3.4	Transportation: Miles: Participant-Directed Services: *Personal Options*	August 1, 2012	January 1, 2013
513.10	Documentation and Record Retention Requirements	August 1, 2012	January 1, 2013

January 1, 2013

513.1 Definitions:

Old Policy:
Intensively Supported Setting (ISS): a residential home setting that is not licensed by the Office of Health Facility and Licensure with one to 3 people living in the home. The member's name is either on the lease or the member pays rent. No biological, adoptive or other family members or natural supports reside in the home setting with the member.

New Policy:
Intensively Supported Setting (ISS): a residential home setting that is not licensed by the Office of Health Facility and Licensure with one to 3 adults living in the home. The member's name is either on the lease or the member pays rent. No biological, adoptive or other family members reside in the home setting with the member. An exception would be when siblings who are also I/DD Waiver members reside in a setting without any other family members.

513.2.1 Bureau for Medical Services Contractual Relationships

Old Policy:
The Bureau for Medical Services (BMS) contracts with an Administrative Services Organization (ASO). The ASO acts as an agent of BMS and administers the operation of the I/DD Waiver Program. The ASO processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility. The ASO conducts education for I/DD Waiver providers, members, advocacy groups, and DHHR. The ASO provides a framework and a process for the purchase of waiver services.

New Policy:
The Bureau for Medical Services (BMS) contracts with an Administrative Services Organization (ASO). The ASO acts as an agent of BMS and administers the operation of the I/DD Waiver Program. The ASO processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility. The ASO conducts education for I/DD Waiver providers, members, advocacy groups, and DHHR. The ASO provides a framework and a process for the purchase of waiver services. At times, the ASO, in collaboration with BMS will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the BMS I/DD Waiver website located at: http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/default.aspx under POLICY CLARIFICATIONS.

513.2.2 Traditional and Agency with Choice Provider Enrollment and Responsibilities

Old Policy:
In addition to provider enrollment requirements in *Chapter 300, Provider Participation Requirements*, I/DD Waiver Program providers must meet all the requirements listed below.

- Receive a Certificate of Need (CON) approval from the West Virginia Health Care Authority through the full length CON process or through the Summary Review process.
- Obtain and maintain a behavioral health license through OHFLAC.
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the I/DD Waiver provider and BMS as well as a valid Medicaid enrollment agreement.
- Ensure that a member or agency staff are not discharged, discriminated or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves the I/DD Waiver provider.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services.
- Ensure that services are delivered and documentation meets regulatory and professional standards before the claim is submitted.
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.
- Begin the mandatory I/DD Waiver Program training for all agency staff on the first day of employment and document all mandatory training on the Certificate of Training Form (WV-BMS-I/DD-06).
- Ensure that all agency staff providing direct care services are fully trained in the proper care of the member to whom they will be providing services prior to billing for services. Fully trained agency staff must be available until newly hired Agency Staff or Qualified Support Workers are fully trained.
- Hires and retains a qualified workforce.
- Subcontracts with licensed individuals or group practices of the behavioral health profession as defined by the Office of Health Facility and Licensure, if contracting occurs.
- Maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the I/DD Waiver Program and all other applicable licensing and certification bodies.
- Provide an assigned agency I/DD Waiver Contact Person whose duties include:
    - Review of Home and Day Program visits to assure compliance with Waiver policy (service coordination provider agencies only);

  - Oversight of agency staff implementing the IPPs of all members in the I/DD Waiver Program; and
  - Communicating with BMS and the ASO.
- Implement the I/DD Waiver Quality Improvement System as further defined in Section 513.2.4.
- Provide each member with maximum choice of I/DD Waiver services within their individualized budgets available in each of the service delivery options.
- Employ or contract with agency staff who meet all the training and credentialing requirements listed under Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 as well as the individual service definitions of this chapter
- Maintain a record of the training verification or recertification on each agency staff.
- Participate in quarterly training sessions and routine conference calls provided by the ASO.
- Ensure that all residential sites (leased or rented by the I/DD Waiver provider) provide a safe environment for the members and agency staff.
- Provide appropriate auxiliary aids and services when necessary to ensure effective communication with members and/or legal representatives when natural or other supports are not available. This includes the use of qualified sign language interpreters, documents in Braille or large print, audio recordings, etc.
- Complies with all American with Disabilities Act (ADA) requirements if applicable.

New Policy:
In addition to provider enrollment requirements in *Chapter 300, Provider Participation Requirements*, I/DD Waiver Program providers must meet all the requirements listed below.

- Receive a Certificate of Need (CON) approval from the West Virginia Health Care Authority through the full length CON process or through the Summary Review process.
- Obtain and maintain a behavioral health license through OHFLAC.
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the I/DD Waiver provider and BMS as well as a valid Medicaid enrollment agreement.
- Ensure that a member or agency staff are not discharged, discriminated or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves the I/DD Waiver provider.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services.

- Ensure that services are delivered and documentation meets regulatory and professional standards before the claim is submitted.
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.
- Begin the mandatory I/DD Waiver Program training for all agency staff on the first day of employment and document all mandatory training on the Certificate of Training Form (WV-BMS-I/DD-06).
- Ensure that all agency staff providing direct care services are fully trained in the proper care of the member to whom they will be providing services prior to billing for services. Health and Safety training may be conducted by personnel deemed qualified by IDT members and documented on the member's IPP. Fully trained agency staff must be available until newly hired Agency Staff or Qualified Support Workers are fully trained.
- Hires and retains a qualified workforce.
- Subcontracts with licensed individuals or group practices of the behavioral health profession as defined by the Office of Health Facility and Licensure, if contracting occurs.
- Maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the I/DD Waiver Program and all other applicable licensing and certification bodies.
- Provide an assigned agency I/DD Waiver Contact Person whose duties include:
    - Review of Home and Day Program visits to assure compliance with Waiver policy (service coordination provider agencies only);
    - Oversight of agency staff implementing the IPPs of all members in the I/DD Waiver Program; and
    - Communicating with BMS and the ASO.
- Implement the I/DD Waiver Quality Improvement System as further defined in Section 513.2.4.
- Provide each member with maximum choice of I/DD Waiver services within their individualized budgets available in each of the service delivery options.
- Employ or contract with agency staff who meet all the training and credentialing requirements listed under Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 as well as the individual service definitions of this chapter
- Maintain a record of the training verification or recertification on each agency staff.
- Participate in quarterly training sessions and routine conference calls provided by the ASO.
- Ensure that all residential sites (leased or rented by the I/DD Waiver provider) provide a safe environment for the members and agency staff.
- Provide appropriate auxiliary aids and services when necessary to ensure effective communication with members and/or legal representatives when natural or other supports are not available. This includes the use of qualified sign language interpreters, documents in Braille or large print, audio recordings, etc.
- Complies with all American with Disabilities Act (ADA) requirements if applicable.

513.2.2.1 Additional Qualifications for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

Old Policy:
All agency staff, except contracted extended professional staff, having direct contact with members must meet the qualifications listed below.

- Approved Criminal Investigation Background (CIB) checks as defined in Section 513.2.2.1.1.
- Approved Protective Services Record Check as defined in Section 513.2.2.1.2
- Are not on the list of excluded individuals maintained by the Office of the Inspector General as defined in Section 513.2.2.1.3.
- Be over the age of 18.
- Have the ability to perform the tasks.
- Documentation of training initially and annually as mandated by OHFLAC including:
    - Training on treatment policies and procedures, including confidentiality training;
    - Training on Consumer Rights;
    - Training on Emergency Procedures, such as Crisis Intervention and restraints;
    - Training on Emergency Care to include Crisis Plans or Emergency Disaster Plans;
    - Training on Infectious Disease Control;
    - Documented training on First Aid by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current First Aid certification upon hire and as indicated per expiration date on the AHA or ARC card;
    - Documented training in Cardiopulmonary resuscitation (CPR) by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current CPR certification upon hire and as indicated per expiration date on the AHA or ARC card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the Agency Staff);
    - Training on the Heimlich maneuver;
    - Training on Member-specific needs (including special needs, health and behavioral health needs); and
    - Training on Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation, including injuries of unknown origin.
- Qualifications must be verified initially as current and updated as necessary.
- Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs.

New Policy:

All agency staff, except contracted extended professional staff, having direct contact with members must meet the qualifications listed below.

- Approved Criminal Investigation Background (CIB) checks as defined in Section 513.2.2.1.1.
- Approved Protective Services Record Check as defined in Section 513.2.2.1.2
- Are not on the list of excluded individuals maintained by the Office of the Inspector General as defined in Section 513.2.2.1.3.
- Be over the age of 18.
- Have the ability to perform the tasks.
- Documentation of training initially and annually as mandated by OHFLAC and the I/DD Waiver manual. For all trainings but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires. These trainings include:
    - Training on treatment policies and procedures, including confidentiality training;
    - Training on Consumer Rights;
    - Training on Emergency Procedures, such as Crisis Intervention and restraints must be provided if the IDT deems necessary based on member assessed needs;
    - Training on Emergency Care to include member-specific Crisis Plans and Emergency Disaster Plans;
    - Training on Infectious Disease Control;
    - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current First Aid certification upon hire and as indicated per expiration date on the card;
    - Documented training in Cardiopulmonary resuscitation (CPR) by an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current CPR certification upon hire and as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the Agency Staff);
    - Training on Member-specific needs (including special needs, health and behavioral health needs); and
    - Training on Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation, including injuries of unknown origin.
- Qualifications must be verified initially as current and updated as necessary.
- Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs.

513.2.2.1.1 Criminal Investigation Background Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

Old Policy:
All I/DD Waiver provider agency staff, except contracted extended professional staff, having direct contact with members must, at a minimum, have results from a state level CIB check which includes fingerprints. This check must be conducted initially and again every 3 years. If the current or prospective employee has lived out of state within the last 5 years, the agency must conduct an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also upon hire. I/DD Waiver providers may do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies to complete these checks that meet OHFLAC standards. I/DD Waiver provider must contact OHFLAC at (304) 558-0050 to verify that a company meets these standards. An individual who is providing services or is employed by an I/DD Waiver provider cannot be considered to provide services nor can be employed if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed I/DD Waiver provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in status of an agency staff member providing I/DD Waiver services, the I/DD Waiver provider must take appropriate action, including notification to the BMS I/DD Program Manager.

New Policy:
All I/DD Waiver provider agency staff, except contracted extended professional staff, having direct contact with members must, at a minimum, have results from a state level CIB check which includes fingerprints. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must conduct an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also upon hire and every 3 years of employment. I/DD Waiver providers may do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by an I/DD Waiver provider cannot be considered to provide services nor can be employed or continue to be employed if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;

- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed I/DD Waiver provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in status of an agency staff member providing I/DD Waiver services, the I/DD Waiver provider must take appropriate action, including notification to the BMS I/DD Program Manager.

513.2.2.1.2 Protective Services Record Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

Old Policy:
All I/DD Waiver provider agency staff hired after January 1, 2009, except for contracted Extended Professional Staff, having direct contact with members must have a WVDHHR Protective Services Record Checks. These must be initiated on each individual upon hire and the results must be considered by the I/DD Waiver provider before continuing employment. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families, Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

New Policy:

No change made, policy remains the name.

513.2.2.1.3 Federal Office of the Inspector General (OIG) Medicaid Exclusion List Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

Old Policy:
The Office of the Inspector General (OIG) Medicaid Exclusion List must be checked by the I/DD Waiver provider for every agency staff who provides Medicaid services prior to employment and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred

New Policy:
The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities must be checked by the I/DD Waiver provider for every agency staff who provides Medicaid services prior to employment and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

513.2.4.4 Self-Reviews

Old Policy:
The ASO prepares and disseminates electronically an I/DD Waiver Self-Review Tool which measures the CMS Quality Assurances. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS quality assurances are met. I/DD Waiver providers must use the approved format for submitting self-reviews so that data related to the CMS quality assurance standards can be tracked and analyzed. Failure to submit the self-reviews may jeopardize the future status of the I/DD Waiver provider as a West Virginia Medicaid provider.

I/DD providers are required to conduct self-reviews and submit to the ASO via electronic format on a quarterly basis. The reporting period is as follows:

- January 1 to March 31 self-reviews submitted by April 15
- April 1 to June 30 self-reviews submitted by July 15
- July 1 to September 30 self-reviews submitted by October 15
- October 1 to December 31 self-reviews submitted by January 15

New Policy:
The ASO prepares and disseminates electronically an I/DD Waiver Self-Review Tool which primarily measures the CMS Quality Assurances. This self review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS quality assurances are met. I/DD Waiver providers must use the approved format for submitting self reviews so that data related to the CMS quality assurance standards can be tracked and analyzed. Failure to submit the self reviews may jeopardize the future status of the I/DD Waiver provider as a West Virginia Medicaid provider.

I/DD providers are required to conduct self reviews, complete an affidavit attesting to the accuracy of the self-review, and submit to the ASO via electronic format every-other-year. The reporting periods will be based on the quarter during which the provider's on-site review take place on alternate years and will be communicated to providers via email.

513.2.4.7 Utilization Guidelines for I/DD Waiver Providers

Old Policy:
None, this is a new section

New Policy:
Each agency must put into place a set of Utilization Guidelines (UG) to ensure that each I/DD Waiver member receives the appropriate services and supports at the right time, in the right amount, and for as long as the member needs the services. Utilization guidelines are a person-centered process that starts with person-centered planning. The purpose of UG is to monitor claims submission and ensure that services provided are in compliance with the I/DD Waiver Manual and existing authorizations.

Agencies providing services must have UG in place that track units of services utilized/billed. It is the expectation that each agency be able to report units used and units still available at the IDT meetings (if not earlier). This is not only necessary for transfer/authorization purposes, but is also necessary for IDTs to make good decisions about purchasing services. Each agency is to have and adhere to a UG policy. With the exception of Crisis Services, agencies must receive prior-authorization for each service provided, as outlined in section 513.11 and specified in each service definition under "Prior Authorization."

The internal policy of each agency must minimally address the following:

- Staff training
- Provider education on how services will be delivered throughout the member's service year. This education should minimally include the following:
    - Schedule of the member
    - Units of service authorized
    - Averages of usage (daily/monthly)
    - Individualized Training (as needed)
    - Requirements and limitations of the particular service provided
- Empowering and educating members and families so that they are able to make informed choices about their services and supports;
- Assessing member's needs:
    - Purchase requests are based on identified need for the coming service year, therefore additional units may not be requested for contingency purposes;
- Choosing services based on member's assessed needs;
- Monitoring service utilization throughout the member's service year;
- Monitoring member's needs and updating services as needed;
- All services delivered must be delivered based on:
    - Assessed need

- Agreement by the IDT
- I/DD Waiver service caps and limitations
- Documentation on the member's IPP

513.3.2.2 Functionality

Old Policy:
The applicant must have substantial deficits in at least 3 of the 6 identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;
- Self-direction; and,
- Capacity for independent living (home living, social skills, employment, health and safety, community and leisure activities).

New Policy:
The applicant must have substantial deficits in at least 3 of the 6 identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;
- Self-direction; and,
- Capacity for independent living which includes the following 6 sub-domains: home living, social skills, employment, health and safety, community and leisure activities. At a minimum, 3 of these sub-domains must be substantially limited to meet the criteria in this major life area.

513.3.4 Slot Allocation Referral and Selection Process

Old Policy:
Provided a funded I/DD Waiver slot is available, the allocation process is based on:

- The chronological order by date of the ASO's receipt of the fully completed initial application (WV-BMS I/DD-1) which includes approval of eligibility from the MECA **or**
- The date of a fair hearing decision if medical eligibility is established as a result of a Medicaid fair hearing.

Once a I/DD Waiver slot is available, the enrollee will receive an informational packet up to 90 days prior to the slot being awarded. A Freedom of Choice form (WV-BMS-I/DD-2) on which the enrollee must indicate the wish to receive home and community based services as opposed to services in an ICF/MR, his/her chosen service option (Traditional or Traditional and Participant-Directed) as well as the chosen Service Coordination provider will be included and must be returned to the ASO within 30 days of receipt of the informational packet.

New Policy:
Provided a funded I/DD Waiver slot is available, the allocation process is based on:

- The chronological order by date of the ASO's receipt of the fully completed initial application (WV-BMS I/DD-1) which includes approval of eligibility from the MECA **or**
- The date of a fair hearing decision if medical eligibility is established as a result of a Medicaid fair hearing.

Once an I/DD Waiver slot is available, the enrollee will receive an informational packet up to 90 days prior to the slot being awarded. A Freedom of Choice form (WV-BMS-I/DD-2) on which the enrollee must indicate the wish to receive home and community based services as opposed to services in an ICF/IID, his/her chosen service option (Traditional or Traditional and Participant-Directed) as well as the chosen Service Coordination provider will be included and must be returned to the ASO within 30 days of receipt of the informational packet.

The enrollee must access I/DD Waiver services within 180 days when the funded slot becomes available or the enrollee will be discharged from the program.

513.4 MEMBER ANNUAL RE-DETERMINATION OF ELIGIBILITY PROCESS

Old Policy:
In order for a member to be re-determined eligible, the member must:

- Meet medical eligibility;
- Meet financial eligibility;
- Be a resident of West Virginia; and
- Have chosen Home and Community-Based Services over services in an institutional setting (ICF/MR).

The member must also have substantial deficits in at least 3 of the 6 identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;

- Self-direction; and
- Capacity for independent living (home living, social skills, employment, health and safety, community and leisure activities).

New Policy:
In order for a member to be re-determined eligible, the member must:

- Meet medical eligibility;
- Meet financial eligibility;
- Be a resident of West Virginia; and
- Have chosen Home and Community-Based Services over services in an institutional setting (ICF/IID).

The member must also have substantial deficits in at least 3 of the 6 identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;
- Self-direction; and
- Capacity for independent living which includes the following 6 sub-domains: home living, social skills, employment, health and safety, community and leisure activities. At a minimum, 3 of these sub-domains must be substantially limited to meet the criteria in this major life area.

513.4.1 Annual Re-determination of Medical Eligibility

Old Policy:
In accordance with federal law, re-determination of medical eligibility must be completed at least annually. The anchor date of the member's medical re-determination is the anniversary date of the first month after the initial medical eligibility was established by the MECA.

At a minimum, annual redetermination of eligibility will include 1 annual functional assessment which includes standardized measures of adaptive behavior in the 6 major life areas completed by the ASO and the results provided to the MECA. The MECA will determine medical eligibility annually based on this assessment of functioning as defined in Section 513.3.

Substantial deficits are defined as standardized scores of 3 standard deviations below the mean or less than 1 percentile when derived from a normative sample that represents the general population of the United States, or the average range or equal to or below the 75 percentile when derived from MR normative populations when mental retardation has been diagnosed and the scores are derived from a standardized measure of adaptive behavior. The scores submitted must be obtained from using an appropriate standardized test for measuring adaptive

behavior that is administered and scored by an individual properly trained and credentialed to administer the test.

The ASO will conduct the functional assessment up to 90 days prior to each member's anchor date. At the time of the annual functional assessment by the ASO, each member or legal representative must complete the Freedom of Choice Form (WV-BMS-I/DD-2) indicating their choice of level of care settings, service coordination agency and service delivery options. If determined medically eligible, the member and Service Coordination provider will also receive the individual budget allocation that was calculated by the ASO based upon the member's assessed needs.

If a member is determined not to be medically eligibility a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the ASO to the member or their legal representative. The member's service coordinator is also notified by the ASO. The denial of medical eligibility may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted by the member or their legal representative to the Board of Review within 90 days of receipt of the Notice of Decision. The Notice of Decision letter also allows the member or their legal representative to request a second medical evaluation.

The second medical evaluation is completed within 60 days by a member of the IPN at the expense of BMS.

If the member's medical eligibility is terminated and the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days of the member or their legal representative's receipt of the Notice of Decision.

If the member is determined to be medically eligible as a result of a Medicaid Fair Hearing, then services will continue if the member or their legal representative requested this within 13 days of the receipt of the Notice of Decision Letter. If services were terminated due to the member or their legal representative not requesting their continuance within 13 days of the receipt of the Notice of Decision letter, then services will begin again on the date of the Hearing Officer's decision.

At any time prior to the Medicaid Fair hearing, the member or legal representative may request a pre-hearing conference. At the pre-hearing conference, the member and/or their legal representative, the ASO and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

More information on appealing medical eligibility can be found in Section 513.5.4 Member Appeals.

New Policy:
In accordance with federal law, re-determination of medical eligibility must be completed at least annually. The anchor date of the member's medical re-determination is the anniversary date of the first month after the initial medical eligibility was established by the MECA.

At a minimum, annual redetermination of eligibility will include 1 annual functional assessment which includes standardized measures of adaptive behavior in the 6 major life areas completed by the ASO and the results provided to the MECA. The MECA will determine medical eligibility annually based on this assessment of functioning as defined in Section 513.3.

Substantial deficits are defined as standardized scores of 3 standard deviations below the mean or less than 1 percentile when derived from a normative sample that represents the general population of the United States, or the average range or equal to or below the 75 percentile when derived from MR normative populations when mental retardation has been diagnosed and the scores are derived from a standardized measure of adaptive behavior. The scores submitted must be obtained from using an appropriate standardized test for measuring adaptive behavior that is administered and scored by an individual properly trained and credentialed to administer the test.

The ASO will conduct the functional assessment up to 90 days prior to each member's anchor date. At the time of the annual functional assessment by the ASO, each member or legal representative must complete the Freedom of Choice Form (WV-BMS-I/DD-2) indicating their choice of level of care settings, service coordination agency and service delivery options. If the member has a legal representative that did not attend the Annual Functional Assessment and complete the Freedom of Choice Form (WV-BMS-I/DD-2), then it is the responsibility of the Service Coordinator to obtain the signature of the Legal Representative prior to or at the Annual IPP. If determined medically eligible, the member and Service Coordination provider will also receive the individual budget allocation that was calculated by the ASO based upon the member's assessed needs.

If a member is determined not to be medically eligibility a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the ASO to the member or their legal representative. The member's service coordinator is also notified by the ASO. The denial of medical eligibility may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted by the member or their legal representative to the Board of Review within 90 days of receipt of the Notice of Decision. The Notice of Decision letter also allows the member or their legal representative to request a second medical evaluation.

The second medical evaluation is completed within 60 days by a member of the IPN at the expense of BMS.

If the member's medical eligibility is terminated and the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must

be submitted within 13 days of the member or their legal representative's receipt of the Notice of Decision.

If the member is determined to be medically eligible as a result of a Medicaid Fair Hearing, then services will continue if the member or their legal representative requested this within 13 days of the receipt of the Notice of Decision Letter. If services were terminated due to the member or their legal representative not requesting their continuance within 13 days of the receipt of the Notice of Decision letter, then services will begin again on the date of the Hearing Officer's decision.

At any time prior to the Medicaid Fair hearing, the member or legal representative may request a pre-hearing conference. At the pre-hearing conference, the member and/or their legal representative, the ASO and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

More information on appealing medical eligibility can be found in Section 513.5.4 Member Appeals.

513.8 INDIVIDUAL PROGAM PLAN (IPP)

Old Policy:
Central to the services that a member receives through the I/DD Waiver program is the member's IPP. Developing the IPP is the process by which the member is assisted by their Interdisciplinary Team which consists of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the I/DD Waiver program policy manual. This team meets to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The content of the IPP must be guided by the member's needs, wishes, desires, and goals but based upon assessed needs. All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the member and the other members of the team.

If the member is their own legal representative, then the member must attend the IPP. If the member has a legal representative, the legal representative must attend the IPP in person or by teleconferencing in extenuating circumstances and the member must also attend if medically and behaviorally able. If the member does not attend due to medical or behavioral issues, the service coordinator must ensure that the member understands the services outlined in their IPP to the best of their ability and is given an opportunity to sign the IPP within 10 days.

Individual Program Planning includes the Initial IPP which must be developed within 7 days of intake/admission to a new provider agency, the annual IPP and subsequent reviews or revisions of the IPP, Critical Juncture, Transfer and Discharge IPPs. Any activity that occurs prior to the meeting or after the meeting is **not** considered Individual Program Planning.

Activities conducted before or after the meeting may meet the criteria for Service Coordination activities.

The IPP should minimally include:

- All components in the WV-BMS-I/DD-05

    - Cover/Demographics
    - Meeting Minutes
    - Circle of Support/Goals and Dreams
    - Summary of Assessment and Evaluation Results
    - Medications
    - Individual Service Plan
        - I/DD Waiver Services
        - Non-I/DD Waiver Services and Natural Supports
    - Individual Habilitation Plan and Task Analysis
    - Tentative Weekly Schedule
    - Signature Sheet (and rationale for disagreement if necessary)
    - Behavior Support Plan or Protocol, if applicable, with signatures of developer and member/legal representative (must indicate consent by member/legal representative)
        - Dates that plan was approved, initiated and will be reviewed. If the plan includes restrictive measures, then approval by the I/DD Waiver Provider's Human Rights Committee must be attached. HRC must monitor plans with adverse procedures at least annually.
    - Crisis Plan
    - Individual Spending Plan if member is self-directing any of the Participant-Directed Services available

A Crisis Plan must be completed for each I/DD Waiver member. This shall be considered an attachment and part of the member's IPP. A Crisis Plan must be personalized and discuss any foreseeable issues which might put the member's health, safety or well-being in jeopardy. A Crisis Plan should incorporate the level of supports which would likely be required for unforeseen circumstances. A Crisis Plan should minimally cover the following events:

- No call/no show of support staff
- Primary caregiver becomes unavailable or unable to provide continued support
- Weather-related/environmental issues (transportation, inability to get to scheduled location, etc.)
- Disaster-related issues (flood, fire, etc.)
- Health/medical issues (medication administration, serious allergies, seizure protocol, if applicable, etc.)
- Termination from I/DD Waiver services
- Any other member-specific issues

The IPP serves as documentation of the IDT team meeting. A team member's signature on the IPP constitutes participation in the team meeting; however a progress note is still required to document the team member's participation in the meeting. Team meeting minutes must be maintained with the IPP to expand discussion of the meeting, record critical issues from the meeting and identify the active participation of each IDT member. The IPP must include the signature of all members who attended and should indicate agreement/disagreement with the IPP, date of the meeting and the total time spent in the meeting for each team member. The member or their legal representative must agree with the plan for it to be considered a valid IPP. A copy of the IPP is maintained in all participating provider agency records and distributed to all team members within 14 days of the date of the IDT team meeting by the Service Coordinator.

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may participate by teleconferencing, however they may not bill for the time spent in the IDT if participating by teleconference and the Service Coordinator must note on the signature sheet that they attended by phone, If the legal representative attends by telephone, the service coordinator must obtain their signature within 10 days. When a member has been admitted to a crisis respite site, then the Service Coordinator may attend and bill for their services while conducting the IPP over the telephone.

An IPP includes the completed IPP (WV-BMS-I/DD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans if the member self directs eligible services and meeting minutes.

The IPP must be developed on an annual basis. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days. The IPP must be updated at critical juncture meetings to include IDT recommendations. All Medley Class Members must have IDT meetings every quarter, but the Medley Advocate may choose to only attend the 6-month and the annual IDT.

MEDICAID CANNOT REIMBURSE FOR SERVICES RENDERED WHEN THE IPP HAS EXPIRED, HAS NOT BEEN REVIEWED WITHIN REQUIRED TIMELINES AND/OR DOES NOT INCLUDE REQUIRED SIGNATURES OR SERVICES.

New Policy:
Central to the services that a member receives through the I/DD Waiver program is the member's IPP. Developing the IPP is the process by which the member is assisted by their Interdisciplinary Team which consists of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the I/DD Waiver program policy manual. This team meets to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The content of the IPP must be guided by the member's needs, wishes, desires, and goals but based upon assessed needs. All IPP meetings should be scheduled at a time and

location that takes into consideration the schedule and availability of the member and the other members of the team.

If the member is their own legal representative, then the member must attend the IPP. If the member has a legal representative, the legal representative must attend the IPP in person or by teleconferencing in extenuating circumstances and the member must also attend if medically and behaviorally able. If the member does not attend due to medical or behavioral issues, the service coordinator must ensure that the member understands the services outlined in their IPP to the best of their ability and is given an opportunity to sign the IPP within 10 days.

Individual Program Planning includes the Initial IPP which must be developed within 7 days of intake/admission to a new provider agency, the annual IPP and subsequent reviews or revisions of the IPP, Critical Juncture, Transfer and Discharge IPPs. Any activity that occurs prior to the meeting or after the meeting is **not** considered Individual Program Planning. Activities conducted before or after the meeting may meet the criteria for Service Coordination activities.

All IPPs must be disseminated to all team members within 14 days and must minimally include:

- All components in the WV-BMS-I/DD-05
    - Cover/Demographics
    - Meeting Minutes
    - Circle of Support/Goals and Dreams
    - Summary of Assessment and Evaluation Results
    - Medications
    - Individual Service Plan
        - I/DD Waiver Services
        - Non-I/DD Waiver Services and Natural Supports
    - Individual Habilitation Plan and Task Analysis if the member receives formal training
    - Tentative Weekly Schedule
    - Signature Sheet (and rationale for disagreement if necessary)
    - Behavior Support Plan or Protocol, if applicable, with signatures of developer and member/legal representative (must indicate consent by member/legal representative)
        - Dates that plan was approved, initiated and will be reviewed. If the plan includes restrictive measures, then approval by the I/DD Waiver Provider's Human Rights Committee must be attached. HRC must monitor plans with adverse procedures at least annually.
    - Crisis Plan to include Emergency Disaster Plans
    - Individual Spending Plan if member is self-directing any of the Participant-Directed Services available

A Crisis Plan must be completed for each I/DD Waiver member. This shall be considered an attachment and part of the member's IPP. A Crisis Plan must be personalized and discuss any foreseeable issues which might put the member's health, safety or well-being in jeopardy. A

Crisis Plan should incorporate the level of supports which would likely be required for unforeseen circumstances. A Crisis Plan should minimally cover the following events:

- No call/no show of support staff
- Primary caregiver becomes unavailable or unable to provide continued support
- Weather-related/environmental issues (transportation, inability to get to scheduled location, etc.)
- Disaster-related issues (flood, fire, etc.)
- Health/medical issues (medication administration, serious allergies, seizure protocol, if applicable, etc.)
- Termination from I/DD Waiver services
- Any other member-specific issues

The IPP serves as documentation of the IDT team meeting. A team member's signature on the IPP constitutes participation in the team meeting; however a progress note is still required to document the team member's participation in the meeting. Team meeting minutes must be maintained with the IPP to expand discussion of the meeting, record critical issues from the meeting and identify the active participation of each IDT member. The IPP must include the signature of all members who attended and should indicate agreement/disagreement with the IPP, date of the meeting and the total time spent in the meeting for each team member. The member or their legal representative must agree with the plan for it to be considered a valid IPP. A copy of the IPP is maintained in all participating provider agency records and distributed to all team members within 14 days of the date of the IDT team meeting by the Service Coordinator.

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may participate by teleconferencing, however they may not bill for the time spent in the IDT if participating by teleconference and the Service Coordinator must note on the signature sheet that they attended by phone, If the legal representative attends by telephone, the service coordinator must obtain their signature within 10 days. When a member has been admitted to a crisis respite site, then the Service Coordinator may attend and bill for their services while conducting the IPP over the telephone.

An IPP includes the completed IPP (WV-BMS-I/DD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans if the member self directs eligible services and meeting minutes.

The IPP must be developed on an annual basis. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days. The IPP must be updated at critical juncture meetings to include IDT recommendations.

All Medley Class Members must have IDT meetings every quarter, but the Medley Advocate may choose to only attend the 6-month and the annual IDT.

MEDICAID CANNOT REIMBURSE FOR SERVICES RENDERED WHEN THE IPP HAS EXPIRED, HAS NOT BEEN REVIEWED WITHIN REQUIRED TIMELINES AND/OR DOES NOT INCLUDE REQUIRED SIGNATURES OR SERVICES.

513.8.2.4 Critical Juncture IDT Meeting

Old Policy:
This meeting is held as soon as possible when there is a significant change in the member's assessed needs and/or planned services. A Critical Juncture may be the result of a change in the member's medical/physical status, behavioral status or availability of natural supports. The IPP must be updated to include IDT recommendations.

See Section 513.6 for appropriate reasons for discharge of a member from I/DD Waiver Services.

New Policy:
This meeting is held as soon as possible when there is a significant change in the member's assessed needs and/or planned services. A Critical Juncture may be the result of a change in the member's medical/physical status, behavioral status or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes and signatures of all IDT members indicating their attendance and agreement or disagreement.

A face-to-face meeting must be held under any of the following circumstances:

- All team members do not agree with services or service mix;
- When a new goal will be implemented for the member;
- The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required;
- The member changes residential setting (example: moves from Natural Family to ISS);
- The member who lives in an ISS, Group Home or Specialized Family Care Home moves;
- The member goes into crisis placement;
- The member has a change in legal representative status;
- The primary caregiver changes or passes away;
- The member elects to change Service Delivery Model;
- The member receives a new service not previously received.

See Section 513.6 for appropriate reasons for discharge of a member from I/DD Waiver Services.

513.9.1.1 Behavior Support Professional: Traditional Option

Definition of Service:

Old Policy:
This service is provided to members with identified maladaptive behaviors and documented social behavior skill deficits documented through 1 of the following conditions:

- Member must currently exhibit maladaptive behaviors so severe that the adaptive functioning and ability to receive adaptive training is limited or impossible unless maladaptive behaviors are reduced or eliminated.
- Member may have a history of behaviors beyond 1 year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending behaviors that result in bodily harm to others or self.
- Member must have identified behaviors on the IPP that require tracking of behavioral data for the functional assessment.
- Member must have a functional assessment that outlines 1 or more specific target behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan.

The BSP is responsible to identify targeted maladaptive behaviors; develop hypotheses and Positive Behavior Support plans; develop habilitation plans and provide training in the person-specific aspects and method of a plan of intervention to the direct care staff (i.e. family, person-centered support workers, facility-based day habilitation workers, supportive employment providers, crisis workers and respite workers). The BSP also provides evaluation/monitoring of the effectiveness of the Positive Behavior Support plan through analysis of programming results.

I/DD Waiver provider agencies who submit their curriculum for approval to the West Virginia Positive Behavior Support (WV-PBS) Network may allow their agency staff who was formerly credentialed as Therapeutic Consultant Behavior Analysts or Therapeutic Consultant Behavior Specialists before October 1, 2011 to bill the BSP code as long as they meet all other requirements listed below. The WV-PBS Network approves all curriculums that meet the Association of Positive Behavior Support (PBS) standards of practice within 6 months of submission and the West Virginia I/DD Waiver provider completes training of agency staff within 6 months of approval of the curriculum. All curriculums submitted must include a minimum of 20 hours of training in APBS standards of practice and 10 hours of mentoring. This mentoring training is not member-specific and is not billable.

All newly hired agency staff must be either completely trained in a curriculum which has been approved by the WV-PBS Network or meet other requirements below before being allowed to bill the BSP code.

The Behavior Support Professional may perform the activities listed below:

- Take responsibility for all aspects of Positive Behavior Support services.
- Complete behavioral assessment or evaluation consisting of activities such as functional assessment of targeted behavior or analysis of behavioral data.

- Facilitate the development of Positive Behavior Support plans addressing behavioral protocols and behavioral guidelines.
- Train direct care staff to implement Positive Behavior Support plans.
- Develop behavioral protocols and behavioral guidelines for direct care staff or families.
- Develop methodology for intervention with the individual.
- Assess, evaluate and monitor the effectiveness of Positive Behavior Support plans.
- Develop adaptive habilitation plans based upon the member's assessed adaptive and maladaptive needs.
- Collaborate with Therapeutic Consultant(s) (when applicable) to ensure that positive behavior support strategies are consistently applied within all training strategies.
- Train direct care staff, model training strategies and observe staff to ensure that proper implementation of training strategies are imbedded across all aspects of habilitation. This may include training on members' health and safety needs as well as speech, physical and occupational therapy treatment activities.
- Facilitate person-centered planning as a component of the Positive Behavior Support Plan.
- Present proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.

Definition of Service:
New Policy:
This service is **ONLY** provided to members who exhibit 1 or more of the following:

- Member must exhibit documented maladaptive behaviors on the current Inventory for Client and Agency Planning (ICAP) with severity level of "very serious," or "extremely serious" in at least 1 of the following categories: Hurtful to Self, Hurtful to Others, and/or Destructive to Property; AND/OR

- Member must have current documented severe maladaptive behaviors that are Hurtful to Self, Hurtful to Others, and/or Destructive to Property, that have occurred since last ICAP was administered. These behaviors must be documented through a current Functional Assessment, current behavior data documentation, and/or WV IMS incident reports; AND/OR

- Member must have a documented history of maladaptive behaviors within the past year that have resulted in severe outcomes (i.e.-possible incarceration, life-threatening to member/others, arson/fire-setting, sexual assault). These behaviors must be documented through a current Positive Behavior Support Plan, current Functional Assessment, or other documentation that supports the maladaptive behavior(s) have occurred within the past year.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

In order to qualify to train others using an approved curriculum, an individual must meet 1 of the following 3 criteria:

- Be the developer of an approved training as indicated on the submitted application;
- Be able to provide documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer);
- Be a Board Certified Behavior Analyst or Assistant and have documentation certifying completion of the facilitated Overview of Positive Behavior Support.

The Behavior Support Professional must perform the following activities for those members who meet the criteria in section 513.9.1.1 and who are prior-authorized for this service:

- Complete a Functional Assessment to identify targeted maladaptive behaviors;
- Create Positive Behavior Support plans to meet Association for Positive Behavior Support standards of practice;
- Provide training to direct care staff who will implement the plan (i.e. family, person-centered support workers, facility-based day habilitation workers, supported employment providers, crisis workers, and respite workers);
- Evaluate/monitor the effectiveness of the Positive Behavior Support plan through analysis of programming results.

The BSP may perform all of the services listed under the Therapeutic Consultant definition, as well as the following services for those members who meet the criteria in section 513.9.1.1 and who are prior-authorized for this service:

- Train direct care workers in all aspects of PBSPs implementation(i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers);
- Assess, evaluate and monitor the effectiveness of PBSPs;
- Collect and evaluate data and completes a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan or to generate a Positive Behavior Support plan;
- Collaborate with Therapeutic Consultant(s) from other agency(s) to ensure that positive behavior support strategies are consistently applied across all environments;
- Facilitate person-centered planning as a component of the Positive Behavior Support plan;
- Present proposed restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information regarding the member;

- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.
- May provide on-site training to the support staff in behavior/crisis situations.
- May bill for phone consultation during behavioral crisis situations.
- May bill for developing/updating the behavioral crisis section of the member's crisis plan if a Therapeutic Consultant is not performing this function.
- May verify data compiled by all Person-Centered Support staff for accuracy.
- May bill for attendance of and contribution to Futures Planning sessions, including PATHs and MAPs.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with Therapeutic Consultant Services.
- Member is limited to 1 BSP.
- If the member receives all direct care services from a single I/DD Waiver provider, the member is limited to 1 BSP or TC.
- If the member receives direct care services from more than 1 I/DD Waiver provider, the member/legal representative is responsible for choosing which provider will provide BSP services.
- Agency staff providing BSP services may not be an individual who lives in the member's own residence or family residence.
- If the assigned BSP is unavailable due to an emergency or illness another BSP or TC may provide services in their absence.
- Direct care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/MR or another WV waiver program for planning purposes.
- BSP services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.

- Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
- Filing, collating, writing notes to staff.
- Phone calls to staff.
- Observing staff while training individuals without a clinical reason.
- Administering assessments not warranted or requested by the member or their legal representative.
- Making plans for a parent for a weekend visit.
- Working in the home with providing direct care staff coverage.
- Sitting in the waiting room for a doctor or medical appointment.
- Conducting a home visit routinely and without justification – only service coordinators are required to make monthly home visits.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized budget**.**
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with Therapeutic Consultant services.
- Member is limited to 1 BSP.
- If the member receives direct care services from more than 1 I/DD Waiver provider, the member/legal representative is responsible for choosing which provider will provide BSP services.
- Agency staff providing BSP services may not be an individual who lives in the member's own residence or family residence.
- If the assigned BSP is unavailable due to an emergency or illness another BSP or TC may provide services in their absence.
- Direct care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- BSP services may not be billed for traveling to complete BSP activities.
- BSP services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring, and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
    - Filing, collating, writing notes to staff.

- Phone calls to staff.
- Observing staff while training individuals without a clinical reason.
- Administering assessments not warranted or requested by the member or their legal representative.
- Making plans for a parent for a weekend visit.
- Working in the home with providing direct care staff coverage.
- Sitting in the waiting room for a doctor or medical appointment.
- Conducting a home visit routinely and without justification—only service coordinators are required to make monthly home visits.

Agency Staff Qualifications:
Old Policy:
In addition to meeting all the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3, agency staff providing BSP services must meet at least 1 of the standards listed below.

- Be a Board Certified Assistant Behavior Analyst (BCaBA) Certificate- Bachelor's degree, 1 year professional experience working with individuals with I/DD and completion of the West Virginia Positive Behavior Support (WV-PBS) Network's 3-hour overview of Positive Behavior Support; or
- Be a Board Certified Behavior Analyst (BCBA) Certificate-Master's degree, 1 year professional experience working with individuals with I/DD and completion of the WV-PBS Network's 3 hour overview of Positive Behavior Support; or
- Have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree or a Masters of Arts (MA) or Masters of Science (MS) in a human services field and 2 years professional experience in the I/DD field and documented evidence of enrollment in the APBS standards of practice coursework/training as evidenced by: Enrollment in an approved BCBA or BCaBA university training course or enrollment in a specific curriculum training program that is pre-approved as meeting the APBS standards of practice by the WV-PBS Network or by an approved state agency. Agency staff must also be credentialed as a Therapeutic Consultant Behavior Analyst or a Therapeutic Consultant Behavior Specialist before October 1, 2011.

By January 1, 2013, the BSP must have 1 of the minimum acceptable credentials listed below.

- Be a Board Certified Assistant Behavior Analyst (BCaBA) Certificate-Bachelor's degree, 1 year professional experience working with individuals with I/DD and completion of the 3-hour overview of Positive Behavior Support; or
- Be a Board Certified Behavior Analyst (BCBA) Certificate-Master's degree, 1 year professional experience working with individuals with I/DD and completion of the 3-hour overview of Positive Behavior Support; or
- Have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree or a Masters of Arts (MA) or Masters of Science (MS) in a human services field and 2 years professional experience in the I/DD field and documented evidence of completion of APBS standards

of practice coursework/training as evidenced by documentation of successful completion of an approved BCBA or BCaBA university training course or completion of agency specific curriculum based on the APBS standards of practice that have been approved by the WV-PBS Network or by an approved state agency.

Agency Staff Qualifications:
New Policy:

In addition to meeting all requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3, agency staff providing BSP services must meet at least 1 of the standards listed below.

- Be a Board Certified Assistant Behavior Analyst (BCaBA) Certificate-Bachelor's degree, 1 year professional experience working with individuals with I/DD and completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network; or
- Be a Board Certified Behavior Analyst (BCBA) Certificate-Master's degree, 1 year professional experience working with individuals with I/DD and completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network; or
- Have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree and 2 years professional experience in the I/DD field or a Master of Arts (MA) or Master of Science (MS) in a human services field and 1 year professional experience in the I/DD field and documented evidence of successful completion coursework/training as evidenced by completion of a training curriculum approved by the WV- APBS Network or by an approved state agency.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

513.9.1.2 Crisis Services: Traditional Option:

Definition of Service:
Old Policy:
The goal of this service is to respond to a crisis immediately, assess and stabilize the situation as quickly as possible. Crisis services provided are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. Except in emergent situations, this service requires prior authorization. This service is a 2:1 ratio (agency staff to member ratio). The additional agency staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and behavioral support.

Definition of Service:
New Policy:
The goal of this service is to respond to a crisis immediately, assess and stabilize the situation as quickly as possible. Crisis services provided by awake and alert staff are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. Except in emergent situations, this service requires prior authorization. This service is a 2:1 ratio (agency staff to member ratio). The additional agency staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and behavioral support.

Limitations/Caps
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 336 units/336 hours per member's annual IPP year.
- May be provided concurrently with Service Coordination, Therapeutic Consultant, BSP Transportation and up to 2 hours of LPN nursing services per day.
- Person-Centered Supports, Facility-Based Day Habilitation, LPN when provided more than 2 hours a day, Respite and Supported Employment services may not be provided concurrently with this service.
- This service is not intended for use as emergency response for ongoing behavioral challenges.
- The agency staff to member ratio is 2:1.
- Agency staff providing Crisis services may not be an individual who lives in the member's own or family residence.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 336 units/336 hours per member's annual IPP year.
- May be provided concurrently with Service Coordination, Therapeutic Consultant, BSP Transportation and up to 2 hours of LPN nursing or RN nursing services per day.
- Person-Centered Supports, Facility-Based Day Habilitation, LPN when provided more than 2 hours a day, Respite and Supported Employment services may not be provided concurrently with this service.
- This service is not intended for use as emergency response for ongoing behavioral challenges.
- The agency staff to member ratio is 2:1.

- Agency staff providing Crisis services may not be an individual who lives in the member's own or family residence.

513.9.1.5.1 Environmental Accessibility Adaptations: Home: Traditional Option, Limitations/Caps:

Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- EAA-Home is not intended to replace the member's, member's family or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing and electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation. (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences must be portable.
- $1000 available per member's annual IPP year in combination with Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.

New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- EAA-Home is not intended to replace the member's, member's family or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing and electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation. (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences must be portable.
- $1000 available per member's annual IPP year in combination with Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.

- The service coordination agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.9.1.5.2 Environmental Accessibility Adaptations: Vehicle: Traditional Option, Limitations/Caps:

Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- $1000 available per member's annual IPP year in combination with Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance and repairs of a vehicle except upkeep and maintenance of the modifications.

New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- $1000 available per member's annual IPP year in combination with Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance and repairs of a vehicle except upkeep and maintenance of the modifications.
- The service coordination agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.9.1.6 Facility-Based Day Habilitation: Traditional Option

Definition of Service:
Old Policy:
Facility-Based Day Habilitation is a structured program that use meaningful and productive activities designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. The services must be based on assessment, be person-

centered/goal oriented, and be meaningful/productive activities that are guided by the member's strengths, needs, wishes, desires, and goals.

Facility-Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the member. Activities must consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant or BSP (if applicable).

Facility-Based Day Habilitation activities must be based at the licensed site, but the member may access community services and activities from the licensed site.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Facility-Based Day Habilitation Program services include, but are not limited to:

- Development of self-care skills;
- Use of community services and businesses;
- Emergency skills training;
- Mobility skills training;
- Nutritional skills training;
- Social skills training;
- Communication and speech instruction (prescribed by a Speech Language Pathologist ;)
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
- Interpersonal skills instruction;
- Functional academic training such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, voting training;
- Self-administration of medication training;
- Independent living skills training;
- Training the individual to follow directions and carry out assigned duties;
- Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site;
- Assistance to adjust to the production and performance standards of the workplace;
- Compliance training in workplace rules or procedures;
- Compliance with attendance to work activity training;
- Assistance with workplace problem solving; and
- Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas.).

Facility-based Day Habilitation staff may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO and IDT meetings if requested by the member or their legal representative.

New Policy:
Facility-Based Day Habilitation is a structured program that use meaningful and productive activities designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. The services must be provided by awake and alert staff and based on assessment, be person-centered/goal oriented, and be meaningful/productive activities that are guided by the member's strengths, needs, wishes, desires, and goals.

Facility-Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the member. Activities must consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant or BSP (if applicable).

Facility-Based Day Habilitation activities must be based at the licensed site, but the member may access community services and activities from the licensed site.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Facility-Based Day Habilitation Program services include, but are not limited to:

- Development of self-care skills;
- Use of community services and businesses;
- Emergency skills training;
- Mobility skills training;
- Nutritional skills training;
- Social skills training;
- Communication and speech instruction (prescribed by a Speech Language Pathologist ;)
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
- Interpersonal skills instruction;
- Functional academic training such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, voting training;
- Self-administration of medication training;
- Independent living skills training;
- Training the individual to follow directions and carry out assigned duties;
- Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site;
- Assistance to adjust to the production and performance standards of the workplace;
- Compliance training in workplace rules or procedures;
- Compliance with attendance to work activity training;
- Assistance with workplace problem solving; and
- Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas).

- Facility-based Day Habilitation staff may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO and IDT meetings if requested by the member or their legal representative.

Limitations/Caps
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of Facility-Based Day Habilitation cannot exceed 6.240 units/1560 hours (Average 6 hours/day) per member's IPP year. When the member accesses other direct care services, these units are counted toward the daily cap of all direct care services listed in the Person-Centered Supports sections in the Traditional Option., excluding Respite.
- This service may not be billed concurrently with any other direct care services.
- Up to 48 units/12hours of Facility Day Habilitation services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or Registered Nurses (RN) may bill for providing training to facility-based day habilitation staff.
- Agency staff to member ratios for this service are 1:1-2, 1:3-4, and 1:5-6.
- Agency staff providing Facility-Based Day Habilitation services may not be an individual who lives in the member's home.

New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of Facility-Based Day Habilitation cannot exceed 6.240 units/1560 hours (Average 6 hours/day) per member's IPP year. When the member accesses other direct care services, these units are counted toward the daily cap of all direct care services listed in the Person-Centered Supports sections in the Traditional Option., excluding Respite.
- This service may not be billed concurrently with any other direct care services.
- Up to 48 units/12hours of Facility Day Habilitation services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or Registered Nurses (RN) may bill for providing training to facility-based day habilitation staff.
- Agency staff to member ratios for this service are 1:1-2, 1:3-4, and 1:5-6.

- Agency staff providing Facility-Based Day Habilitation services may not be an individual who lives in the member's home.
- Only members 18 years of age and over may access this service.

513.9.1.8.1 Person-Centered Support: Agency: Traditional Option

Definition of Service:
Old Policy:
Person-Centered Support (PCS) services consist of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS services may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

Agency staff administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

PCS services may include member specific training. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO is permitted if requested by the member or their legal representative.

Definition of Service:
New Policy:
Person-Centered Support (PCS) provided by awake and alert staff services consist of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS services may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

Agency staff administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

PCS services may include member specific training. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO is permitted if requested by the member or their legal representative.

PCS staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of member are not compromised.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Agency services cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child. The IDT must make every effort to meet the member's assessed needs through natural supports.
- PCS: Agency may not substitute for federally mandated educational services.
- Agency staff providing PCS: Agency services may not be any individual who lives in the member's home.
- Up to 48 units/12hours of PCS: Agency services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS staff.
- The agency staff to member ratio codes for this service are 1:1, 1:2, 1:3 and 1:4.
- 1:1 and 1:2 are the only codes available in the member's family residence and in Specialized Family Care Homes.
- This service may not be billed concurrently with any other direct care service.

- 11,680 units/2920 hours (based upon average of 8 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available under the Traditional Option excluding Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services available under the Traditional Option excluding Respite.
- 35,040 units/8760 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings. This is in combination with all direct care services available under the Traditional Option.

PCS: Agency is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.

PCS: Agency is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Agency services cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child. The IDT must make every effort to meet the member's assessed needs through natural supports.
- PCS: Agency may not substitute for federally mandated educational services.
- Agency staff providing PCS: Agency services may not be any individual who lives in the member's home.
- Up to 48 units/12hours of PCS: Agency services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS staff.
- The agency staff to member ratio codes for this service are 1:1, 1:2, 1:3 and 1:4.
- 1:1 and 1:2 are the only codes available in the member's family residence and in Specialized Family Care Homes.
- This service may not be billed concurrently with any other direct care service.
- 11,680 units/2920 hours (based upon average of 8 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible

to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.

- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- 35,712 units/8928 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings, to include training. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (when LPN units exceed 2,920 units), PCS: Agency with Choice and PCS: Personal Options.
- PCS: Agency is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.
- PCS: Agency is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

513.9.1.8.2 Person-Centered Support: Family: Traditional Option

Definition of Service
Old Policy:
Person-Centered Support (PCS): Family consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community. PCS: Family may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS: Family services must be assessment based and outlined on the member's IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

PCS: Family services may include member specific training, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

Agency Staff providing PCS: Family must be a family member living in the member's home or a certified Specialized Family Care Provider providing this service in a certified Specialized Family Care Home. PCS: Family may not be provided to a member by the member's spouse.

Definition of Service:
New Policy:
Person-Centered Support (PCS): Family is provided by awake and alert staff and consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community. PCS: Family may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS: Family services must be assessment based and outlined on the member's IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

PCS: Family services may include member specific training, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

Agency Staff providing PCS: Family must be a family member living in the member's home or a certified Specialized Family Care Provider providing this service in a certified Specialized Family Care Home. PCS: Family may not be provided to a member by the member's spouse.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Family cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child.
- This service may not be provided by the member's spouse.
- PCS: Family may not substitute for federally mandated educational services.
- The amount of PCS: Family provided must be identified on the member's IPP.
- Up to 48 units/12hours of Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS: Family agency staff.
- Agency staff to member ratio codes for PCS: Family are 1:1 and 1:2.
- This service may not be billed concurrently with any other direct care service.
- 11,680 units/2920 hours (based upon average of 8 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available under the Traditional Option excluding Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct services available under the Traditional Option excluding Respite.

PCS: Family is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.

PCS: Family is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Family cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child.
- This service may not be provided by the member's spouse.
- PCS: Family may not substitute for federally mandated educational services.
- The amount of PCS: Family provided must be identified on the member's IPP.

- Up to 48 units/12hours of Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS: Family agency staff.
- Agency staff to member ratio codes for PCS: Family are 1:1 and 1:2.
- This service may not be billed concurrently with any other direct care service.
- 11,680 units/2920 hours (based upon average of 8 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.

PCS: Family is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.

PCS: Family is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

513.9.1.10.1 Respite: Agency: Traditional Option

Definition of Service
Old Policy:
Respite: Agency services are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Services consist of temporary care services for an individual who cannot provide for all of their own needs.

Respite Agency services may be used to:

- Allow the primary care-giver to have planned time from the caretaker role;
- Provide assistance to the primary care-giver in crisis and emergency situations; and

- Ensure the physical and/or emotional well-being of the primary care-giver by temporarily relieving them of the responsibility of providing care.

Agency staff providing Respite: Agency services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by ASO if requested by the member or their legal representative.

Definition of Service:
New Policy:
Respite: Agency services provided by awake and alert staff are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Services consist of temporary care services for an individual who cannot provide for all of their own needs.

Respite Agency services may be used to:

- Allow the primary care-giver to have planned time from the caretaker role;
- Provide assistance to the primary care-giver in crisis and emergency situations; and
- Ensure the physical and/or emotional well-being of the primary care-giver by temporarily relieving them of the responsibility of providing care.
- Support the member while the primary care-giver works outside the home.

Agency staff providing Respite: Agency services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by ASO if requested by the member or their legal representative.

Respite Agency staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of member are not compromised.

Limitations/Caps:
Old Policy:
- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Respite: Agency services are not available to members living in ISS or licensed group home settings.
- Respite: Agency services are not to replace natural supports available to the member to include non-custodial parent;

- Respite: Agency services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite: Agency is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to staff providing Respite: Agency Services.
- Respite: Agency Services may not be provided in an ICF/MR facility,
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year.
- This service may not be billed concurrently with any other direct care service.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Respite: Agency services are not available to members living in ISS or licensed group home settings.
- Respite: Agency services are not to replace natural supports (which includes a non-custodial parent) available to the member.
- Respite: Agency services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite: Agency is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to staff providing Respite: Agency Services.
- Respite: Agency Services may not be provided in an ICF/IID facility,
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year. This is in combination with all other respite services:

Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite.

- This service may not be billed concurrently with any other direct care service.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.

513.9.1.10.2 Respite: Crisis Site: Traditional Option

Definition of Service:
Old Policy:
Respite: Crisis Site Services are specifically designed to provide temporary substitute care for an individual who is in need of an alternative residential setting due to behavioral needs or lack of supports. Training programs on the member's IPP may be provided by respite direct care staff.

The services are to be utilized only in licensed crisis sites and used on a short-term basis not to exceed a maximum stay of 30 days per admission without prior authorization from the ASO.

Respite: Crisis Site services usually occur after a critical juncture in treatment and must be approved by the IDT. If Respite: Crisis Site services are utilized due to a member's emergent need there must be a plan to transition the member back into the community developed at the time of admission by the service coordinator and the length of stay in the Crisis Respite site may not exceed 30 days per admission,

Service Coordinators must review the Crisis Respite Directory on the BHHF website and call the contact person listed in the directory or follow after-hours procedures available at on the Bureau for Behavioral Health and Health facilities website: www.wvdhhr.org/bhhf.

The referral packet to the Respite: Crisis Site must include the IPP that identifies the services to be provided and assessments as appropriate.

Definition of Service:
New Policy:
Respite: Crisis Site Services provided by awake and alert staff are specifically designed to provide temporary substitute care for an individual who is in need of an alternative residential setting due to behavioral needs or lack of supports. Training programs on the member's IPP may be provided by respite direct care staff.

The services are to be utilized only in licensed crisis sites and used on a short-term basis not to exceed a maximum stay of 30 days per admission without prior authorization from the ASO.

Respite: Crisis Site services usually occur after a critical juncture in treatment and must be approved by the IDT. If Respite: Crisis Site services are utilized due to a member's emergent need there must be a plan to transition the member back into the community developed at the time of admission by the service coordinator and the length of stay in the Crisis Respite site may not exceed 30 days per admission,

Service Coordinators must review the Crisis Respite Directory on the BHHF website and call the contact person listed in the directory or follow after-hours procedures available at on the Bureau for Behavioral Health and Health facilities website: http://www.dhhr.wv.gov/bhhf/resources/Pages/DevelopmentalDisabilitiesCrisis.aspx.

The referral packet to the Respite: Crisis Site must include the IPP that identifies the services to be provided and assessments as appropriate.

Crisis Respite Agency staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of member are not compromised.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year.
- PCS cannot be billed in a Crisis Respite Site.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- This service may not be billed concurrently with any other direct care service.
- Respite: Crisis Site must be prior authorized by the ASO. Under emergent circumstances which place the member's or others' health and safety at risk, Respite: Crisis Site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

Limitations/Caps:
New Policy

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite.

- PCS cannot be billed in a Crisis Respite Site.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- This service may not be billed concurrently with any other direct care service.
- Respite: Crisis Site must be prior authorized by the ASO. Under emergent circumstances which place the member's or others' health and safety at risk, Respite: Crisis Site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

513.9.1.11 Service Coordination: Traditional Option, Definition of Service

Old Policy:
Service Coordination services establish, along with the member, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a member is utilized in making meaningful choices with regard to their life and their inclusion in the community.

Once the member/legal representative has chosen a Service Coordination provider from the available I/DD Waiver providers, the agency assigns a Service Coordinator to the member. The member/legal representative may request the assignment of a specific Service Coordinator (SC) and when possible the agency honors the request. The member/legal representative may choose to transfer to a different SC provider at any time and for any reason.

The Service Coordinator must, at a minimum, perform the following activities listed below.

- Assist the member and/or legal representative with re-determination of financial eligibility as required at the DHHR office in the county where the member lives.
- Verify financial eligibility during monthly home visits.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a member is found to be ineligible for I/DD Waiver Services during annual eligibility or financial redetermination.
- Provide oral and written information about the I/DD Waiver provider agency's rights and grievance procedures for members served by the agency.
- Assist with procurement of all services that are appropriate and necessary for each member within and beyond the scope of the I/DD Waiver Program.
- Inform families or custodians of children less than 3 years of age about the availability of Birth to Three Services.
- Act as an advocate for the member. The I/DD Waiver Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L.99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for

specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.

- Provide education, linkage and referral to community resources,
- Promote a valuable and meaningful social role for the member in the community while recognizing the member's unique cultural and personal value system.
- Interface with the ASO on behalf of the member in regard to the assessment process, purchase of services and budget process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs.
- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Notify IDT members 30 days in advance of meeting.
- Support the member as necessary to convene and conduct IDT meetings.
- Coordinate the development of IPPs at least annually. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral and service objectives of the IPP.
- Disseminate copies of the IPP to the IDT members and Participant-Directed service Option providers (if applicable) within 14 days of the IDT meeting.
- Monitor to ensure that the member's health and safety needs are addressed.
- Comply with reporting requirements of the WV IMS for members on their caseload.
- Personally meet monthly with the member and their paid or natural supports who are present with the member the time of the visit at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented and that the member continues to be financially eligible. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-I/DD-03).
- Personally meet at least every other month with the member and their support staff at the member's facility-based day program (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-I/DD-03).
- Provide planning and coordination before, during and after crises, including notifying the ASO if a member is admitted to a crisis site or state institution.

- Process Freedom of Choice forms (WV-BMS-I/DD-2) in the CareConnection® within 2 business days any time a member requests a change of service delivery options.
- Coordinate Transfer/Discharge meetings to ensure the linkage to a new service provider or service delivery option and access to services when transferring services from 1 provider agency to another or to another type of service delivery option. Coordination efforts must continue until the transfer of services is finalized.
- Travel as necessary to complete Service Coordination activities related to the IPP.
- Provide information and assistance regarding participant-directed services options during annual IPP meetings and upon request by the member or legal representative.
- Inform the member of their rights at least annually.
- Attend and participate in the annual functional assessment for eligibility conducted by ASO.
- Present member's proposed restrictive measures to the I/DD Waiver provider agency's Human Rights Committee (HRC) if no other professional is presenting the same information.
- Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly and reviewed at least annually by the HRC and by the IDT at every IDT meeting.

New Policy:
Service Coordination services establish, along with the member, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a member is utilized in making meaningful choices with regard to their life and their inclusion in the community.

Once the member/legal representative has chosen a Service Coordination provider from the available I/DD Waiver providers, the agency assigns a Service Coordinator to the member. The member/legal representative may request the assignment of a specific Service Coordinator (SC) and when possible the agency honors the request. The member/legal representative may choose to transfer to a different SC provider at any time and for any reason.

The Service Coordinator must, at a minimum, perform the following activities listed below.

- Assist the member and/or legal representative with re-determination of financial eligibility as required at the DHHR office in the county where the member lives.
- Verify financial eligibility during monthly home visits.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a member is found to be ineligible for I/DD Waiver Services during annual eligibility or financial redetermination.
- Provide oral and written information about the I/DD Waiver provider agency's rights and grievance procedures for members served by the agency.

- Assist with procurement of all services that are appropriate and necessary for each member within and beyond the scope of the I/DD Waiver Program including annual medical and other evaluations as applicable to the member.
- Inform families or custodians of children less than 3 years of age about the availability of Birth to Three Services.
- Act as an advocate for the member. The I/DD Waiver Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L.99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.
- Provide education, linkage and referral to community resources,
- Promote a valuable and meaningful social role for the member in the community while recognizing the member's unique cultural and personal value system.
- Interface with the ASO on behalf of the member in regard to the assessment process, purchase of services and budget process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs.
- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Notify IDT members 30 days in advance of meeting.
- Support the member as necessary to convene and conduct IDT meetings.
- Coordinate the development of IPPs at least annually. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral and service objectives of the IPP.
- Disseminate copies of all IPPs to the IDT members and Participant-Directed service Option providers (if applicable) within 14 days of the IDT meeting.
- Upload the ISP, the Demographic/cover sheet and signature page into the CareConnection® within 14 days of the IDT meeting.
- Upload into the CareConnection® any additional documentation requested by BMS or the ASO.
- Disseminate copies of the budget sheet from the I/DD Waiver CareConnection® website, once finalized.
- Monitor to ensure that the member's health and safety needs are addressed.
- Comply with reporting requirements of the WV IMS for members on their caseload.

- Personally meet monthly with the member and their paid or natural supports who are present with the member the time of the visit at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented and that the member continues to be financially eligible. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-I/DD-03).
- Personally meet at least every other month with the member and their support staff at the member's facility-based day program (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-I/DD-03).
- Provide planning and coordination before, during and after crises, including notifying the ASO if a member is admitted to a crisis site or state institution.
- Process Freedom of Choice forms (WV-BMS-I/DD-2) in the CareConnection® within 2 business days any time a member requests a change of service delivery options.
- Coordinate Transfer/Discharge meetings to ensure the linkage to a new service provider or service delivery option and access to services when transferring services from 1provider agency to another or to another type of service delivery option. Coordination efforts must continue until the transfer of services is finalized.
- Travel as necessary to complete Service Coordination activities related to the IPP.
- Provide information and assistance regarding participant-directed services options during annual IPP meetings and upon request by the member or legal representative.
- Inform the member of their rights at least annually.
- Attend and participate in the annual functional assessment for eligibility conducted by ASO.
- Present member's proposed restrictive measures to the I/DD Waiver provider agency's Human Rights Committee (HRC) if no other professional is presenting the same information.
- Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly and reviewed at least annually by the HRC and by the IDT at every IDT meeting.
- May bill for attendance of and contribution to Futures Planning sessions, including PATHs and MAPs.

513.9.1.12.1 Skilled Nursing: Licensed Practical Nurse: Traditional Option

Definition of Service:
Old Policy:
Nursing services listed in the service plan are within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by a LPN under the supervision and monitoring of a RN actively licensed to practice in the State. Nursing services that must be provided by a LPN

include but are not limited to: (Note: If these services are provided by an RN then the LPN code must be billed for reimbursement)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);
- Reviewing and verifying physician orders are current, properly documented and communicated to direct care staff and others per I/DD Waiver provider policy;
- Direct nursing care including medication/treatment administration;
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Review scheduled medical appointments before occurrence and communicate this information to others per I/DD Waiver provider policy;
- Facilitate procurement of and monitoring of medical equipment;
- Keep emergency contact information updated and accurate;
- Bill for travel time between ISS, licensed group home and licensed day program settings for the purpose of passing medications.

If a member requires more than 2 hours per day of LPN service, the Request for Nursing Service (WV-BMS-I/DD-09) must be submitted to the ASO for prior authorization.

If the member receives 2 or more hours of skilled nursing services per day, then the LPN is responsible for providing direct care supports and training.

In ISS or licensed group homes, the total number of service units may exceed 24 hours per day when the LPN also passes medication.

The LPN may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO at the request of the member or their legal representative.

Definition of Service:
New Policy:
Nursing services listed in the service plan are within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by a LPN under the supervision and monitoring of a RN actively licensed to practice in the State. Nursing services that must be provided by an awake and alert LPN include but are not limited to: (Note: If these services are provided by an RN then the LPN code must be billed for reimbursement)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);

- Reviewing and verifying physician orders are current, properly documented and communicated to direct care staff and others per I/DD Waiver provider policy;
- Direct nursing care including medication/treatment administration;
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Review scheduled medical appointments before occurrence and communicate this information to others per I/DD Waiver provider policy;
- Facilitate procurement of and monitoring of medical equipment;
- Keep emergency contact information updated and accurate;
- Bill for travel time between ISS, licensed group home and licensed day program settings for the purpose of passing medications.
- Train members on individualized medical and health needs, such as wound-care, medically necessary diets, etc.

If a member requires more than 2 hours per day of LPN service, the Request for Nursing Service (WV-BMS-I/DD-09) must be submitted to the ASO for prior authorization.

If the member receives 2 or more hours of skilled nursing services per day, then the LPN is responsible for providing direct care supports and training.

In ISS or licensed group homes, the total number of service units may exceed 24 hours per day when the LPN also passes medication.

The LPN may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO at the request of the member or their legal representative.

In a 3-person home which requires a nurse 24 hours/day, staff may bill LPN 1:3, with no other staff 24 hours/day –or- bill LPN 1:1 plus an additional staff person billing direct supports 1:2. With this option, each member in the home could be considered for authorization for up to 8 hours of LPN 1:1 per day. If the LPN is working with a particular member (such as medication administration) he/she would bill LPN 1:1.

If an LPN is traveling to pass medications at an ISS, licensed group home or licensed facility-based day program, the LPN should bill 1:1 for 1 member during travel time. The time should be disseminated equally among all members receiving medication administration (i.e. bill for member A on day 1, bill for member B on day 2, etc.) so that the travel billing is fairly distributed across member purchase requests and will not disproportionately use 1 member's individualized budget over another's.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized budget.

- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of LPN services cannot exceed 11,680 units/2920 hours (Average 8 hours/day) per member's annual IPP year. When the member accesses other direct care services, these units are counted toward the cap listed in the Person-Centered Supports sections in the Traditional Option, excluding Respite
- This service may not be billed concurrently with any other direct care services.
- Agency staff to member ratio codes are 1:1, 1:2 and 1:3.
- Agency staff providing Skilled Nursing LPN services may not be an individual who lives in the member's home.
- LPN services may not be billed for completing administrative activities including these listed below.
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the I/DD Waiver provider but not the I/DD Waiver manual.
    - Waiting at a physician's office.
    - Conducting group training on general medical topics.
    - Orientation training that is not member-specific.
    - Reviewing incident reports.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of LPN services cannot exceed 11,680 units/2920 hours (Average 8 hours/day) per member's annual IPP year or the monetary equivalent of 8 hours of 1:1 LPN service when alternate LPN service ratios are used.
- When the member accesses other direct care services, any LPN units in excess of 2920 are counted toward the cap listed in the Person-Centered Supports sections in the Traditional Option, excluding Respite
- This service may not be billed concurrently with any other direct care services.
- Agency staff to member ratio codes are 1:1, 1:2 and 1:3.
- Agency staff providing Skilled Nursing LPN services may not be an individual who lives in the member's home.
- LPN services may not be billed for completing administrative activities including these listed below.
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the I/DD Waiver provider but not the I/DD Waiver manual.
    - Waiting at a physician's office.
    - Conducting group training on general medical topics.

- Orientation training that is not member-specific.
- Reviewing incident reports.

513.9.1.12.1.2 Skilled Nursing: Licensed Registered Nurse: Traditional Option, Definition of Service

Old Policy:
RN Skilled Nursing services listed in the service plan are within the scope of the West Virginia Nurse Practice Act, ordered by a physician and are provided by a licensed RN licensed to practice in the State. RN Skilled Nursing services are services which only a licensed RN can perform. The service must be provided by a RN under the direction of a physician. The RN may perform clinical supervision of LPN and AMAP staff.

RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of a LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code.

The RN may also bill for training of staff in the member's home, ISS, licensed group and licensed day program settings on the member's specific medical needs and related interventions as recommended by the member's treatment team.

The RN may travel between ISS, licensed group home and licensed facility day program settings in order to pass medications.

The RN may attend and participate in the IPP and the annual assessment of functioning for eligibility conducted by ASO based upon the member or their legal representative's request.

Direct care services provided by the RN must be billed utilizing the appropriate direct care service code.

New Policy:
RN Skilled Nursing services listed in the service plan are within the scope of the West Virginia Nurse Practice Act, ordered by a physician and are provided by a licensed RN licensed to practice in the State. RN Skilled Nursing services are services which only a licensed RN can perform. The service must be provided by a RN under the direction of a physician. The RN may perform clinical supervision of LPN and AMAP staff.

RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of a LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code.

The RN may also bill for training of staff in the member's home, ISS, licensed group and licensed day program settings on the member's specific medical needs and related interventions as recommended by the member's treatment team.

The RN may travel between ISS, licensed group home and licensed facility day program settings in order to pass medications.

The RN may attend and participate in the IPP and the annual assessment of functioning for eligibility conducted by ASO based upon the member or their legal representative's request.

Direct care services provided by the RN must be billed utilizing the appropriate direct care service code.

The RN may bill to complete assessments if a member's medical needs warrant an individualized assessment.

The RN must complete a summary of services provided if necessitated by a change in the member's medical needs, such as Emergency Room visits, medication changes, diagnostic changes, new treatments recommended by physician, etc.

The RN may bill to consult with LPNs who are providing direct care when an urgent, member-specific medical need arises.

513.9.1.12.2.1 Skilled Nursing: Licensed Registered Nurse: Individual Program Planning: Traditional Option, Definition of Service

Old Policy:
This is a service that allows the RN to attend a member's IDT meeting to present assessments or evaluations completed for the purpose of integrating recommendations, training goals and intervention strategies into the member's IPP.

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The RN participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

New Policy:
This is a service that allows the RN to attend a member's IDT meeting in person or by video-conferencing to present assessments or evaluations completed for the purpose of integrating recommendations, training goals and intervention strategies into the member's IPP.

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The RN participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

513.9.1.14 Supported Employment: Traditional Option, Definition of Service:

Old Policy:
Supported Employment Services are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing support based upon the member's level of need.

Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of the member's on-the-job work activities);
- Job development and placement for a specific waiver member with the member present;
- On-the-job training in work and work-related skills;
- Accommodation of work performance task;
- Supervision and monitoring by a job coach;
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors;
- Retraining as jobs change or job tasks change;
- Training in skills essential to obtain and retain employment, such as the effective use of community resources;
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment.

Supported Employment Services must be supervised by a Therapeutic Consultant. In addition to the standard training requirements, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction.

Persons providing supported employment services may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.

Documentation is maintained in the file of each member receiving this service that a referral was made to a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) before this service was provided.

New Policy:
Supported Employment Services provided by awake and alert staff are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing support based upon the member's level of need.

Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of the member's on-the-job work activities);
- Job development and placement for a specific waiver member with the member present;
- On-the-job training in work and work-related skills;
- Accommodation of work performance task;
- Supervision and monitoring by a job coach;
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors;
- Retraining as jobs change or job tasks change;
- Training in skills essential to obtain and retain employment, such as the effective use of community resources;
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment.

Supported Employment Services must be supervised by a Therapeutic Consultant. In addition to the standard training requirements, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction.

Persons providing supported employment services may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.

Documentation is maintained in the file of each member receiving this service that a referral was made to a program funded under section 110 of the Rehabilitation Act of 1973 or the

Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) before this service was provided.

513.9.1.15 Therapeutic Consultant: Traditional Option

Definition of Service:
Old Policy:
Therapeutic Consultant develops training plans and provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., person-centered support workers, facility day habilitation providers and supportive employment providers). Also, the Therapeutic consultant provides training for respite workers (if applicable for "respite-relevant" training objectives or health or safety training objectives only). This service is provided to members with the assessed need for adaptive skills training. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. This monitoring is performed and documented at minimum on a monthly basis. The Therapeutic Consultant observes the individual prior to developing a training plan. The Therapeutic Consultant follows up once the plan has been implemented to observe progress and revise the plan, as needed.

The Therapeutic Consultant may perform the following functions:

- Develops task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual;
- Evaluates environment(s) for implementation of the plan which creates the optimal environment for learning;
- Assists members in selecting the most suitable environment for their learning needs;
- Trains primary direct workers (i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines);
- Assesses, evaluates and monitors the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training;
- Collects and evaluates data and completes a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan;
- Provides direct care services when needed and bills the appropriate direct care service code;
- Attends and participates in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO when requested by the member or their legal representative; and
- Presents proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.

Definition of Service:
New Policy:
Therapeutic Consultant develops training plans and provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., person-centered support workers, facility day habilitation providers and supportive employment providers). Also, the Therapeutic consultant provides training for respite workers (if applicable for —respite-relevant training objectives or health or safety training objectives only). This service is provided to members with the assessed need for adaptive skills training. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. This monitoring is performed and documented at minimum on a monthly basis. The Therapeutic Consultant observes the individual prior to developing a training plan. The Therapeutic Consultant follows up once the plan has been implemented to observe progress and revise the plan, as needed.

The Therapeutic Consultant may perform the following functions:

- Develops task analysis portion of the IHP/ISP and person specific strategy or methodology for development of habilitation plans.
- May develop Interactive Guidelines or Behavior Protocols for individuals who do not meet the criteria for having a Behavior Support Plan developed by a Behavior Support Professional.
- Evaluates environment(s) for implementation of the ISP which creates the optimal environment for habilitation plans.
- Assists members in selecting the most suitable environment for their habilitation needs.
- Trains primary direct workers (i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers) in person-specific aspects habilitation plans or guidelines.
- Provides direct care services when needed and bills the appropriate direct care service code.
- Attends and participates in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO when requested by the member or their legal representative.
- Presents proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.
- May bill for developing/updating the behavioral crisis section of the member's crisis plan if a Behavior Support Professional is not performing this function.
- May verify data compiled by all Person-Centered Support staff for accuracy.
- May bill for attendance of and contribution to Futures Planning sessions, including PATHs and MAPs.

The Therapeutic Consultant may also perform the following functions if they have met the training requirements as a BSP as identified in section 513.9.1.1:

- Train direct care workers in all aspects of PBSPs implementation(i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers).
- Assess, evaluate and monitor the effectiveness of PBSPs.
- Collect and evaluate data and complete a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan or to generate a Positive Behavior Support plan.
- Collaborate with Therapeutic Consultant(s) from other agency(s) to ensure that positive behavior support strategies are consistently applied across all environments.
- Facilitate person-centered planning as a component of the Positive Behavior Support plan.
- Present proposed restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information regarding the member.
- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.
- May provide on-site training to the support staff in behavior/crisis situations.
- May bill for phone consultation during behavioral crisis situations.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with BSP.
- Job Placement activities are limited to 20 units/5 hours per quarter.
- Agency staff providing Therapeutic Consultant services may not be an individual who lives in the member's home.
- Direct care services provided by the TC must be billed utilizing the appropriate direct care service code.
- TC services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/MR or another WV waiver program for planning purposes.
- TC services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).

- Filing, collating, writing notes to staff.
- Phone calls to staff.
- Observing staff while training individuals without a clinical reason.
- Administering assessments not warranted or requested by the member.
- Making plans for a parent for a weekend visit.
- Working in the home with providing direct care staff coverage.
- Sitting in the waiting room for a doctor or medical appointment.
- Conducting a home visit routinely and without justification–only service coordinators are required to make monthly home visits.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with BSP.
- Job Placement activities are limited to 20 units/5 hours per quarter.
- Agency staff providing Therapeutic Consultant services may not be an individual who lives in the member's home.
- Direct care services provided by the TC must be billed utilizing the appropriate direct care service code.
- TC services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- TC services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
    - Filing, collating, writing notes to staff.
    - Phone calls to staff.
    - Observing staff while training individuals without a clinical reason.
    - Administering assessments not warranted or requested by the member.
    - Making plans for a parent for a weekend visit.
    - Working in the home with providing direct care staff coverage.
    - Sitting in the waiting room for a doctor or medical appointment.
    - Conducting a home visit routinely and without justification–only service coordinators are required to make monthly home visits.
    - TC services cannot be billed for traveling to complete TC services.

Agency Staff Qualifications:
Old Policy:
All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to 1 of the following requirements:

- Four year degree in a human service field and 1 or more years of professional experience in the I/DD field; or
- Four year degree in a human service field and less than 1 year of professional experience in the I/DD field. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of habilitation programming for 6 months. This must be verified by supervisory documentation once per month; or
- Four year degree in a non-human service field and 1 year professional experience in the I/DD field. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of habilitation programming for 6 months. This must be verified by supervisory documentation once per month).

Agency Staff Qualifications:
New Policy:
All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to 1 of the following requirements:

- Four year degree in a human service field and 1 or more years of professional experience in the I/DD field and completion of the facilitated 3 hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network; or
- Four year degree in a human service field and less than 1 year of professional experience in the I/DD field and completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of habilitation programming for six months. This must be verified by supervisory documentation once per month; or
- Four year degree in a non-human service field and 1 year professional experience in the I/DD field completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of habilitation programming for 6 months. This must be verified by supervisory documentation once per month).

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

513.9.1.16.1 Transportation: Miles: Traditional Option, Limitations/Caps

Old Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 9,600 miles per member's annual IPP year (based on average of 800 miles per month).
- Member must be present in vehicle if mileage is billed.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

New Policy:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 9,600 miles per member's annual IPP year (based on average of 800 miles per month).
- Member must be present in vehicle if mileage is billed. If more than 1 member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

513.9.1.16.2 Transportation: Trips: Traditional Option, Definition of Service:

Old Policy:

Transportation services are provided to the I/DD Waiver member in the I/DD Waiver provider's mini-van or mini-bus for trips to and from the member's home, licensed Facility-based Day Habilitation Program or Supported Employment site or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

The agency mini-bus or mini-van must have proof of current vehicle insurance and registration inside the vehicle in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections.

Agency passenger mini-bus or mini-van must have had the original capacity to transport more than 7 passengers but less than 16 passengers.

New Policy:
Transportation services are provided to the I/DD Waiver member in the I/DD Waiver provider's mini-van or mini-bus for trips to and from the member's home, licensed Facility-based Day Habilitation Program or Supported Employment site or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

The agency mini-bus or mini-van must have proof of current vehicle insurance and registration inside the vehicle in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections.

Agency passenger mini-bus or mini-van must have had the original capacity to transport more than 6 passengers but less than 16 passengers.

513.9.1 Participant-Directed Services

Old Policy:
This option provides each eligible member with the opportunity to exercise choice and control over the participant-directed services they receive. The participant-directed services which members may self-direct are:

- Person-Centered Support Services
- Respite
- Transportation
- Participant-directed Goods and Services

Two Financial Management Service (FMS) models are available to members to support their use of participant-directed services. These are the Agency with Choice (AwC) FMS Model and the *Personal Options* FMS Model.

Under the AwC FMS model, the member's chosen I/DD Waiver provider is the Common Law Employer of the Agency Staff employed to provide services to the member. The AwC I/DD Waiver provider is responsible for all payroll functions, including determining wages and benefits to the Agency Staff. The member is a Managing Employer who shares in the responsibility of hiring, training, scheduling, supervising and dismissing the member's Agency Staff. The member may appoint a representative to assist with these functions. The relationship between the AwC I/DD Waiver provider and the member or their representative (when applicable) is that of a Co-Employer.

Under the AwC FMS model, no Agency Staff's hourly wage may exceed the Medicaid rate minus all mandatory deductions.

Under the AwC FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

Under the *Personal Options* FMS Model, the member is the Common Law Employer of the Qualified Support Workers hired by the member. The *Personal Options* FMS acts as the fiscal/employer agent to the member and is responsible for managing the receipt and distribution of the member's participant-directed budget funds, processing and paying Qualified Support Workers' payroll and transportation reimbursement as well as payment of vendors' invoices for approved participant-directed goods and services. The *Personal Options* FMS also provides information and assistance to members, their representatives and employees as appropriate. The members and their representatives, if applicable, control the work being performed on the member's behalf by hiring, training, scheduling, supervising and dismissing the member's direct care workers. A member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

Under the *Personal Options* FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member, no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

The Traditional Service Option, which includes the full array of services, is still available to members who choose AwC or *Personal Options*, however the 4 services mentioned above may be participant-directed. The member who chooses to direct part or all of these services is required to purchase Service Coordination through the Traditional Service Option. Other services chosen by the member that are not part of the 4 participant-directed services also need to be purchased through the Traditional Service Option before any or all of the 4 participant-directed services may be purchased.

The Participant-Directed Service Option is available to every eligible I/DD Waiver member with the following exception: Members living in OHFLAC licensed residential settings are not eligible for Participant-Directed Services.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s).

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

The Agency with Choice participant-directed service option is described more fully in section 513.9.2.1. The *Personal Options* participant-directed service option is described more fully in Section 513.9.2.2.

New Policy:
This option provides each eligible member with the opportunity to exercise choice and control over the participant-directed services they receive. The participant-directed services which members may self-direct are:

- Person-Centered Support Services
- Respite
- Transportation
- Participant-directed Goods and Services

Two Financial Management Service (FMS) models are available to members to support their use of participant-directed services. These are the Agency with Choice (AwC) FMS Model and the *Personal Options* FMS Model.

Under the AwC FMS model, the member's chosen I/DD Waiver provider is the Common Law Employer of the Agency Staff employed to provide services to the member. The AwC I/DD Waiver provider is responsible for all payroll functions, including determining wages and benefits to the Agency Staff. The member is a Managing Employer who shares in the responsibility of hiring, training, scheduling, supervising and dismissing the member's Agency Staff. The member may appoint a representative to assist with these functions. The relationship between the AwC I/DD Waiver provider and the member or their representative (when applicable) is that of a Co-Employer.

A member's representative may not be a paid employee providing AwC I/DD Waiver services to the member.

Under the AwC FMS model, no Agency Staff's hourly wage may exceed the Medicaid rate minus all mandatory deductions.

Under the *Personal Options* FMS Model, the member is the Common Law Employer of the Qualified Support Workers hired by the member. The *Personal Options* FMS acts as the fiscal/employer agent to the member and is responsible for managing the receipt and distribution of the member's participant-directed budget funds, processing and paying Qualified Support Workers' payroll and transportation reimbursement as well as payment of vendors' invoices for approved participant-directed goods and services. The *Personal Options* FMS also provides information and assistance to members, their representatives and employees as appropriate. The members and their representatives, if applicable, control the work being performed on the member's behalf by hiring, training, scheduling, supervising and dismissing the member's direct care workers. A member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

A member's representative may not be a paid employee providing *Personal Options* I/DD Waiver services to the member.

The Traditional Service Option, which includes the full array of services, is still available to members who choose AwC or *Personal Options*, however the 4 services mentioned above may be participant-directed. The member who chooses to direct part or all of these services is required to purchase Service Coordination through the Traditional Service Option. Other services chosen by the member that are not part of the 4 participant-directed services also need to be purchased through the Traditional Service Option before any or all of the 4 participant-directed services may be purchased.

The maximum amount of a member's participant-directed budget is the equivalent monetary value of direct care services units, transportation and Participant-Directed Goods and Services units available, based on the age, residential setting, needs of the member and units available. When a member is accessing direct care services, whether in the Traditional or Self Directed Option, the total amount of direct care services in both Options must be added together and may not exceed the caps in both Options combined. Direct care services are defined as PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation, LPN, Agency with Choice PCS and *Personal Options* PCS. For example, an adult living at home with his/her parents and his/her IDT has determined the member needs 12 hours of direct care services, his/her budget supports this amount and the team has chosen to utilize 6 hours of Supported Employment and 2 hours of Person-Centered Support: Agency for a total of 8 hours of Traditional direct care services daily. This leaves the monetary equivalent of 4 hours of *Personal Options* PCS that is transferred into the member's self-directed budget. If this adult member has been determined to need 9600 units of transportation by his/her IDT, his/her budget supports this amount and the team chooses to utilize 6000 units of Traditional mileage for the member to be transported to and from their Supported Employment job site then this leaves the monetary equivalent of 3600 units of *Personal Options* Transportation that is transferred into the

member's self-directed budget. This member may also have been determined to need 2 hours of respite daily, his team and his budget supports this need and chooses to self-direct this entire service. The monetary equivalent of 2 hours of *Personal Options* Respite Services is transferred to the member's self-directed budget. If the member has been determined to need 1000 units of either EAA/Home or Vehicle and Participant-Directed Goods and Services combined, his team and his budget supports this need and he/she chooses to use 600 units of EAA/Home, then this leaves the monetary equivalent of 400 units of Participant-Directed Goods and Services that is transferred into the member's self-directed budget.

Once all of the equivalent monies are transferred into the member's self-directed budget, the member and/or their legal/non-legal representative, along with their Personal Options Resource Consultant, create a spending plan. At this time, the member and/or their legal/non-legal representative choose the types of services, the amount of services and the wages of the member's employees within the parameters of the entire self-directed budget.

The Participant-Directed Service Option is available to every eligible I/DD Waiver member with the following exception: Members living in OHFLAC licensed residential settings are not eligible for Participant-Directed Services.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s). The Service Coordinator must enter a request into the CareConnection® for these services.

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

The Agency with Choice participant-directed service option is described more fully in section 513.9.2.1. The *Personal Options* participant-directed service option is described more fully in Section 513.9.2.2.

513.9.2.1.1.2 Goods and Services: Participant-Directed Option: Agency with Choice Model

Definition of Service:
Old Policy:

Goods and Services are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment;
- The member does not have the funds to purchase the item or service or the item or service is not available through another source; and
- Goods and Services are purchased from the member's participant-directed budget.

Definition of Service:
New Policy:
Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

Goods and Services are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment.
- The member does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the Agency with Choice I/DD Waiver agency.
- Participant-directed Goods and Services are purchased from the participant-directed budget.
- The need for PDGS supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the Agency with Choice I/DD Waiver provider and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.
- The need must be documented on the Annual IPP unless it is a new need which must be documented on a Critical Juncture IPP.
    - NOTE: All services must be based on assessed need and within a member's individualized budget. If the need was documented on the Annual IPP, but not incorporated into the budget at that time and the member is over budget, then modifications of the services already purchased must occur before this authorization will be approved. If this is a new need, then it should be presented as a need to increase the budget based on a new need.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- To access Participant-directed Goods and Services the member must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – *Personal Options* Option.
- The following represents a non-inclusive list of non-permissible Goods and Services:
    - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services;
    - Goods, services and supports available through another source;
    - Goods, services or supports provided to or benefiting persons other than the individual member;
    - Room and board;
    - Personal items and services not related to the qualifying disability;
    - Gifts for workers/family/friends, payments to someone to serve as a representative,
    - Clothing, food and beverages;
    - Electronic entertainment equipment;
    - Utility payments;
    - Swimming pools and spas;
    - Costs associated with travel;
    - Household furnishings such as comforters, linens, drapes and furniture
    - Vehicle expenses including routine maintenance and repairs, insurance and gas money;
    - Medications, vitamins and herbal supplements;
    - Illegal drugs or alcohol;
    - Experimental or investigational treatments
    - Printers;
    - Monthly internet service;
    - Yard work;
    - Household cleaning supplies;
    - Home maintenance;
    - Pet care;
    - Respite services;
    - Spa services;
    - Education;

- Personal hygiene items;
- Day care; and
- Discretionary cash.

New Policy:
Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- To access Participant-directed Goods and Services the member must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – *Personal Options* Option.
- The AwC provider must not pay PDGS funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- The following represents a non-inclusive list of non-permissible Goods and Services:
  - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services;
  - Goods, services and supports available through another source;
  - Goods, services or supports provided to or benefiting persons other than the individual member;
  - Room and board;
  - Personal items and services not related to the qualifying disability;
  - Gifts for workers/family/friends, payments to someone to serve as a representative,
  - Clothing, food and beverages;
  - Electronic entertainment equipment;
  - Utility payments;
  - Swimming pools, hot tubs and spas;
  - Costs associated with travel;
  - Household furnishings such as comforters, linens, drapes and furniture
  - Vehicle expenses including routine maintenance and repairs, insurance and gas money;
  - Medications, vitamins and herbal supplements;
  - Illegal drugs or alcohol;
  - Experimental or investigational treatments
  - Printers;
  - Monthly internet service;

- Yard work;
- Household cleaning supplies;
- Home maintenance;
- Pet care;
- Respite services;
- Spa services;
- Education;
- Personal hygiene items;
- Day care; and
- Discretionary cash.

513.9.2.1.1.3 Person-Centered Support: Participant-Directed Option: Agency with Choice Model, Definition of Service:

Old Policy:
Person-Centered Support (PCS) consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS services must be assessment-based, outlined on the member's IPP and may not exceed the annual individualized participant-directed budget allocation.

Agency staff passing medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Agency Staff who provide Person-Centered Support may not be the member's spouse.

Agency staff providing PCS services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

New Policy:
AwC Person-Centered Support (PCS) provided by awake and alert staff consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS services must be assessment-based, outlined on the member's IPP and may not exceed the annual individualized participant-directed budget allocation.

Agency staff passing medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Agency Staff who provide Person-Centered Support may not be the member's spouse.

Agency staff providing PCS services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

PSC staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget. The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.

- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- This service may not be billed concurrently with any other direct care service.
- PCS cannot replace the routine care, and supervision which is expected to be provided by the parent of a minor member or by a Specialized Family Care Provider providing care to a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- The member's appointed representative may also be employed by the member paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed as stated below:
    - The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
    - The representative may not be paid for more than 40 hours per week for working for the member.
- PCS may not substitute for federally mandated educational services.
- PCS must be based upon assessed needs, address identified health and safety issues and be outlined in the member's IPP.
- PCS is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary change in environment.
- PCS is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

New Policy:

- The amount of service is limited by the member's individualized participant-directed budget. The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- AwC: Personal Options services are limited to the equivalent monetary value of 11,680 units/2920 hours (based upon average of 8 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920), AwC: PCS and

Personal Options: PCS excluding Traditional Respite, AwC Respite and *Personal Options* Respite.

- AwC: Personal Options services are limited to the equivalent monetary value of 17,520 units/4380 hours (based upon average of 12 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920 units), AwC : PCS and *Personal Options: PCS* excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- AwC: Personal Options services are limited to the monetary equivalent value of 35,712 units/8928 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings, to include training. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (when LPN units exceed 2,920 units) and PCS: Agency with Choice.
- This service may not be billed concurrently with any other direct care service.
- AwC: PCS cannot replace the routine care, and supervision which is expected to be provided by the parent of a minor member or by a Specialized Family Care Provider providing care to a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- The member's appointed representative may not be employed by the member for providing AwC I/DD Waiver services.
- AwC: PCS may not substitute for federally mandated educational services.
- AwC: PCS must be based upon assessed needs, address identified health and safety issues and be outlined in the member's IPP.
- AwC: PCS is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary change in environment.
- AwC: PCS is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of AwC: Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

513.9.2.1.1.4 Respite: Participant-Directed Option: Agency with Choice Model

Definition of Service:
Old Policy:
Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member.

The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the primary care-giver for temporary relief and to help prevent the breakdown of the primary care-giver due to the physical burden and emotional stress of providing continuous support and care to the member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite Care may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Respite staff.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

Definition of Service:
New Policy:
Respite Services provided by awake and alert staff are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the primary care-giver for temporary relief and to help prevent the breakdown of the primary care-giver due to the physical burden and emotional stress of providing continuous support and care to the member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite Care may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations

- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- Support the member while the primary care-giver works outside the home.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Respite staff.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.
- AwC PSC staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- AwC: Respite services are limited to the equivalent monetary value of 6,912 units/1728 hours (Average of 144 hours a month or 4.73 hours a day) AwC Respite per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite.

- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- AwC: Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite services may not be used to replace natural supports (which includes non-custodial parents) available to the member.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

513.9.2.1.5 Transportation: Miles – Participant-Directed Option: Agency with Choice Model, Limitations/Caps

Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

New Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed. If more than 1 member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.

- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

513.9.2.2 Participant-Directed Services: *Personal Options* Financial Management Service Option

Old Policy:
Another Financial Management Service (FMS) model available to members to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the member is the Common Law Employer of the Qualified Support Workers they hire directly. The member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

No Qualified Support Worker's hourly wage may exceed the Medicaid rate minus all mandatory deductions. All Qualified Support Worker's hired by the member must meet the requirements in Sections 513.9.2.1, 513.9.2.1.1 and 513.9.2.1.2.

Under the *Personal Options* FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

The *Personal Options* Fiscal/Employer Agent is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying Qualified Support Workers' payroll and reimbursements for transportation as well as vendors' invoices for approved participant-directed goods and services. The Personal Options Fiscal/Employer Agent is also required to provide information and assistance to members and their representatives as appropriate.

Under *Personal Options* FMS option, the member is the Common Law Employer of the Qualified Support Workers they hire directly.

New Policy:
Another Financial Management Service (FMS) model available to members to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the member is the Common Law Employer of the Qualified Support Workers they hire directly. The member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

A member's representative may not be a member's employee providing *Personal Options* I/DD Waiver services to the member.

No Qualified Support Worker's hourly wage may exceed the Medicaid rate minus all mandatory deductions. All Qualified Support Worker's hired by the member must meet the requirements in Sections 513.9.2.1, 513.9.2.1.1 and 513.9.2.1.2.

The *Personal Options* Fiscal/Employer Agent is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying Qualified Support Workers' payroll and reimbursements for transportation as well as vendors' invoices for approved participant-directed goods and services. The Personal Options Fiscal/Employer Agent is also required to provide information and assistance to members and their representatives as appropriate.

Under *Personal Options* FMS option, the member is the Common Law Employer of the Qualified Support Workers they hire directly.

513.9.2.2.1 Qualifications for Qualified Support Workers: Participant-Directed Option, *Personal Options,*

Old Policy:
All Qualified Support Workers must meet the qualifications listed below.

- Must be 18 years of age or over;
- Have the ability to perform the participant-specific required tasks;
- Have documentation of initial and renewal of training requirements:
    - Documented training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and annually thereafter;
    - Documented training on Emergency Care such as a Crisis Plan, Emergency Worker Back-up Plan and Emergency Disaster Plan upon hire and on an as needed basis thereafter;
    - Documented training on Infectious Disease Control upon hire and annually thereafter;

- Documented training on First Aid by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current First Aid certification upon hire and as indicated per expiration date on the AHA or ARC card;
- Documented training in Cardiopulmonary resuscitation (CPR) by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current CPR certification upon hire and as indicated per expiration date on the AHA or ARC card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the QSW);
- Documented training on Member-specific needs (including special needs, health and behavioral health needs) upon hire and on an as needed basis thereafter; and
- Documented training in Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation upon hire and annually thereafter.

- Qualifications must be verified initially upon hire as current and updated as necessary.
- The QSW may be responsible for the certain costs, i.e. CPR and First Aid certifications, CIB/NCIC background checks.

New Policy:

All Qualified Support Workers must meet the qualifications listed below. For all trainings but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires. These trainings include:

- Must be 18 years of age or over;
- Have the ability to perform the participant-specific required tasks;
- Have documentation of initial and renewal of training requirements:
  - Documented training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and annually thereafter;
  - Documented training on Emergency Care such as a Crisis Plan, Emergency Worker Back-up Plan and Emergency Disaster Plan upon hire and on an as needed basis thereafter;
  - Documented training on Infectious Disease Control upon hire and annually thereafter;
  - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current First Aid Certification upon hire and as indicated per expiration date on the card;
  - Documented training in Cardiopulmonary resuscitation (CPR) by an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current CPR certification upon hire and as indicated per expiration date

on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the QSW);
    - Documented training on Member-specific needs (including special needs, health and behavioral health needs) upon hire and on an as needed basis thereafter; and
    - Documented training in Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation upon hire and annually thereafter.
- Qualifications must be verified initially upon hire as current and updated as necessary.
- The QSW may be responsible for the certain costs, i.e. CPR and First Aid certifications, CIB/NCIC background checks.

513.9.2.2.1.2 Criminal Investigation Background (CIB) Check Requirements for Qualified Support Workers, Participant-Directed Option, *Personal Options,*

Old Policy:
All Qualified Support Workers having direct contact with members must, at a minimum, have a state level CIB check initiated upon hire which includes fingerprints. This check must be conducted initially and again every 3 years. If the current or prospective employee has lived out of state within the last 5 years, the Qualified Support Worker must have an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also initiated upon hire and every 3 years of employment. An individual cannot be employed by a member/Employer who is directing their own services if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;

- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be made available to the member before continuing the employment of the Qualified Support Worker.

New Policy:
All Qualified Support Workers having direct contact with members must, at a minimum, have a state level CIB check initiated upon hire which includes fingerprints. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the employer of record must require an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also upon hire and every 3 years of employment. The employer of record or Personal Options may choose to do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received, however, only on-line companies that check counties in which the applicant has lived and worked within the last 5 years may be utilized. An individual cannot be employed or continue to be employed by a member/Employer who is directing their own services if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;

- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be made available to the member before continuing the employment of the Qualified Support Worker.

513.9.2.2.1.3 Federal Office of the Inspector General (OIG) Medicaid Exclusion List Requirements for Qualified Support Workers, Participant-Directed Option, *Personal Options*

Old Policy:
The Office of the Inspector General (OIG) Medicaid Exclusion List must be checked by the *Personal Options* F/EA agent for every Qualified Support Worker who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/.

New Policy:
The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities must be checked by the Fiscal/Employer agent (Personal Options) for every employee who provides Medicaid services prior to employment and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

513.9.2.2.1.4 Protective Services Record Check for Qualified Support Workers, Participant-Directed Option, *Personal Options*

Old Policy: NEW SECTION

New Policy:
All Qualified Support Workers hired after July 1, 2012 having direct contact with members must have a WVDHHR Protective Services Record Checks. These must be initiated on each individual upon hire. The results must be considered by the Fiscal/Employer Agent (Personal Options) before continuing employment. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families, Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the Qualified Support Worker's personnel file.

513.9.2.3.1 Goods and Services: *Personal Options* Participant-Directed Option

Definition of Service:
Old Policy:
Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment.
- The member does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the *Personal Options* F/EA
- Participant-directed Goods and Services are purchased from the participant-directed budget.
- The need for PDGS supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the *Personal Options* F/EA and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.

Definition of Service:
New Policy:
Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment.
- The member does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the *Personal Options* F/EA
- Participant-directed Goods and Services are purchased from the participant-directed budget.
- The need for PDGS supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the *Personal Options* F/EA and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.
- The need must be documented on the Annual IPP unless it is a new need which must be documented on a Critical Juncture IPP.

- NOTE: All services must be based on assessed need and within a member's individualized budget. If the need was documented on the Annual IPP, but not incorporated into the budget at that time and the member is over budget, then modifications of the services already purchased must occur before this authorization will be approved. If this is a new need, then it should be presented as a need to increase the budget based on a new need.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – Agency with Choice.
- To access Participant-directed Goods and Services the member must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- The following represents non-permissible Goods and Services:
  - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services;
  - Goods, services and supports available through another source;
  - Goods, services or supports provided to or benefiting persons other than the individual member;
  - Room and board;
  - Personal items and services not related to the qualifying disability;
  - Gifts for workers/family/friends, payments to someone to serve as a representative,
  - Clothing, food and beverages;
  - Electronic entertainment equipment;
  - Utility payments;
  - Swimming pools and spas;
  - Costs associated with travel;
  - Household furnishings such as comforters, linens, drapes and furniture
  - Vehicle expenses including routine maintenance and repairs, insurance and gas money;
  - Medications, vitamins and herbal supplements;
  - Illegal drugs or alcohol;
  - Experimental or investigational treatments
  - Printers;
  - Monthly internet service;
  - Yard work;

- Household cleaning supplies;
- Home maintenance;
- Pet care;
- Respite services;
- Spa services;
- Education;
- Personal hygiene items;
- Day care; and
- Discretionary cash.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – Agency with Choice.
- The *Personal Options* provider must not pay PDGS funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- To access Participant-directed Goods and Services the member must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- The following represents non-permissible Goods and Services:
  - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services;
  - Goods, services and supports available through another source;
  - Goods, services or supports provided to or benefiting persons other than the individual member;
  - Room and board;
  - Personal items and services not related to the qualifying disability;
  - Gifts for workers/family/friends, payments to someone to serve as a representative,
  - Clothing, food and beverages;
  - Electronic entertainment equipment;
  - Utility payments;
  - Swimming pools, hot tubs and spas;
  - Costs associated with travel;
  - Household furnishings such as comforters, linens, drapes and furniture
  - Vehicle expenses including routine maintenance and repairs, insurance and gas money;

- Medications, vitamins and herbal supplements;
- Illegal drugs or alcohol;
- Experimental or investigational treatments
- Printers;
- Monthly internet service;
- Yard work;
- Household cleaning supplies;
- Home maintenance;
- Pet care;
- Respite services;
- Spa services;
- Education;
- Personal hygiene items;
- Day care; and
- Discretionary cash.

513.9.2.3.2 Person-Centered Support: *Personal Options,* Participant-Directed Option

Definition of Service:
Old Policy:
Person-Centered Support (PCS) consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care
- Receptive or expressive language
- Learning
- Mobility
- Self-direction
- Capacity for Independent Living

PCS services must be assessment based and outlined on the member's spending plan. PCS activities may be completed in the member's residence or in public community settings. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs. Qualified Support Workers (QSW) Staff providing PCS services may participate in person-centered planning, IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

Definition of Service:
New Policy:
Person-Centered Support (PCS) provided by awake and alert staff consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care
- Receptive or expressive language
- Learning
- Mobility
- Self-direction
- Capacity for Independent Living

PCS services must be assessment based and outlined on the member's spending plan. PCS activities may be completed in the member's residence or in public community settings. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs. Qualified Support Workers (QSW) Staff providing PCS services may participate in person-centered planning, IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

The QSW may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS services are available to members living in the following types of residential settings: the member's family residence, Specialized Family Care Homes and unlicensed ISS.
- This service may not be billed concurrently with any other direct care service.

- PCS cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor member or a Specialized Family Care Provider caring for a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- The member's appointed representative may also be employed by the member paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed as stated below:
    - The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
    - The representative may not be paid for more than 40 hours per week for working for the member.
- PCS may not substitute for federally mandated educational services.
- PCS is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.
- PCS is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- PCS may not be provided by the member's spouse.
- Up to 48 units/12hours of Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Personal Options services are available to members living in the following types of residential settings: the member's family residence, Specialized Family Care Homes and unlicensed ISS.
- PCS: Personal Options services are limited to the equivalent monetary value of 11,680 units/2920 hours (based upon average of 8 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920 units), AwC: PCS and *Personal Options:* PCS excluding Traditional Respite, AwC Respite and *Personal Options* Respite.

- PCS: Personal Options services are limited to the equivalent monetary value of 17,520 units/4380 hours (based upon average of 12 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920 units), AwC: PCS, *Personal Options:* PCS excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- PCS: Personal Options services are limited to the equivalent monetary value of 35,712 units/8928 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings, to include training. This is in combination with all direct care services available: PCS: Agency, Supported Employment, Facility-Based Day Habilitation and LPN (when LPN units exceed 2,920 units) and PCS: Agency with Choice.
- This service may not be billed concurrently with any other direct care service.
- PCS: Personal Options cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor member or a Specialized Family Care Provider caring for a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- A member's representative may not be a paid employee providing *Personal Options* I/DD Waiver services to the member.
- PCS: Personal Options may not substitute for federally mandated educational services.
- PCS: Personal Options is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.
- PCS: Personal Options is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- PCS: Personal Options may not be provided by the member's spouse.
- Up to 48 units/12hours of *Personal Options: PCS* services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

Qualified Support Worker Qualifications:
Old Policy:
All of the requirements in section 513.9.2.2.1, 513.9.2.2.2 and 513.9.2.2.3 must be met.

Qualified Support Worker Qualifications:
New Policy:
All of the requirements in sections 513.9.2.2.1.1, 513.9.2.2.1.2, 513.9.2.2.1.3 and 513.9.2.2.1.4 must be met.

513.9.2.3.3 Respite: Participant-Directed Option: *Personal Options* Model

Definition of Service:
Old Policy:
Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- This service may not be billed concurrently with any other direct care service.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may provide training to Respite staff.
- Allow the QSW to attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

Definition of Service:
New Policy:
Respite Services provided by awake and alert staff are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- Support the member while the primary care-giver works outside the home.
- This service may not be billed concurrently with any other direct care service.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may provide training to Respite staff.
- Allow the QSW to attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.
- The QSW may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

New Policy:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.

- *Personal Options*: Respite services are limited to the equivalent monetary value of 6,912 units/1728 (Average of 144 hours a month or 4.73 hours a day) AwC Respite per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite. The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- *Personal Options:* Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite services may not be used to replace natural supports (which includes non-custodial parents) available to the member..
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- *Personal Options*: Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.

Qualified Support Worker Qualifications:
Old Policy:
All of the requirements in section 513.9.2.2.1, 513.9.2.2.2 and 513.9.2.2.3 must be met.

Qualified Support Worker Qualifications:
New Policy:
All of the requirements in sections 513.9.2.2.1.1, 513.9.2.2.1.2, 513.9.2.2.1.3 and 513.9.2.2.1.4 must be met.

513.9.2.3.4 Transportation: Miles: *Personal Options* Participant-Directed Option,

Definition of Service:
Old Policy:

- Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program or Supported Employment activities, or to a community-based planned activity or service which is based on assessed need.

- This service may be billed concurrently with Person-Centered Support Services: *Personal Options* option or Respite: *Personal Options* option.

New Policy:

- Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program or Supported Employment activities, or to a community-based planned activity or service which is based on assessed need.
- This service may be billed concurrently with Person-Centered Support Services: *Personal Options* option or Respite: *Personal Options* option.
- The number of miles per service must be included on the member's IPP.

Limitations/Caps:
Old Policy:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed.
- Must be related to an assessed need in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of Wes Virginia.
- The amount of transportation provided to a member directing their services must be identified on their spending plan and may not exceed the annual participant-directed budget allocation.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

Limitations/Caps:
New Policy:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed. If more than one member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.

- Must be related to an assessed need in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of Wes Virginia.
- The amount of transportation provided to a member directing their services must be identified on their spending plan and may not exceed the annual participant-directed budget allocation.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

Qualified Support Worker Qualifications:
Old Policy:
All of the requirements in section 513.9.2.2.1, 513.9.2.2.2 and 513.9.2.2.3 must be met in addition to the following requirement:

- The Qualified Support Worker must have a valid driver's license, proof of current vehicle insurance and registration in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

Qualified Support Worker Qualifications:
New Policy:
All of the requirements in sections 513.9.2.2.1.1, 513.9.2.2.1.2, 513.9.2.2.1.3 and 513.9.2.2.1.4 must be met in addition to the following requirement:

- The Qualified Support Worker must have a valid driver's license, proof of current vehicle insurance and registration in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

513.10 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS, SPECIFIC REQUIREMENTS

Old Policy:
I/DD Waiver Program provider agencies must maintain a specific record for all services received for each I/DD Waiver Program member including, but not limited to:

- Each I/DD Waiver provider who provides Service Coordination services is required to maintain all required I/DD Waiver documentation on behalf of the State of West Virginia and for state and federal monitors.

- All I/DD Waiver Program forms as applicable to the policy requirement or service code requirement.
- Agencies that wish to computerize any of the forms, may do so, however once the automated IPP becomes available through the CareConnection®, it must be used by all agencies. All basic components must be included and the name/number indicated on the form (refer to *Chapter 300, Provider Participation Requirements,* for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS web site (www.dhhr.wv.gov/bms).
- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the I/DD Waiver Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation requirements are detailed in Section 513.9, including all subsections of 513.9, Description of Covered Services.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the Service Coordination provider record. In the course of monitoring of the IPP and services, the Service Coordinator may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.

New Policy:
I/DD Waiver Program provider agencies must maintain a specific record for all services received for each I/DD Waiver Program member including, but not limited to:

- Each I/DD Waiver provider who provides Service Coordination services is required to maintain all required I/DD Waiver documentation on behalf of the State of West Virginia and for state and federal monitors.
- All I/DD Waiver Program forms as applicable to the policy requirement or service code requirement.
- Agencies that wish to computerize any of the forms, may do so, however once the automated IPP becomes available through the CareConnection®, it must be used by all agencies. All basic components must be included and the name/number indicated on the form (refer to *Chapter 300, Provider Participation Requirements,* for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS web site (www.dhhr.wv.gov/bms).
- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the I/DD Waiver Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation

requirements are detailed in Section 513.9, including all subsections of 513.9, Description of Covered Services.

- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the Service Coordination provider record. In the course of monitoring of the IPP and services, the Service Coordinator may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it. In addition to all documentation required by other state agencies (OHFLAC), the I/DD Waiver provider must disseminate this information to the member when the member resides in their natural family home. The I/DD Waiver provide must ensure that the following is maintained in the member's home when the member resides in an ISS or group home setting:
    - Personal demographic/emergency contact information. If community activities are planned, a copy will be taken in a sealed envelope for emergency use only.
    - Current complete IPP including current psychological, social and physical evaluations (if applicable), current behavior support plan, activity schedule, Crisis Plan, IHP and IEP.
    - (ISS/GH) Current doctor's orders for every medication administered at that site, even if the client self-administers
    - Current daily direct support documentation, task analysis and/or staff notes
    - (ISS/GH) Current MARs
    - Copies of other pertinent medical or evaluative information relevant to treatment

CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR I/DD WAIVER SERVICES
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CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR I/DD WAIVER SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for payment of services provided to eligible West Virginia Medicaid members under the Waiver Program for persons with Mental Retardation and/or Developmental Disabilities. These members may or may not be eligible for other Medicaid services.

The policies and procedures set forth herein are regulations governing the provision of services under the Mental Retardation and/or Developmental Disabilities Waiver of the Medicaid Program Administered by the DHHR under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. This program is hereafter referred to as the Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver Program.

All services, except Participant-Directed Goods and Services are available through the Traditional Service Option offered by I/DD Waiver providers state-wide. Each member must purchase service coordinator services through the Traditional Option. For more detailed information on the Traditional Service Option, see section 513.9.1.

Four services are available through the Participant-Directed Option to members who are eligible and who choose to direct part or all of the 4 services available through this option. These 4 services (Person-Centered Supports, Respite, Transportation and Goods and Services) are described more fully in section 513.9.2. There are 2 Participant-Directed Financial Management Services available to assist members with self-directing these services: Agency with Choice

Model and *Personal Options* Model. Members may choose all of their services through the Traditional Option or the member may choose to mix Traditional Option services and Participant-Directed Option Services. Members who choose to do this must first purchase those Traditional services that may not be self-directed, including service coordination, before cashing out their remaining budget to purchase one or all of the 4 Participant-Directed services available.

All required documentation forms are available on the Bureau for Medical Services website: http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/default.aspx

513.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Acronyms and Definitions,* of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of the services in the I/DD Waiver Program described in this chapter.

Activities of Daily Living (ADLs): activities usually performed in the course of a normal day in an individual's life, such as eating, dressing, bathing and personal hygiene, mobility, and toileting.

Administrative Service Organization (ASO): the contracted agent of BMS responsible for processing initial applications, investigating complaints, assessing waiver members' needs, functionality and supports and determining an individualized budget. The ASO also provides education for members, their families, their workers and I/DD Waiver providers. The ASO interfaces with the claims management system to ensure that purchased services are properly reimbursed.

Agency with Choice (AwC) Service Financial Management Service Agency: an agency who meets all the qualifications of an I/DD Waiver provider and is approved as an Agency with Choice by BMS to assist members and/or their legal/non-legal representatives with directing participant-directed services.

Agency Staff: staff employed or contracted by an I/DD Waiver provider to provide services to members in the I/DD Waiver program through both the Traditional Option and the Agency with Choice Option.

Aging and Disability Resource Centers (ADRCs): the state agency sponsored by the West Virginia Bureau of Senior Services who have a wide-ranging list of resources available for informational purposes. These services and supports can help the member remain at home and active in the community by providing a comprehensive assessment of the member's needs and empower the member to make informed choices and decisions regarding long-term care.

Annual "Anchor" Date: the annual date by which the member's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following

the date when initial medical eligibility was established by the Medical Eligibility Contracted Agent (MECA). This date will also serve as the annual IPP date.

Approved Medication Assistive Personnel (AMAP): an **unlicensed** staff member who meets the eligibility requirements to become an AMAP, has successfully completed the required training and competency testing and has been deemed competent by the RN to administer medications to residents in the covered facilities in accordance to WV State Code 16-5O and Legislative Rule 64CSR60.

Board of Review: the agency under the West Virginia DHHR and the Office of Inspector General that provides impartial hearings to members who are aggrieved by an adverse action including denial of eligibility, eligibility terminations or denial of a covered benefit or service.

CareConnection®: a HIPAA compliant software system that couples technology with clinical practice to offer an effective, efficient platform for ASO services.

Circle of Support: a group of people with an interest in the member who offer either evaluation, planning, advocacy, or support to the member on an ongoing basis.

Common Law Employer: the entity that is viewed by the IRS, United States Customs and Immigration Service, state tax and labor departments as the employer. In the AwC FMS Model, the I/DD Waiver provider is the Common Law Employer and in the *Personal Options* FMS Model, the member is the Common Law Employer.

Co-Employer: the relationship between a member and an I/DD Waiver provider who is a certified Agency with Choice (AwC) provider in which the member and the AwC provider share in the responsibility of hiring, training, scheduling, supervising and dismissing the member's agency staff while the AwC provider is fully responsible for all payroll functions, including determining wages and benefits of agency staff.

Critical Juncture: any time that there is a significant event or change in the member's life that requires a meeting of the Interdisciplinary Team (IDT). The occurrence may require that a service needs to be decreased, increased or changed. A critical juncture constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Days: calendar days unless otherwise specified.

Developmental Disability: persons with related conditions who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches

age 22; it is likely to continue indefinitely; it results in substantial functional limitations in 3 or more of the following areas of major life activity:

(1) Self-care,
(2) Understanding and use of language,
(3) Learning,
(4) Mobility,
(5) Self-direction, and,
(6) Capacity for independent living. (Refer to Code of Federal Regulations 42 CFR 435.1010).

Direct Care Services: Person-Centered Support, Respite, Facility-based Day Habilitation, Crisis, Supported Employment and LPN (when LPN services are provided for more than 2 hours per day) services available through the I/DD Waiver program.

Extended Professional Staff: WV Licensed Dietitians, Occupational Therapists, Physical Therapists and Speech Therapists who are enrolled Medicaid providers who contract with an I/DD Waiver provider to provide services in their specialty.

Financial Management Service (FMS): a general term applied to a service/function that assists a member to:

a) manage and direct the distribution of funds contained in the participant-directed budget;
b) facilitate the employment of staff by the member by performing as the member's agent such employer responsibilities as verifying worker qualifications, processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and,
c) performing fiscal accounting and making expenditure reports to the participant and/or their legal representative. In the I/DD Waiver, both Agency with Choice (AwC) and *Personal Options* are models of Financial Management Services.

Human Services Field Degree: Four year degree from accredited college or university in one of the following fields: Psychology; Criminal Justice; Board of Regents; Recreational Therapy; Political Science; Nursing; Sociology; Social Work; Counseling; Teacher Education; Behavioral Health; Liberal Arts or other degree approved by the West Virginia Board of Social Work Examiners**.**

Incident: any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Independent Psychologist (IP): a West Virginia licensed psychologist who is a WV Medicaid Provider who performs comprehensive psychological evaluations independent of I/DD Waiver providers and who is a member of the Independent Psychologist Network trained by the Medical Eligibility Contracted Agent (MECA).

Independent Psychological Evaluation (IPE): an evaluation completed by a psychologist of the Independent Psychologist Network which includes background information, behavioral observations, documentation that addresses the 6 major life areas, developmental history, mental status examination, diagnosis and prognosis.

Independent Psychologist Network (IPN): West Virginia licensed psychologists who are enrolled West Virginia Medicaid Providers and have completed the required IPN Training provided by the Medical Eligibility Contracted Agent (MECA) training and agreed to complete the IPE as defined.

Individual Education Plan (IEP): the legal document that defines an individual's special education program and includes the disability under which the individual qualifies for Special Education Services, the services the school will provide, the individual's yearly goals and objectives and any accommodations that must be made to assist in the individual's learning.

Individual Program Plan (IPP): the required document outlining activities that primarily focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by members of the I/DD Waiver Program. It is designed to ensure accessibility, accountability, and continuity of support and services. The content of the IPP must be guided by the member's needs, wishes, desires and goals but based on the member's assessed needs.

Individual Program Planning: the process by which the member is assisted by a team consisting of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the I/DD Waiver program policy manual who meet to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The purpose of IPP planning is to identify and address a member's assessed needs.

Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver Program: the program formerly referred to as the MR/DD Waiver Program funded by the Center for Medicare and Medicaid and administered by the Bureau for Medical Services. This program offers a comprehensive scope of services and supports to eligible I/DD Waiver program members. Authorized services, if applicable, must be rendered by enrolled I/DD Waiver providers within the scope of their licenses and in accordance with all state and federal requirements. BMS also contracts with an ASO to perform waiver operations including annual functional assessment for eligibility and budget determinations for active program members, prior authorization of services, and quality assurance/improvement functions. BMS contracts with a MECA to assess and determine initial medical eligibility for program applicants as well as review and approve annual re-determination of eligibility for waiver services. BMS contracts with a Claims Agent to process Medicaid claims. BMS also contracts with any qualified Agency with Choice (AwC) and with one Fiscal Employer Agent (F/EA) known as *Personal Options* to provide Financial Management Services to waiver members who choose to direct their own services through the participant-directed service options. *Personal Options* also provides Information and Referral services to members choosing that Participant-Directed Option. The Office of Health Facility

Licensure and Certification (OHFLAC) provides monitoring and supervision of members' health and welfare through oversight of I/DD Waiver providers.

Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver Provider: an agency that has been granted a Certificate of Need (CON) from the West Virginia Health Care Authority or an exemption from the CON Summary Review Committee and is licensed by OHFLAC to provide behavioral health services and is an enrolled West Virginia Medicaid provider.

Intensively Supported Setting (ISS): a residential home setting that is not licensed by the Office of Health Facility and Licensure with one to 3 adults living in the home. The member's name is either on the lease or the member pays rent. No biological, adoptive or other family members reside in the home setting with the member. An exception would be when siblings who are also I/DD Waiver members reside in a setting without any other family members.

Interdisciplinary Team (IDT): the member, service coordinator and when applicable, the legal representative and/or professionals, paraprofessionals, and others who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs. The IDT meetings are guided by the member's needs, wishes, desires, and goals.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID): an institution for persons with mental retardation that provides, in a protected residential setting, ongoing evaluation, planning, 24 hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability as defined in 42 CFR 435.1010.

Legal Representative: the parent of a minor child or a court appointed legal guardian for an adult or child or anyone with the legal standing to make decisions for the member.

Licensed Home: a residential setting that is owned, leased and/or operated by an I/DD Waiver provider and licensed by Office of Health Facility and Licensure.

Managing Employer: the member or their legal representative who use the AwC FMS model to direct some of their services by controlling the work being performed by sharing in the responsibility of hiring, training, scheduling, supervising and dismissing the member's agency staff, but not determining wages or benefits.

Medicaid Fair Hearing: the formal process by which a member or applicant may appeal a decision if the individual feels aggrieved by an adverse action that is consistent with state and federal law, including eligibility denials, eligibility terminations or when denied a covered benefit or service. This process is conducted by an impartial Board of Review Hearing Officer.

Medical Eligibility Contracted Agency (MECA): means the contracted agent of BMS responsible for the determination of medical eligibility for I/DD Waiver applicants, annual

redeterminations of continued eligibility for members and recruiting and training licensed psychologists for participation in the IPN.

Medication Administration Record (MAR): is the report that serves as a legal record of the drugs administered to a member by a nurse or other healthcare professional, such as an Approved Medication Assistive Personnel (AMAP).

Medley Advocate: Employees of the designated Medley Advocacy Agency who advocate for the inclusion of services appropriate to the individual and for services consistent with the principles of least restrictive alternative and the member's choice.

Medley Class Member: Individuals with a diagnosis of mental retardation who were institutionalized prior to the age of 23 in a West Virginia state institution i.e. Weston State Hospital, William Sharpe Hospital, Huntington State Hospital, Mildred Bateman Hospital, Colin-Anderson Center, Greenbrier Center, Spencer State Hospital, Lakin State Hospital or Hopemont State Hospital for at least 30 days and whose birth date is on or after April 1, 1956.

Member's Family Residence: a residence where the member has a 911 address and lives with at least one biological, adoptive, natural or other family member.

Mental Retardation (Intellectual Disability): is defined as a condition which is usually permanent and originates prior to the age of 18. This condition results in significantly below average intellectual functioning as measured on standardized tests of intelligence (IQ of 70 or below) along with concurrent impairments in age appropriate adaptive functioning. Causes of mental retardation (intellectual disability) may vary and degree of intellectual impairment can range from mild to profound. (See DSM-IV for further explanation.)

Personal Options **Financial Management Services Model:** the Fiscal/Employer Agent (F/EA) Financial Management Service that is a contracted subagent of BMS that assists the member and/or their legal/non-legal representative with exercising employer and budget authority by assisting with the hiring of member's Qualified Support Workers and completing payroll functions. The F/EA also provides Information and Assistance (I&A) to members choosing to direct the available services.

Natural Supports: Family, friends, neighbors or anyone who provides a service to a member but is not reimbursed.

Non-legal Representative: a person freely appointed by the member or their legal representative to assist the member or their legal representative with the responsibilities of participant direction, including exercising budget authority and employer authority.

Office of Health Facility Licensure and Certification (OHFLAC): the state agency that inspects and licenses I/DD Waiver providers to assure the health and safety of I/DD Waiver members. Licensed entities include but are not limited to behavioral health providers, I/DD

Waiver providers, facility-based day programs, group homes, supported employment facilities and service coordination agencies.

Participant-Directed Services: Four services (Person-Centered Supports, Respite, Transportation and Goods & Services) that an I/DD Waiver member not living in a licensed setting may choose to self-direct. The member may determine what mix of personal assistance supports and services work best for them.

Pre-hearing Conference: a meeting requested by the applicant or member and/or legal representative to review the information submitted for the medical eligibility determination and the basis for the denial/termination. A Medicaid Fair Hearing pre-hearing conference may be requested any time prior to a Medicaid Fair Hearing.

Professional Experience: a position that requires a minimum of a Bachelor's degree or a professional license, such as an LPN.

Public Community Location: any community setting open to the general public such as libraries, banks, stores, post offices, etc.

Public Education Services: school services for students through the end of the school year when the student turns 21 years of age or the student has met graduation requirements for a standard high school diploma as defined by the Individuals with Disabilities Education Act (IDEA) and WV policy 2419.

Qualified Support Worker: direct care workers employed by the self-directing member who provide person-centered support services, respite services or transportation services to the member through one of the Participant-Directed Options.

Resource Consultant: a representative from the Fiscal/Employer Agent's Financial Management Service who assists the member and/or their legal/non-legal representative who choose this Participant-Directed Option with the responsibilities of self-direction; developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; provides resources to assist the member with locating staff,; providing information and resources to help purchase goods and services; helping to complete required paperwork for this service option; and helping the member select a representative to assist them, as needed.

Safe Environment: a place where people feel secure; where they are not at risk of being subject to harm, abuse, neglect or exploitation; and where they have the freedom to make choices without fear of recourse.

Specialized Family Care Provider (SFCP): an individual who operates a foster-care home which has received certification through the WVDHHR Specialized Family Care Program. Both the home and the individual providing services are certified by a Specialized Family Care Family Based Care Specialist.

Stand-by Staff: Agency staff that are on stand-by status to replace Electronic Monitoring and On-Site Surveillance within 20 minutes or less of notification by base monitoring staff.

Traditional Services: home and community-based services that help members of the I/DD Waiver program maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them.

West Virginia Incident Management System (WV IMS): a web-based program used by I/DD Waiver providers, AwC providers and *Personal Options* staff to report simple, critical and abuse, neglect and exploitation incidents to the ASO and BMS.

513.2 PROGRAM DESCRIPTION

The I/DD Waiver Program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities. It is administered by BMS pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid (CMS), the federal agency responsible for the I/DD Waiver Program. The I/DD Waiver Program is a program that reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The I/DD Waiver Program provides services in natural settings, homes and communities where the member resides, works and shops.

513.2.1 Bureau for Medical Services Contractual Relationships

The Bureau for Medical Services (BMS) contracts with an Administrative Services Organization (ASO). The ASO acts as an agent of BMS and administers the operation of the I/DD Waiver Program. The ASO processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility. The ASO conducts education for I/DD Waiver providers, members, advocacy groups, and DHHR. The ASO provides a framework and a process for the purchase of waiver services. At times, the ASO, in collaboration with BMS will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the BMS I/DD Waiver website located at: http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/default.aspx under POLICY CLARIFICATIONS.

The ASO provides authorization for services that are based on the member's assessed needs and provides service registration information to the claims payer. BMS contracts with I/DD Waiver providers for the provision of services for members.

BMS contracts with a Medical Eligibility Contracted Agent (MECA) to determine initial and re-determination eligibility of prospective and active members and to recruit and train licensed psychologists to participate in the Independent Psychologist Network. The ASO and the MECA work together to process initial applications and re-determination packets.

BMS contracts with a Fiscal/ Employer Agent (F/EA) to administer the *Personal Options* Financial Management Services (FMS) program. The F/EA is as a subagent of BMS for the purpose of performing employer and payroll functions for members wishing to self direct some of their services through the *Personal Options* FMS..

BMS also contracts with licensed I/DD Waiver providers who wish to participate in the West Virginia Medicaid Program. This includes an additional certification with I/DD Waiver providers who wish to provide the Participant-Directed Agency with Choice Financial Management Service Option.

A contact list for the ASO, MECA and *Personal Options* is located in Section 513.14.

513.2.2 Traditional and Agency with Choice Provider Enrollment and Responsibilities

In addition to provider enrollment requirements in *Chapter 300, Provider Participation Requirements*, I/DD Waiver Program providers must meet all the requirements listed below.

- Receive a Certificate of Need (CON) approval from the West Virginia Health Care Authority through the full length CON process or through the Summary Review process.
- Obtain and maintain a behavioral health license through OHFLAC.
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the I/DD Waiver provider and BMS as well as a valid Medicaid enrollment agreement.
- Ensure that a member or agency staff are not discharged, discriminated or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves the I/DD Waiver provider.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services.
- Ensure that services are delivered and documentation meets regulatory and professional standards before the claim is submitted.
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.
- Begin the mandatory I/DD Waiver Program training for all agency staff on the first day of employment and document all mandatory training on the Certificate of Training Form (WV-BMS-I/DD-06).
- Ensure that all agency staff providing direct care services are fully trained in the proper care of the member to whom they will be providing services prior to billing for services. Health and Safety training may be conducted by personnel deemed qualified by IDT

- members and documented on the IPP. Fully trained agency staff must be available until newly hired Agency Staff or Qualified Support Workers are fully trained.
- Hires and retains a qualified workforce.
- Subcontracts with licensed individuals or group practices of the behavioral health profession as defined by the Office of Health Facility and Licensure, if contracting occurs.
- Maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the I/DD Waiver Program and all other applicable licensing and certification bodies.
- Provide an assigned agency I/DD Waiver Contact Person whose duties include:
    - Review of Home and Day Program visits to assure compliance with Waiver policy (service coordination provider agencies only);
    - Oversight of agency staff implementing the IPPs of all members in the I/DD Waiver Program; and
    - Communicating with BMS and the ASO.
- Implement the I/DD Waiver Quality Improvement System as further defined in Section 513.2.4.
- Provide each member with maximum choice of I/DD Waiver services within their individualized budgets available in each of the service delivery options.
- Employ or contract with agency staff who meet all the training and credentialing requirements listed under Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 as well as the individual service definitions of this chapter
- Maintain a record of the training verification or recertification on each agency staff.
- Participate in quarterly training sessions and routine conference calls provided by the ASO.
- Ensure that all residential sites (leased or rented by the I/DD Waiver provider) provide a safe environment for the members and agency staff.
- Provide appropriate auxiliary aids and services when necessary to ensure effective communication with members and/or legal representatives when natural or other supports are not available. This includes the use of qualified sign language interpreters, documents in Braille or large print, audio recordings, etc.
- Complies with all American with Disabilities Act (ADA) requirements if applicable.

513.2.2.1 Additional Qualifications for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

All agency staff, except contracted extended professional staff, having direct contact with members must meet the qualifications listed below.

- Approved Criminal Investigation Background (CIB) checks as defined in Section 513.2.2.1.1.
- Approved Protective Services Record Check as defined in Section 513.2.2.1.2
- Are not on the list of excluded individuals maintained by the Office of the Inspector General as defined in Section 513.2.2.1.3.

- Be over the age of 18.
- Have the ability to perform the tasks.
- Documentation of training initially and annually as mandated by OHFLAC and the I/DD Waiver manual. For all trainings but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires. These trainings include:

    - Training on treatment policies and procedures, including confidentiality training;
    - Training on Consumer Rights;
    - Training on Emergency Procedures, such as Crisis Intervention and restraints must be provided if the IDT deems necessary based on member assessed needs;
    - Training on Emergency Care to include member-specific Crisis Plans and Emergency Disaster Plans;
    - Training on Infectious Disease Control;
    - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current First Aid certification upon hire and as indicated per expiration date on the card;
    - Documented training in Cardiopulmonary resuscitation (CPR) by an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current CPR certification upon hire and as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the Agency Staff);
    - Training on Member-specific needs (including special needs, health and behavioral health needs); and
    - Training on Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation, including injuries of unknown origin.
- Qualifications must be verified initially as current and updated as necessary.
- Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs.

513.2.2.1.1 Criminal Investigation Background Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

All I/DD Waiver provider agency staff, except contracted extended professional staff, having direct contact with members must, at a minimum, have results from a state level CIB check which includes fingerprints. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must conduct an additional federal background

check utilizing fingerprints through the National Crime Information Database (NCID) also upon hire and every 3 years of employment. I/DD Waiver providers may do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by an I/DD Waiver provider cannot be considered to provide services nor can be employed or continue to be employed if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed I/DD Waiver provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in status of an agency staff member providing I/DD Waiver services, the I/DD Waiver provider must take appropriate action, including notification to the BMS I/DD Program Manager.

513.2.2.1.2 Protective Services Record Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

All I/DD Waiver provider agency staff hired after January 1, 2009, except for contracted Extended Professional Staff, having direct contact with members must have a WVDHHR Protective Services Record Checks. These must be initiated on each individual upon hire. The results must be considered by the I/DD Waiver provider before continuing employment. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families, Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

513.2.2.1.3 Federal Office of the Inspector General (OIG) Medicaid Exclusion List Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities must be checked by the I/DD Waiver provider for every agency staff who provides Medicaid services prior to employment and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

513.2.3 Reporting Requirements

Anyone providing services to an I/DD Waiver member who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), West Virginia State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-352-6513, 7 days a week, 24 hours day. A Child Protective Services (CPS) or an Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

The I/DD Waiver provider must also report suspected incidence of abuse and neglect to OHFLAC. OHFLAC may be contacted at telephone at (304) 558-0050 or reports may be faxed to (304) 558-2515. OHFLAC may assist with referring the report to the proper authorities.

I/DD providers must utilize the West Virginia Incident Management System to track the types of incidents listed below.

- **Simple Incidents**--any unusual event occurring to a member that needs to be recorded and investigated for risk management or quality improvement purposes. Examples would be a minor assault by another member with injury resulting; seizures in an individual not prone to seizures; injuries of unknown origin; high rates of uncharacteristic self-injurious behavior with no significant negative outcome;

- suicidal threats or gestures without significant injury; medication error with minimal or no negative outcome; etc.
- **Critical Incidents**--those incidents with a high likelihood of producing real or potential harm to the health and well-being of the person or persons served but not involving abuse or neglect.
- **Abuse, Neglect and Exploitation Incidents--**those incidents which meet the following definitions of abuse, neglect or exploitation.
    - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.
    - Abuse also includes psychological abuse which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
    - Abuse also includes verbal abuse which means use of oral, written or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to yelling or using demeaning, derogatory, vulgar, profane or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking or humiliating a person in any way; and making sexual innuendo.
    - Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to person, or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that placed or may have placed a person at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
    - Exploitation means the unlawful expenditure or willful dissipation of the funds or assets owned or paid to or for the benefit of an incapacitated individual.

The I/DD Waiver provider is responsible for tracking incidents and taking appropriate action on an individual and systemic basis in order to prevent harm to the health and safety of the members. All incidents must be entered into the WV IMS within 48 hours of the occurrence of the incident or of when the I/DD Waiver provider becomes aware of the incident. The I/DD Waiver provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

Incidents pertaining to members who direct services through the *Personal Options* FMS model are also required to be reported through the WV IMS and the appropriate Protective Services

entity. Details regarding the reporting requirements for these self-directing members are available in Section

The Service Coordination provider must submit a Mortality Notification (WV-BMS-I/DD-11) to the ASO within 7 days from the date of death and to OHFLAC within 24 hours of the death of the member or when the I/DD Waiver provider becomes aware of the member's death.

The Service Coordination provider must notify the ASO in writing, if they are forced to exceed the maximum case load cap due to staff vacancy. The Service Coordination provider must address the following in writing within 48 hours of exceeding their caseload cap:

- The number of members per each Service Coordinator whose case load exceeds 20 members (e.g. Service Coordinator Name, # of members).
- The agency plan, including time lines for hiring and training new Service Coordinators.
- The agency's back-up plan to cover emergencies that occur due to exceeding the maximum case load cap.

The Service Coordinator is responsible for submitting and maintaining accurate and current member data in the ASO's CareConnection® including name, address, telephone numbers, Service Coordination provider, status of financial eligibility, legal representative name and contact information, etc.

The Service Coordinator is required to notify the ASO of a member's transfer to another Service Coordination provider or if the member chooses another service delivery system within 2 working days. The Service Coordinator must transfer the member in the CareConnection® by the effective date of the transfer.

- The transferring agency is responsible for the notification by submitting the Member Transfer/Discharge Form (WV-BMS-I/DD-10). This form must include the last date of service provided.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

513.2.4 Quality Improvement System

BMS is responsible for building and maintaining the I/DD Waiver's Quality Improvement System (QIS). The I/DD Waiver provider is responsible for participating in all activities related to the QIS. The I/DD Waiver's QIS is used by BMS and the ASO as a continuous system that measures system performance, tracks remediation activities and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and member outcomes, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies.

The Quality Improvement System (QIS) is designed to:

1) Collect the data necessary to provide evidence that the 6 CMS Quality Assurances are being met; and,
2) Ensure the active involvement of interested parties in the quality improvement process.

513.2.4.1 Centers for Medicare and Medicaid (CMS) Quality Assurances

The CMS mandates the I/DD Waiver program guarantee the following 6 Quality Assurances:

1) **I/DD Waiver Administration and Oversight:** The State Medicaid agency is actively involved in the oversight of the I/DD Waiver, and is ultimately responsible for all facets of the I/DD Waiver program;
2) **Level of Care:** Persons enrolled in the I/DD Waiver have needs consistent with an institutional level of care;
3) **Provider qualifications:** I/DD Waiver providers are qualified to deliver services/supports;
4) **Service Plan:** Members have a service plan that is appropriate to their needs and preference and receive the services/supports specified in the service plan;
5) **Health and Welfare:** Members' health and welfare are safeguarded; and
6) **Financial Accountability:** Claims for I/DD Waiver services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all 6 Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include I/DD Waiver provider reviews, incident management reports, member complaints/grievances, OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input.

513.2.4.2 I/DD Waiver Provider Reviews

The primary means of monitoring the quality of the I/DD Waiver services is through provider reviews conducted by the OHFLAC and the ASO as determined by BMS by a defined cycle.

The ASO performs on-site and desk documentation provider reviews, face-to-face member/legal representative and staff interviews, home visits and day program visits to validate certification documentation and address CMS quality assurance standards. Targeted on-site I/DD Waiver provider reviews and/or desk reviews may by conducted by OHFLAC and/or the ASO in follow up to Incident Management Reports, complaint data, Plan of Corrections, etc.

Upon completion of each provider review, the ASO conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the ASO will make available to the provider a draft exit report and a Plan of Correction to be completed by the I/DD Waiver provider. If potential disallowances are identified, the I/DD Waiver provider will have 30

days from receipt of the draft exit report to send comments back to the ASO. After the 30 day comment period has ended, BMS will review the draft exit report and any comments submitted by the I/DD Waiver provider and issue a final report to the I/DD Waiver provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of I/DD Waiver Services. A cover letter to the I/DD Waiver provider's Executive Director will outline the following options to effectuate repayment:

(1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
(2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
(3) A recovery schedule of up to a 12 month period, through monthly payments or the placement of a lien against future payments.

If the I/DD Waiver provider disagrees with the final report, the I/DD Waiver provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Common Chapter 800, General Administration* of the West Virginia Medicaid Provider Manual. The I/DD Waiver provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention. **The letter must be addressed to:**

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the ASO review, then the I/DD Waiver provider will receive a final letter and a final report from BMS.

Reviews of participant-directed services are included in Section 513.9.2.1 for AwC and Section 513.9.2.2 for *Personal Options.*

513.2.4.3 Plan of Correction

In addition to the draft exit report sent to the I/DD Waiver providers, the ASO will also send a draft Plan of Correction (POC) electronically. I/DD Waiver providers are required to complete the POC and electronically submit a POC to the ASO for approval within 30 calendar days of receipt of the draft POC from the ASO. BMS may place a hold on claims if an approved POC is not received by the ASO within the specified time frame. The POC must include:

1. How the deficient practice for the members cited in the deficiency will be corrected; What system will be put into place to prevent recurrence of the deficient practice;
2. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
3. The date the Plan of Correction will be completed; and
4. Any provider-specific training requests related to the deficiencies.

513.2.4.4 Self-Reviews

The ASO prepares and disseminates electronically an I/DD Waiver Self-Review Tool which primarily measures the CMS Quality Assurances. This self review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS quality assurances are met. I/DD Waiver providers must use the approved format for submitting self reviews so that data related to the CMS quality assurance standards can be tracked and analyzed. Failure to submit the self reviews may jeopardize the future status of the I/DD Waiver provider as a West Virginia Medicaid provider.

I/DD providers are required to conduct self reviews, complete an affidavit attesting to the accuracy of the self-review, and submit to the ASO via electronic format every-other-year. The reporting periods will be based on the quarter during which the provider's on-site review take place on alternate years and will be communicated to providers via email.

513.2.4.5 Training and Technical Assistance

The ASO develops and conducts training for I/DD Waiver providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

513.2.4.6 Quality Improvement Advisory (QIA) Council

The QIA Council is the focal point of stakeholder input for the I/DD Waiver Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The role of the QIA Council is to advise and assist BMS and the ASO staff in program planning, development and evaluation consistent with its stated purpose. In this role, the QIA Council uses the I/DD Waiver Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend Program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives; and
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is comprised of: former and/or current members (or their legal representatives) of the I/DD Waiver Program, service providers, advocates and other allies of people with intellectual and/or developmental disabilities.

513.2.4.7 Utilization Guidelines for I/DD Waiver Providers

Each agency must put into place a set of Utilization Guidelines (UG) to ensure that each I/DD Waiver member receives the appropriate services and supports at the right time, in the right amount, and for as long as the member needs the services. Utilization guidelines are a person-centered process that starts with person-centered planning. The purpose of UG is to monitor claims submission and ensure that services provided are in compliance with the I/DD Waiver Manual and existing authorizations.

Agencies providing services must have UG in place that track units of services utilized/billed. It is the expectation that each agency be able to report units used and units still available at the IDT meetings (if not earlier). This is not only necessary for transfer/authorization purposes, but is also necessary for IDTs to make good decisions about purchasing services. Each agency is to have and adhere to a UG policy. With the exception of Crisis Services, agencies must receive prior-authorization for each service provided, as outlined in section 513.11 and specified in each service definition under “Prior Authorization.”

The internal policy of each agency must minimally address the following:

- Staff training
- Provider education on how will be delivered throughout the member’s service year. This education should minimally include the following:
    - Schedule of the member
    - Units of service authorized
    - Averages of usage (daily/monthly)
    - Individualized Training (as needed)
    - Requirements and limitations of the particular service provided
- Empowering and educating members and families so that they are able to make informed choices about their services and supports;
- Assessing member’s needs:
    - Purchase requests are based on identified need for the coming service year, therefore additional units may not be requested for contingency purposes;
- Choosing services based on member’s assessed needs;
- Monitoring service utilization throughout the member’s service year;
- Monitoring member’s needs and updating services as needed;
- All services delivered must be delivered based on:
    - Assessed need
    - Agreement by the IDT
    - I/DD Waiver service caps and limitations
    - Documentation on the member’s IPP

513.2.5 Service Limitations and Service Exclusions

Services governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements*, of the Provider Manual and Section 513.8 of this chapter. Reimbursement for services is made pursuant to *Chapter 600,* however, the following limitations also apply to the requirements for payment of services that are appropriate and necessary for I/DD Waiver Program Services described in this chapter.

- I/DD Waiver services are made available with the following limitations:
  - All members must live in West Virginia;
  - All I/DD Waiver regulations and policies must be followed in the provision of the services. This includes the requirement that all I/DD Waiver providers be licensed in the State of West Virginia and enrolled in the West Virginia Medicaid Program;
  - The services provided must conform with the stated goals and objectives on the member's IPP; and
  - Individual Member budgets and limitations described in this manual must be followed.
- I/DD Waiver services may be provided within 30 miles of the West Virginia border to members residing in a county bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Information*, of the West Virginia Medicaid Provider Manual, BMS will not pay for the following services:
  - The I/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973;
  - Public school services;
  - Person-Centered Support Services payments may not be made for room and board or the cost of facility maintenance and upkeep;
  - Birth-to-Three services paid for by Title C of Individuals with Disabilities Education Act (IDEA) for children enrolled in the I/DD Waiver program; and
  - I/DD Waiver services may not be provided concurrently unless otherwise indicated in the service definition. For example Person-Centered Support services may not be provided concurrently with the individual's Facility-Based Day Habilitation Program, School-based services, Crisis services, Supported Employment services, LPN Services in excess of 2 hours per day or Respite Care services.
- Reimbursement for I/DD Waiver services cannot be made for:
  - Service provided outside a valid IPP;
    - To be considered valid, the IPP must be current (dated within the past year and reviewed with last 6 months by IDT), signed by all required IDT members and include all provided services.
  - Services provided when eligibility has not been established;
  - Services provided when there is no IPP;
  - Services provided without supporting documentation;
  - Services provided by unqualified staff; and
  - Services provided outside the scope of a defined service.

513.3 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

In order for an applicant to be found eligible for the I/DD Waiver Program, they must:

- Meet medical eligibility
- Meet financial eligibility
- Be a resident of West Virginia
- Have chosen Home and Community-Based Services over services in an institutional setting (ICF/IID facility)

Enrollment in the I/DD Waiver Program is dependent upon the availability of a funded I/DD Waiver slot.

The applicant must have a written determination that they meet medical eligibility criteria. Initial medical eligibility is determined by the MECA through review of an Independent Psychological Evaluation (IPE) report completed by a member of the Independent Psychologist Network (IPN); which may include: background information, mental status examination, a measure of intelligence, adaptive behavior, achievement and any other documentation deemed appropriate.

If an I/DD Waiver slot is available, then the applicant must establish financial eligibility before being enrolled in the I/DD Waiver program. If a slot is not available, the applicant is placed on a wait list. When a slot becomes available, then the applicant in informed and must establish financial eligibility before being enrolled on the I/DD Waiver program.

513.3.1 Application Process

Each new applicant must follow the eligibility process listed below for both medical eligibility and financial eligibility. An applicant first has medical eligibility determined and then has financial eligibility determined when a funded slot is available.

513.3.1.1 Initial Eligibility Determination Process

An applicant may obtain an application form (WV-BMS-I/DD-1) from local Behavioral Health Centers, I/DD Waiver providers, local/county DHHR Offices, Aging and Disability Resource Centers (ADRC), the ASO or the BMS website.

Completed applications must be submitted to the ASO at:

IRG d/b/a APS Healthcare
100 Capitol Street
Suite 600
Charleston, WV 25301

Or the completed application may be faxed via the secure EFax:

1-866-521-6882
Or emailed to secure email to:
wviddwaiver@apshealthcare.com

Upon receipt of the WV-BMS-I/DD-1, the ASO time dates and stamps the application.

The ASO contacts the applicant within 3 business days upon receipt of the WV-BMS-I/DD-1 and provides a list of psychologists in the IPN trained by the MECA who are available within the applicant's geographical area. The applicant chooses a psychologist in the IPN and works with the ASO to schedule the appointment within 14 days.

Psychologists in the IPN are identified and placed on a list following documented training by the MECA. The IP is responsible for completing an IPE and submitting it to the ASO. The ASO will verify the IPE is complete, signed and dated and will forward to the MECA. The IPE includes clinical verification that mental retardation with concurrent substantial deficits in 3 or more of the 6 major life areas (as defined in Section 513.3.2.2) was manifested prior to age 22 **or** a related condition which constitutes a severe and chronic disability with concurrent substantial deficits in 3 or more of the 6 major life areas was manifested prior to age 22. The evaluation includes assessments which support the diagnostic considerations offered and relevant measures of adaptive behavior.

The IPE evaluation is utilized by the MECA to make a medical eligibility determination.

The IP completes the IPE and submits it to the ASO within 60 days of the initial application.

The MECA makes a written final medical eligibility determination within 30 days of receipt of the completed IPE report and application from the ASO and a written decision is mailed to the applicant and/or their legal representative.

If an applicant is determined to be medically eligible, a funded I/DD Waiver slot is available and financial eligibility is established, then the applicant is enrolled into the Waiver program. If a slot is not available, then the applicant will be placed on a wait list until a funded slot allocation is available and financial eligibility is established.

If an applicant is determined not to be medically eligible by the MECA, a written Notice of Decision, a Request for a Medicaid Fair Hearing form and a copy of the IPE is mailed by certified mail by the ASO to the applicant or their legal representative. This denial of medical eligibility may be appealed by the applicant or their legal representative through the Medicaid Fair hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 days of receipt of the Notice of Decision. The Notice of Decision letter also allows the applicant or their legal representative to request a second medical evaluation.

The second medical evaluation is completed within 60 days by a different member of the IPN at the expense of BMS. If an applicant is determined to be medically eligible, a slot is available and

financial eligibility is established, then the applicant is enrolled into the Waiver program. If a slot is not available, then the applicant will be placed on a wait list until a funded slot allocation is available and financial eligibility is established.

If the applicant is again determined not to be medically eligible based on the second medical evaluation, then the applicant or their legal guardian will receive a written Notice of Decision, a Request for a Medicaid Fair Hearing form and a copy of the second IPE by certified mail by the ASO. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled.

The applicant or legal representative may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the applicant and/or their legal representative, the ASO and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the denial.

The applicant shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge by BMS.

If the denial of initial medical eligibility is reversed by the Hearing Officer, the applicant will be placed on the wait list based on the date of the Hearing Officer's decision. When a slot is available, the applicant will be enrolled on the program once financial eligibility is established,

The applicant who is determined not to be medically eligible may re-apply to the I/DD Waiver program at any time.

The applicant's right to a medical eligibility determination within 90 days may be forfeited if the applicant does not submit follow up information needed to complete the IPE to the IP within a reasonable timeframe specified by the IP. Examples of follow up documentation requested by the IP may include, but may not be limited to:

- IEP for school aged children;
- Birth to Three assessments;
- Medical records to support the presence of a severe related condition; and
- Any other additional documentation deemed necessary by the IP to complete the IPE.

513.3.2 Initial Medical Eligibility

To be medically eligible, the applicant must require the level of care and services provided in an ICF/IID as evidenced by required evaluations and other information requested by the IP or the MECA and corroborated by narrative descriptions of functioning and reported history. An ICF/IID provides services in an institutional setting for persons with intellectual disability or a related condition. An ICF/IID provides monitoring, supervision, training, and supports.

Evaluations of the applicant must demonstrate:

- A need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and/or increase independence in activities of daily living and
- A need for the same level of care and services that is provided in an ICF/IID.

The MECA determines the qualification for an ICF/IID level of care (medical eligibility) based on the IPE that verifies that the applicant has mental retardation with concurrent substantial deficits manifested prior to age 22 **or** a related condition which constitutes a severe and chronic disability with concurrent substantial deficits manifested prior to age 22. For the I/DD Waiver program, individuals must meet criteria for medical eligibility not only by test scores, but also narrative descriptions contained in the documentation.

In order to be eligible to receive I/DD Waiver Program Services, an applicant must meet the medical eligibility criteria in each of the following categories:

a. Diagnosis;
b. Functionality; and
c. Need for active treatment

513.3.2.1 Diagnosis

The applicant must have a diagnosis of mental retardation with concurrent substantial deficits manifested prior to age 22 **or** a related condition which constitutes a severe and chronic disability with concurrent substantial deficits manifested prior to age 22.

Examples of related conditions which may, if severe and chronic in nature, may make an individual eligible for the I/DD Waiver Program include but are not limited to, the following:

- Autism;
- Traumatic brain injury;
- Cerebral Palsy;
- Spina Bifida; and
- Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.

Additionally, the applicant who has a diagnosis of mental retardation or a severe related condition with associated concurrent adaptive deficits must meet the following requirements:

- Likely to continue indefinitely; and,

- Must have the presence of at least 3 substantial deficits out of the 6 identified major life areas listed in Section 513.3.2.2.

513.3.2.2 Functionality

The applicant must have substantial deficits in at least 3 of the 6 identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;
- Self-direction; and,
- Capacity for independent living which includes the following 6 sub-domains: home living, social skills, employment, health and safety, community and leisure activities. At a minimum, 3 of these sub-domains must be substantially limited to meet the criteria in this major life area.

Substantial deficits are defined as standardized scores of 3 standard deviations below the mean or less than one percentile when derived from a normative sample that represents the general population of the United States, or the average range or equal to or below the 75 percentile when derived from MR normative populations when mental retardation has been diagnosed and the scores are derived from a standardized measure of adaptive behavior. The scores submitted must be obtained from using an appropriate standardized test for measuring adaptive behavior that is administered and scored by an individual properly trained and credentialed to administer the test. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological report, the IEP, Occupational Therapy evaluation, etc. if requested by the IP for review.

513.3.2.3 Active Treatment

Documentation must support that the applicant would benefit from continuous active treatment. Active treatment includes aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program.

513.3.3. Initial Financial Eligibility

Upon notification that an I/DD Waiver slot is available, the applicant or legal representative must make an application for financial eligibility at a local/county DHHR office.

An applicant for I/DD Waiver services who is not currently a member in a full-coverage Medicaid group and receives a medical card completes the application form, DFA-1, with an Economic

Services Worker (ESW) who processes the application, makes a financial eligibility decision and notifies the applicant through written form (Economic Services Notification Letter – ESNL-A). **The member's Notice of Decision letter for medical eligibility for the I/DD Waiver Program must be presented to the ESW before financial eligibility can be determined.**

An applicant for I/DD Waiver services, who is a member in a full-coverage Medicaid group such as an SSI or Deemed SSI, completes an abbreviated application form, the DFA-LTC-5 which evaluates annuities, trusts, and/or potential transfers of resources in relation to financial eligibility for the additional I/DD Waiver services. The ESW also provides written verification (ESNL-A) of financial application to the member and/or their legal representative.

When approved financially by the ESW, the ESW will process the assistance group in the data system, Recipient Automated Payment and Information Data System (RAPIDS), which will facilitate triggers to BMS in order for payment for eligible medical services to occur to eligible Medicaid providers.

513.3.3.1 Determination of Initial Financial Eligibility

The applicant must meet the following financial eligibility criteria:

Income

The applicant's monthly income may not exceed 300% of the current maximum monthly Supplemental Security Income (SSI) payment for a single individual. Applicants who are found to be financial eligible will receive a letter (ESNL-A) from DHHR. The maximum monthly SSI payment may be found by contacting the local county DHHR office or local Social Security Administration office.

- Only the applicant's personal income is considered for determination.
- The parent's or spouse's income is not considered for determining financial eligibility.
- An applicant does not have to be SSI eligible to become eligible for the I/DD Waiver Program.

Assets

- An individual's assets, excluding residence, furnishings and personal vehicle (owned and registered in member's name) may not exceed $2,000.
- The parent's assets are not considered for determining financial eligibility.

513.3.4 Slot Allocation Referral and Selection Process

Provided a funded I/DD Waiver slot is available, the allocation process is based on:

- The chronological order by date of the ASO's receipt of the fully completed initial application (WV-BMS I/DD-1) which includes approval of eligibility from the MECA **or**

- The date of a fair hearing decision if medical eligibility is established as a result of a Medicaid fair hearing.

Once an I/DD Waiver slot is available, the enrollee will receive an informational packet up to 90 days prior to the slot being awarded. A Freedom of Choice form (WV-BMS-I/DD-2) on which the enrollee must indicate the wish to receive home and community based services as opposed to services in an ICF/IID, his/her chosen service option (Traditional or Traditional and Participant-Directed) as well as the chosen Service Coordination provider will be included and must be returned to the ASO within 30 days of receipt of the informational packet.

The enrollee must access I/DD Waiver services within 180 days when the funded slot becomes available or the enrollee will be discharged from the program.

If the enrollee chooses to self-direct some of their services through a Participant-Directed Option then they must choose their FMS Option (Agency with Choice or *Personal Options*). Upon receipt of the complete and signed Freedom of Choice form, the ASO will refer the member to his/her chosen Service Coordination provider and if indicated, AwC or *Personal Options* agency. The SC provider may reject the referral only if:

1) it appears to have been received in error;
2) the SC provider is at maximum service capacity and unable to accept referrals until additional Service Coordinators are hired or
3) the SC provider is unable to meet the referred member's medical and/or behavioral needs.

Service Coordination providers that reject referrals due to service capacity or inability to meet medical or behavioral needs may not receive future referrals until the capacity/service issues are resolved.

Before an allocated slot can be accessed by the applicant and their chosen I/DD Waiver provider, proof of financial eligibility (ESNL-A) obtained from the WV DHHR during the financial eligibility determination must be presented to the I/DD Waiver provider.

513.3.5 Eligibility Effective Date

The initial effective date of a Medical Card for an applicant who has not previously acquired one is the **latest** of the following 2 dates (provided the member has a slot allocation):

- The date of initial medical eligibility which is established by the MECA **or**
- The date on which the applicant was approved for financial eligibility at a local/county DHHR office. The applicant will receive a letter from DHHR (ESNL-A) stating the date the applicant is financially eligible for the program.

513.4 MEMBER ANNUAL RE-DETERMINATION OF ELIGIBILITY PROCESS

In order for a member to be re-determined eligible, the member must:

- Meet medical eligibility;
- Meet financial eligibility;
- Be a resident of West Virginia; and
- Have chosen Home and Community-Based Services over services in an institutional setting (ICF/IID).

The member must also have substantial deficits in at least 3 of the 6 identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;
- Self-direction; and
- Capacity for independent living which includes the following 6 sub-domains: home living, social skills, employment, health and safety, community and leisure activities. At a minimum, 3 of these sub-domains must be substantially limited to meet the criteria in this major life area.

513.4.1 Annual Re-determination of Medical Eligibility

In accordance with federal law, re-determination of medical eligibility must be completed at least annually. The anchor date of the member's medical re-determination is the anniversary date of the first month after the initial medical eligibility was established by the MECA.

At a minimum, annual redetermination of eligibility will include 1 annual functional assessment which includes standardized measures of adaptive behavior in the 6 major life areas completed by the ASO and the results provided to the MECA. The MECA will determine medical eligibility annually based on this assessment of functioning as defined in Section 513.3.

Substantial deficits are defined as standardized scores of 3 standard deviations below the mean or less than 1 percentile when derived from a normative sample that represents the general population of the United States, or the average range or equal to or below the 75 percentile when derived from MR normative populations when mental retardation has been diagnosed and the scores are derived from a standardized measure of adaptive behavior. The scores submitted must be obtained from using an appropriate standardized test for measuring adaptive behavior that is administered and scored by an individual properly trained and credentialed to administer the test.

The ASO will conduct the functional assessment up to 90 days prior to each member's anchor date. At the time of the annual functional assessment by the ASO, each member or legal representative must complete the Freedom of Choice Form (WV-BMS-I/DD-2) indicating their

choice of level of care settings, service coordination agency and service delivery options. If the member has a legal representative that did not attend the Annual Functional Assessment and complete the Freedom of Choice Form (WV-BMS-I/DD-2), then it is the responsibility of the Service Coordinator to obtain the signature of the Legal Representative prior to or at the Annual IPP. If determined medically eligible, the member and Service Coordination provider will also receive the individual budget allocation that was calculated by the ASO based upon the member's assessed needs.

If a member is determined not to be medically eligibility a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the ASO to the member or their legal representative. The member's service coordinator is also notified by the ASO. The denial of medical eligibility may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted by the member or their legal representative to the Board of Review within 90 days of receipt of the Notice of Decision. The Notice of Decision letter also allows the member or their legal representative to request a second medical evaluation.

The second medical evaluation is completed within 60 days by a member of the IPN at the expense of BMS.

If the member's medical eligibility is terminated and the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days of the member or their legal representative's receipt of the Notice of Decision.

If the member is determined to be medically eligible as a result of a Medicaid Fair Hearing, then services will continue if the member or their legal representative requested this within 13 days of the receipt of the Notice of Decision Letter. If services were terminated due to the member or their legal representative not requesting their continuance within 13 days of the receipt of the Notice of Decision letter, then services will begin again on the date of the Hearing Officer's decision.

At any time prior to the Medicaid Fair hearing, the member or legal representative may request a pre-hearing conference. At the pre-hearing conference, the member and/or their legal representative, the ASO and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

More information on appealing medical eligibility can be found in Section 513.5.4 Member Appeals.

513.4.2 Annual Re-determination of Financial Eligibility

All I/DD Waiver members, except for Supplemental Security Income (SSI) recipients, must have financial eligibility re-determined annually by their local or county DHHR. Members who are found financially eligible will receive documentation from the DHHR (ESNL-A) which the

member needs to present to their service coordination provider. The member must provide their Notice of Decision letter re-establishing their medical eligibility to the DHHR before financial eligibility can be established. Members must meet the following financial eligibility criteria:

Income

The member's monthly income may not exceed 300% of the current maximum monthly SSI payment for a single individual. The maximum monthly SSI payment may be found by contacting the local county DHHR office or local Social Security Administration office.

- Only the applicant's personal income is considered for determination.
- The parent's or spouse's income is not considered for determination.

Assets

- An individual's assets, excluding residence, furnishings and personal vehicle (owned and registered in member's name) may not exceed $2,000.
- The parent's assets are not considered for determining financial eligibility.

A member's income and assets are evaluated using the same criteria used during the initial financial eligibility determination.

513.5 RIGHTS AND RESPONSIBILITIES OF MEMBERS/LEGAL REPRESENTATIVES

513.5.1 Member/Legal Representative Rights

The member retains all rights afforded to them under the law and the list below is intended to be limited to their rights as a member participating in the I/DD Waiver Program.

- Members and/or their legal representatives have the right to choose between home and community-based services as an alternative to institutional care and a choice of service delivery options by the ASO through the completion of a Freedom of Choice form (WV-BMS-I/DD-2) upon enrollment in the program and at least annually thereafter.
- Members and/or their legal representatives have a choice of I/DD Waiver providers.
- Members and/or their legal representatives have the right to address dissatisfaction with services through the I/DD Waiver provider's grievance procedure.
- Members directing their services through AwC or *Personal Options* will also have the right to address dissatisfaction regarding Financial Management Services. Each AwC provider and *Personal Options* must have a procedure for responding to and tracking member complaints.
- Members or their legal representatives have the right to access the Medicaid Fair Hearing process consistent with state and federal law.
- Members have the right to be free from abuse, neglect and financial exploitation.

- Members and/or their legal representatives have the right to be notified and attend any and all of their IDT meetings, including critical juncture meetings.
- Members and/or their legal representatives have the right to choose who they wish to attend their IDT meetings, in addition to those attendees required by regulations.
- Members and/or their legal representatives have the right to obtain advocacy if they choose to do so.
- Members and/or their legal representatives have the right to file a complaint with the ASO regarding the results of their functional assessment.
- Members and/or their legal representatives have the right to have all assessments, evaluations, medical treatments, budgets and IPPs explained to them in a format they can understand, even if they have a legal representative making the final decisions in regard to their health care.
- Members and/or their legal representative have the right to make decisions regarding their services.
- Members have the right to receive reasonable accommodations afforded to them under the ADA.

Each member is informed of these rights by their I/DD Waiver provider service coordination agency upon enrollment and at least annually thereafter.

513.5.2 Member/Legal Representative's Responsibilities

The member and/or their legal representative (if applicable) have the following responsibilities:

- To be present during IDT meetings. It is strongly recommended that the member, if medically and behaviorally able, be present and actively involved in their person-centered plan and IDT meetings. In extremely extenuating circumstances, the legal representative or other team members may participate by teleconferencing if they do not bill for the time spent in the IDT. The member **must** be present if they do not have a legal representative;
- To participate in the annual assessments for determination of medical eligibility and individualized budget;
- To participate in re-determination of financial eligibility at their local DHHR as required;
- To comply with all I/DD Waiver policies including monthly home visits by the service coordinator;
- To implement the portions of the IPP for which they have accepted responsibility; and
- To maintain a safe home environment for all service providers; and
- To provide their service coordinator with income information so financial eligibility can be monitored; and
- To notify their service coordinator immediately if the member's living arrangements change, the member's needs change, the member is hospitalized or if the member needs to have a critical juncture meeting.

Failure to comply with these responsibilities may jeopardize the member's continuation of I/DD Waiver services.

513.5.3 Member Grievances/Complaints

Members have a right to obtain oral and written information on the agency's rights and grievance policies. If a member or their legal representative is dissatisfied with the quantity of services or the provider of service, it is recommended that they follow the I/DD Waiver provider agency's grievance process. If the issue is not resolved at this level, the member or legal representative may file a formal complaint with the ASO. If the issue cannot be satisfactorily resolved through the ASO's intervention, the member or legal representative may choose another provider of service or request a Medicaid Fair Hearing consistent with state and federal law.

If a member or their legal representative is dissatisfied with the content of the annual functional assessment, they must notify the ASO within 60 days of assessment date. The Assessment Data Modification Request (WV-BMS-I/DD-13) form must be fully completed and must cite the items in question. The ASO reviews the items in question and gives a written response which may include adjustments or revisions to the assessment findings and/or budget amount.

The IDT must make every effort to purchase services within the budget allocated by the ASO. If the IDT cannot purchase all needed services within the budget, the Service Coordinator must contact the ASO to request additional services. If negotiation is unsuccessful, the Service Coordinator may request a Second Level Negotiation with the ASO for the additional services. The member and/or their legal representative may by-pass the First and Second Level Negotiations with the ASO and request a Medicaid Fair Hearing on the denial of the additional amount of services.

513.5.4 Member Appeals

If a member is determined not to be medically eligible, a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the ASO to the member or their legal representative. A notice is also sent to the member's service coordinator. The termination may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Decision. The member or their legal representative may also request a second medical evaluation.

The second medical evaluation must be completed within 60 days by a member of the IPN. If the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days of the member or their legal representative's receipt of the Notice of Decision. If the Request for Hearing form is not submitted within 13 days of the member or legal representative's receipt of the Notice of Decision, reimbursement for all I/DD Waiver services will cease.

The service coordinator, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge IDT meeting to develop a "back-up" plan for transition because reimbursement for I/DD Waiver services will cease on the 13th day after receipt of the written Notice of Decision letter if the member or their legal guardian does not submit a Request for Hearing form or a request for a second psychological evaluation in the required time frame.

If the member is again denied medical eligibility based on the second medical evaluation,, the member or the legal representative will receive a written Notice of Decision, a Request for a Fair Hearing Form and a copy of the second functional assessment/evaluation by certified mail from the ASO. The member's service coordinator will also receive a notice. The member or their legal representative may appeal this decision through the Medicaid Fair hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Decision

A pre-hearing conference may be requested by the member or their legal representative any time prior to the Medicaid Fair Hearing and the ASO will schedule. At the pre-hearing conference, the member and/or their legal representative, the ASO and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the member is eligible financially for Medicaid services without the I/DD Waiver program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the individual's services will continue with no interruption.

The member and/or their legal representative shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge.

513.6 MEMBER DISCHARGE

A member may be discharged from the I/DD Waiver Program for a reason outlined below. The Service Coordinator must complete and submit to the ASO a copy of the Member Transfer/Discharge Form (WV-BMS-I/DD-10) within 7 days to the ASO .

- A member's income or assets exceed the limits specified in Sections 513.3.3.1 and 513.4.2 of this chapter. The county DHHR office must be contacted, in addition to the ASO, any time an individual's income or assets exceed the limits.
    - The county DHHR office closes the Medicaid file upon notification of the increase in income or assets and notifies the individual and the ASO of termination of the medical card. The Service Coordinator is responsible for monitoring the member's assets and is also the responsible party for reporting when the member's income or assets exceed the limits specified in Section 513.3.3.1 and

- 514.4.2. The Service Coordinator may request information from the member or the member's payee or member's legal representative to ensure that financial eligibility is not "lost" throughout the year due to excessive assets or other reasons.

- The annual functional assessment which is used by the MECA to determine a member's medical eligibility demonstrates that they are no longer medically eligible for the I/DD Waiver Program. The ASO notifies the member or their legal representative and the member's service coordinator of termination of services and of their right to appeal as outlined in Section 513.5.4 of this chapter
- A member or their legal representative voluntarily terminates Waiver services by signing the Transfer/Discharge form (WV-BMS-I/DD-10). The Service Coordinator must convene the IDT in the development of the IPP to transition the member to the new services when applicable.
- A member becomes deceased. The Service Coordinator must complete and submit the Notification of Member Death (WV-BMS-I/DD-11) and notify OHFLAC within 24 hours and submit the completed form to the ASO within 7 days.
- A member or their legal representative fails to comply with all I/DD Waiver policies including monthly home visits by Service Coordinator, participation in required assessments, IDT meetings and IPP development, then the member may be discharged from the I/DD Waiver Program following consultation and approval from the ASO.
- A member does not access or utilize at least one direct care I/DD Waiver Service for a period of 180 consecutive days. If the member or their legal representative signed a Transfer/Discharge Form (WV-BMS-I/DD-10), then it is effective on the date of signature and this rule does not apply.

The Service Coordinator must transfer/discharge the member in the CareConnection® by the effective date of the valid transfer/discharge.

I/DD Waiver providers are prohibited from discharging, discriminating or retaliating in any way against a member and/or their legal representative who has been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process involving the I/DD Waiver provider.

I/DD Waiver service coordination providers may not discharge a member if the member chooses to self-direct part of their services through either of the Participant-Directed service options.

513.7 MEMBER TRANSFER

The member has the right to transfer Service Coordination and other services from the existing provider to another chosen provider at any time for any reason. Transfers must be addressed on the IPP and approved by the member or their legal representative and a representative from the receiving provider as evidenced by their signature on the IPP signature sheet. During the transition from one provider to another, the IPP must be developed and must specifically address the responsibilities and associated time frames of the "transfer-from" and the "transfer-

to" providers. The Service Coordinator must complete and submit the Member Transfer/Discharge Form (WV-BMS-I/DD-10) within 7 days to the ASO. If a transfer IPP is found not to be valid then, the authorizations for services may be rolled back to the transfer-from provider until a valid IPP is held.

An I/DD Waiver provider may not terminate services unless a viable IPP is in place that effectively transfers needed services from one I/DD Waiver provider to another provider and is agreed upon by the member and/or their legal representative and the receiving provider. Providers are prohibited from discriminating in any way against a member or legal representative wishing to transfer services to another provider agency.

513.8 INDIVIDUAL PROGRAM PLAN (IPP)

Central to the services that a member receives through the I/DD Waiver program is the member's IPP. Developing the IPP is the process by which the member is assisted by their Interdisciplinary Team which consists of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the I/DD Waiver program policy manual. This team meets to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The content of the IPP must be guided by the member's needs, wishes, desires, and goals but based upon assessed needs. All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the member and the other members of the team.

If the member is their own legal representative, then the member must attend the IPP. If the member has a legal representative, the legal representative must attend the IPP in person or by teleconferencing in extenuating circumstances and the member must also attend if medically and behaviorally able. If the member does not attend due to medical or behavioral issues, the service coordinator must ensure that the member understands the services outlined in their IPP to the best of their ability and is given an opportunity to sign the IPP within 10 days.

Individual Program Planning includes the Initial IPP which must be developed within 7 days of intake/admission to a new provider agency, the annual IPP and subsequent reviews or revisions of the IPP, Critical Juncture, Transfer and Discharge IPPs. Any activity that occurs prior to the meeting or after the meeting is **not** considered Individual Program Planning. Activities conducted before or after the meeting may meet the criteria for Service Coordination activities.

All IPPs must be disseminated to all team members within 14 days and must minimally include:

- All components in the WV-BMS-I/DD-05
    - Cover/Demographics
    - Meeting Minutes
    - Circle of Support/Goals and Dreams
    - Summary of Assessment and Evaluation Results
    - Medications
    - Individual Service Plan

    - I/DD Waiver Services
    - Non-I/DD Waiver Services and Natural Supports
  - Individual Habilitation Plan and Task Analysis if the member receives formal training
  - Tentative Weekly Schedule
  - Signature Sheet (and rationale for disagreement if necessary)
  - Behavior Support Plan or Protocol, if applicable, with signatures of developer and member/legal representative (must indicate consent by member/legal representative)
    - Dates that plan was approved, initiated and will be reviewed. If the plan includes restrictive measures, then approval by the I/DD Waiver Provider's Human Rights Committee must be attached. HRC must monitor plans with adverse procedures at least annually.
  - Crisis Plan to include Emergency Disaster Plans
  - Individual Spending Plan if member is self-directing any of the Participant-Directed Services available

A Crisis Plan must be completed for each I/DD Waiver member. This shall be considered an attachment and part of the member's IPP. A Crisis Plan must be personalized and discuss any foreseeable issues which might put the member's health, safety or well-being in jeopardy. A Crisis Plan should incorporate the level of supports which would likely be required for unforeseen circumstances. A Crisis Plan should minimally cover the following events:

- No call/no show of support staff
- Primary caregiver becomes unavailable or unable to provide continued support

- Weather-related/environmental issues (transportation, inability to get to scheduled location, etc.)
- Disaster-related issues (flood, fire, etc.)
- Health/medical issues (medication administration, serious allergies, seizure protocol, if applicable, etc.)
- Termination from I/DD Waiver services
- Any other member-specific issues

The IPP serves as documentation of the IDT team meeting. A team member's signature on the IPP constitutes participation in the team meeting; however a progress note is still required to document the team member's participation in the meeting. Team meeting minutes must be maintained with the IPP to expand discussion of the meeting, record critical issues from the meeting and identify the active participation of each IDT member. The IPP must include the signature of all members who attended and should indicate agreement/disagreement with the IPP, date of the meeting and the total time spent in the meeting for each team member. The member or their legal representative must agree with the plan for it to be considered a valid IPP. A copy of the IPP is maintained in all participating provider agency records and distributed to all team members within 14 days of the date of the IDT team meeting by the Service Coordinator.

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may participate by teleconferencing, however they may not bill for the time spent in the IDT if participating by teleconference and the Service Coordinator must note on the signature sheet that they attended by phone, If the legal representative attends by telephone, the service coordinator must obtain their signature within 10 days. When a member has been admitted to a crisis respite site, then the Service Coordinator may attend and bill for their services while conducting the IPP over the telephone.

An IPP includes the completed IPP (WV-BMS-I/DD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans if the member self directs eligible services and meeting minutes.

The IPP must be developed on an annual basis. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days. The IPP must be updated at critical juncture meetings to include IDT recommendations.

All Medley Class Members must have IDT meetings every quarter, but the Medley Advocate may choose to only attend the 6-month and the annual IDT.

MEDICAID CANNOT REIMBURSE FOR SERVICES RENDERED WHEN THE IPP HAS EXPIRED, HAS NOT BEEN REVIEWED WITHIN REQUIRED TIMELINES AND/OR DOES NOT INCLUDE REQUIRED SIGNATURES OR SERVICES.

513.8.1 The Interdisciplinary Team (IDT)

The Interdisciplinary Team participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan. IDT meetings should be held in a location that is convenient to the member.

At a minimum, the IDT consists of:

- The member;
- Their legal representative as applicable;
- The member's Service Coordinator;
- Representatives of all I/DD Waiver providers that provide services to the individual; and
- A Medley Advocate if the member is a Medley Class Member.

If the member is their own legal guardian and is unable to attend due to behavioral or medical issues then the IPP must be rescheduled.

Other members of the IDT may be included, as necessary, to develop a comprehensive IPP and assist the individual. Such members may include:

- Natural supports the member chooses to invite;
- Professionals, such as a Therapeutic Consultant (TC), Behavior Support Professional (BSP), Registered or Licensed Practical Nurse (LPN), Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietician, etc.;
- Direct service workers, such as Day Habilitation Program providers, Person-Centered Support Workers, Respite workers, Supported Employment providers, and LPN's responsible for habilitation programs when the member receives 8 hours or more nursing in one day;
- Service providers from other systems such as the local education agency/public schools, Division of Rehabilitation Services (DRS), or Birth to Three (provided that no duplication of service exists);
- Family Based Care Specialist (when member resides in a Specialized Family Care Home); and
- Advocate (when applicable).

All members of the IDT must sign the IPP signature sheet and indicate their participation in the meeting and should sign indicating agreement or disagreement with the IPP,

If the member or their legal representative is in disagreement with the IPP, then the IPP is not valid.

The Service Coordinator assumes the role of facilitator and coordinator for the meeting; however, the team is directed by the member, if medically and behaviorally able, utilizing a person-centered approach to planning.

513.8.2 Frequency of IDT Meetings and IPP Development

513.8.2.1 Seven Day IDT Meeting

This meeting is mandatory when a member receives an I/DD Waiver slot. This is the initial meeting that occurs within the first 7 days of admission/intake by a new provider agency and must include I/DD Waiver services as well as other support services a member needs to live successfully in the community. This IPP document must reflect a full range of planned services: Medicaid, non-Medicaid and natural supports. This meeting must be documented on the Initial IPP (WV-BMS-I/DD-4) by the member's Service Coordinator. If services can be finalized at this meeting and a full range of planned services are documented, then the Thirty Day IDT meeting will not be necessary.

513.8.2.2 Thirty Day IDT Meeting

The Initial IPP must be finalized within 30 days. The resulting IPP (WV-BMS-I/DD-5) completed by the member's service coordinator identifies the comprehensive array of services necessary to fully support the I/DD Waiver program member. This document must be reviewed annually and at least every 180 days.

513.8.2.3 Transfer/Discharge IDT Meeting

This meeting is held when a program member transfers from one I/DD Waiver provider to another, chooses a different service delivery option or when the member no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member or their legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting IPP to the transfer-to agency within 14 days. The transfer-from agency must also send a Member Transfer/Discharge Form (WV-BMS-I/DD-10) to the ASO within 7 days. If the resulting IPP is found to be not valid because necessary team members did not attend or necessary services were not addressed during the transfer, then the authorizations may be rolled back to the transfer-from agency until a valid IPP is held.

When a member transfers from one residential provider to another or from one day setting to another, a 7 day IDT meeting must occur to outline the services and supports the member needs to successfully access the new setting and services. A thirty day IDT must occur to finalize these services. The Service Coordinator must transfer the member in the CareConnection® by the effective date of the transfer.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s).

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

See Section 513.6 for valid reasons for discharge of a member from I/DD Waiver Services

513.8.2.4 Critical Juncture IDT Meeting

This meeting is held as soon as possible when there is a significant change in the member's assessed needs and/or planned services. A Critical Juncture may be the result of a change in

the member's medical/physical status, behavioral status or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes and signatures of all IDT members indicating their attendance and agreement or disagreement.

A face-to-face meeting must be held under any of the following circumstances:

- All team members do not agree with services or service mix;
- When a new goal will be implemented for the member;
- The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required;
- The member changes residential setting (example: moves from Natural Family to ISS);
- The member who lives in an ISS, Group Home or Specialized Family Care Home moves to a different location;
- The member goes into crisis placement;
- The member has a change in legal representative status;
- The primary caregiver changes or passes away;
- The member elects to change Service Delivery Model;
- The member receives a new service not previously received.

See Section 513.6 for appropriate reasons for discharge of a member from I/DD Waiver Services.

513.8.2.5 Annual, Quarterly and Six-Month IDT Meetings

The IDT must meet up to 30 days prior to the member's annual anchor date to develop the IPP. The effective date of the annual IPP will remain the annual anchor date even if the IPP was held 30 days earlier. The anchor date sets the clock for scheduling all subsequent IPPs. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days. The IPP must be reviewed at critical juncture meetings. Medley Class Members are required to have IDT meetings every quarter, however, the Medley Advocate may choose to only attend the Annual and Six-Month IDT meetings.

513.9 DESCRIPTION OF SERVICE OPTIONS

Two service options are offered in the I/DD Waiver:

1. Traditional Service Option
2. Participant-Directed Service Option (as provided by an Agency with Choice Model or the *Personal Options* Financial Management Service)

The Traditional Service Option is one of the delivery systems offered through the I/DD Waiver. A member has the option to choose all of their services through the Traditional Service Option or a combination of traditional services and the 4 participant-directed services. The 4 services available through the Participant-Directed Option are Person-centered Supports, Respite, Transportation and Goods & Services. All other requested services must be purchased through the Traditional Service Option.

The services available through the Traditional Service Option are fully described in Section 513.9.1.

The Participant-Directed Service Option is the other service delivery system offered through the I/DD Waiver. This system provides each member with the opportunity to exercise choice and control over the participant-directed services they choose and the individuals and organizations who provide them (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their participant-directed budget) is spent (budget authority). The participant-directed services over which members have the opportunity to exercise choice and control are:

- Person-Centered Support Services
- Respite
- Transportation
- Participant-directed Goods and Services

The Participant-Directed Service Option is available to every eligible I/DD Waiver member except for members living in OHFLAC licensed residential settings.

There are 2 Financial Management Service (FMS) models available to members and/or their legal/non-legal representatives to support their use of participant-directed services. These are the Agency with Choice (AwC) FMS model and the *Personal Options* FMS model. Under the AwC model, the I/DD Waiver provider serves as the fiscal agent and the member and/or their legal/non-legal representative along with the AwC provider serve as co-employers. Under the *Personal Options* model, *Personal Options,* serves as the fiscal agent and the member and/or their legal/non-legal representative serve as the employer of record.

Under the AwC FMS model, the member and/or their legal/non-legal representative and the I/DD Waiver provider are co-employers of the Qualified Support Workers for the member. The AwC FMS and the member and/or their legal/non-legal representative are responsible for managing the receipt and distribution of individuals' participant-directed budget funds. The AwC has the responsibility for processing and paying Qualified Support Workers' payroll and vendors' invoices for approved participant-directed goods and services. Together the AwC provider and the member and/or their legal/non-legal representative decide who provides orientation and training to the member's Qualified Support Workers. It may be the AwC provider, the member and/or their legal/non-legal representative or a combination of both.

Under the *Personal Options* FMS model, the member or their legal/non-legal representative is the employer of record of the Qualified Support Workers they hire directly. *Personal Options* acts as the employer agent to the employer of record who is either the member or their legal/non-legal representative. *Personal Options* is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, verifying qualifications of workers, processing and paying Qualified Support Workers' payroll and vendors' invoices for approved participant-directed goods and services, providing orientation on enrolling with and using the

Personal Options FMS and employer skills training to members and representatives, as appropriate.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s).

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

These two options for Financial Management for participant-directed services, Agency with Choice and *Personal Options* are more fully described and defined in Section 513.9.2.

513.9.1 Traditional Service Options

The Traditional Service Option is available to every member enrolled in the I/DD Waiver. These services are available through I/DD Waiver providers after being determined as necessary and appropriate for the I/DD Waiver member. The I/DD Waiver provider has employer authority as well as fiscal responsibility for the services listed on the member's IPP. These services are provided in natural settings where the member resides and participates in community activities.

513.9.1 Behavior Support Professional: Traditional Option

Procedure Code: T2025

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need. Services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites, public community locations and a member's supported work site.

Definition of Service:

This service is **ONLY** provided to members who exhibit 1 or more of the following:

- Member must exhibit documented maladaptive behaviors on the current Inventory for Client and Agency Planning (ICAP) with severity level of "very serious," or "extremely serious" in at least 1 of the following categories: Hurtful to Self, Hurtful to Others, and/or Destructive to Property; AND/OR

- Member must have current documented severe maladaptive behaviors that are Hurtful to Self, Hurtful to Others, and/or Destructive to Property, that have occurred since last ICAP was administered. These behaviors must be documented through a current Functional Assessment, current behavior data documentation, and/or WV IMS incident reports; AND/OR

- Member must have a documented history of maladaptive behaviors within the past year that have resulted in severe outcomes (i.e.-possible incarceration, life-threatening to member/others, arson/fire-setting, sexual assault). These behaviors must be documented through a current Positive Behavior Support Plan, current Functional Assessment, or other documentation that supports the maladaptive behavior(s) have occurred within the past year.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

In order to qualify to train others using an approved curriculum, an individual must meet 1 of the following 3 criteria:

- Be the developer of an approved training as indicated on the submitted application;
- Be able to provide documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer);
- Be a Board Certified Behavior Analyst or Assistant and have documentation certifying completion of the facilitated Overview of Positive Behavior Support.

The Behavior Support Professional must perform the following activities for those members who meet the criteria in section 513.9.1.1 and who are prior-authorized for this service:

- Complete a Functional Assessment to identify targeted maladaptive behaviors;
- Create Positive Behavior Support plans to meet Association for Positive Behavior Support standards of practice;

- Provide training to direct care staff who will implement the plan (i.e. family, person-centered support workers, facility-based day habilitation workers, supported employment providers, crisis workers, and respite workers);
- Evaluate/monitor the effectiveness of the Positive Behavior Support plan through analysis of programming results.

The BSP may perform all of the services listed under the Therapeutic Consultant definition, as well as the following services for those members who meet the criteria in section 513.9.1.1 and who are prior-authorized for this service:

- Train direct care workers in all aspects of PBSPs implementation(i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers);
- Assess, evaluate and monitor the effectiveness of PBSPs;
- Collect and evaluate data and completes a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan or to generate a Positive Behavior Support plan;
- Collaborate with Therapeutic Consultant(s) from other agency(s) to ensure that positive behavior support strategies are consistently applied across all environments;
- Facilitate person-centered planning as a component of the Positive Behavior Support plan;
- Present proposed restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information regarding the member;
- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.
- May provide on-site training to the support staff in behavior/crisis situations.
- May bill for phone consultation during behavioral crisis situations.
- May bill for developing/updating the behavioral crisis section of the member's crisis plan if a Therapeutic Consultant is not performing this function.
- May verify data compiled by all Person-Centered Support staff for accuracy.
- May bill for attendance of and contribution to Futures Planning sessions, including PATHs and MAPs.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

Documentation:
A detailed progress note or evaluation report for each service is required. Documentation must include all of the items listed below:

- Member's Name
- Service Code

- Date of service
- Start time
- Stop time
- Total time spent
- Analysis of the data collected or problem identified
- Clinical outcome of the service provided
- Plan of intervention as the result of the analysis
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget**.**
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with Therapeutic Consultant services.
- Member is limited to 1 BSP.
- If the member receives direct care services from more than 1 I/DD Waiver provider, the member/legal representative is responsible for choosing which provider will provide BSP services.
- Agency staff providing BSP services may not be an individual who lives in the member's own residence or family residence.
- If the assigned BSP is unavailable due to an emergency or illness another BSP or TC may provide services in their absence.
- Direct care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- BSP services may not be billed for traveling to complete BSP activities.
- BSP services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring, and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
    - Filing, collating, writing notes to staff.
    - Phone calls to staff.
    - Observing staff while training individuals without a clinical reason.
    - Administering assessments not warranted or requested by the member or their legal representative.

- Making plans for a parent for a weekend visit.
- Working in the home with providing direct care staff coverage.
- Sitting in the waiting room for a doctor or medical appointment.
- Conducting a home visit routinely and without justification—only service coordinators are required to make monthly home visits.

Agency Staff Qualifications:
In addition to meeting all requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3, agency staff providing BSP services must meet at least 1 of the standards listed below.

- Be a Board Certified Assistant Behavior Analyst (BCaBA) Certificate-Bachelor's degree, 1 year professional experience working with individuals with I/DD and completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network; or
- Be a Board Certified Behavior Analyst (BCBA) Certificate-Master's degree, 1 year professional experience working with individuals with I/DD and completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network; or
- Have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree and 2 years professional experience in the I/DD field or a Master of Arts (MA) or Master of Science (MS) in a human services field and 1 year professional experience in the I/DD field and documented evidence of successful completion coursework/training as evidenced by completion of a training curriculum approved by the WV- APBS Network or by an approved state agency.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

513.9.1.1.2 Behavior Support Professional: Individual Program Planning: Traditional Option

Procedure Code: T2025-HT

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations. The meeting cannot begin at one location and then continue at another location.

Definition of Service:

This is a service that allows the BSP to attend a member's IDT meeting to present assessments or evaluations completed for purpose of integrating recommendations, training goals and intervention strategies into the member's IPP.

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The BSP participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

Documentation:

Documentation must include signature, date of service and the total time spent at the meeting on the member's IPP and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 Events per member's annual IPP year.
- BSP may attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP code, the professional must be physically present for the duration of IPP meeting. IPP cannot be billed for preparation prior or follow-up performed after the IPP meeting.
- This code is limited to the one BSP assigned to the member.
- Agency staff providing BSP services may not be an individual who lives in the member's own residence or family residence.

Agency Staff Qualifications:

In addition to meeting all the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3, agency staff must meet the qualifications defined in Section 513.8.1.1.

513.9.1.2 Crisis Services: Traditional Option

Procedure Code: T2034

Service Units: Unit = I hour

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on specific assessed needs and services must be within the member's individualized budget.

Under emergent circumstances which place the member's or others' health and safety at risk, Crisis Services may be immediately implemented without prior authorization up to a maximum of 72 hours.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS and public community locations.

Definition of Service:

The goal of this service is to respond to a crisis immediately, assess and stabilize the situation as quickly as possible. Crisis services provided by awake and alert staff are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. Except in emergent situations, this service requires prior authorization. This service is a 2:1 ratio (agency staff to member ratio). The additional agency staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and behavioral support.

Documentation:

A detailed progress note is required. If the Direct Support Service Log (WV-BMS-I/DD-07) is used, the service log and progress note must both be completed by all agency staff providing this service. Documentation must include all the items listed below.

- Member's Name
- Service code
- Date
- Start time
- Stop time
- Summary of the crisis service interventions
- Total time spent
- Signature of agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.

- 336 units/336 hours per member's annual IPP year.
- May be provided concurrently with Service Coordination, Therapeutic Consultant, BSP Transportation and up to 2 hours of LPN nursing or RN nursing services per day.
- Person-Centered Supports, Facility-Based Day Habilitation, LPN when provided more than 2 hours a day, Respite and Supported Employment services may not be provided concurrently with this service.
- This service is not intended for use as emergency response for ongoing behavioral challenges.
- The agency staff to member ratio is 2:1.
- Agency staff providing Crisis services may not be an individual who lives in the member's own or family residence.

Agency Staff Qualifications:

All the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.3 Dietary Therapy: Traditional Option

Procedure Code: 97802-AE

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Dietary Services are provided directly to the member by an agency staff that is a licensed, registered dietitian and may include:

- Nutritional assessment and therapy for diseases that have a nutrition component;
- Preventive health and diet assessment;
- Weight management therapy;
- Design of menus;
- Screening;
- Assessments;
- Planning and reporting;
- Direct therapeutic intervention;

- Consultation or demonstration of techniques with other service providers and family members; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the ASO if requested by the member or legal representative

Direct care services provided by the dietitian must be billed utilizing the appropriate direct care procedure code.

Documentation:

A detailed progress note or evaluation report for each service is required. Documentation must include all the items listed below.

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 416 units/104 hours available per member's annual IPP year in combination with Physical Therapy and Occupational Therapy.
- The agency staff to member ratio is 1:1.
- Agency Staff providing Dietary Therapy services may not be an individual who lives in the member's home.

Agency Staff Qualifications:

All the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a licensed Dietitian in the State of WV.

If the Dietitian is contracted by the I/DD Waiver provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Dietitian only needs to be licensed to practice in the State of WV.

513.9.1.4 Electronic Monitoring/Surveillance System and On-Site Response: Traditional Option

Procedure Code: S5161-U1 1:1 ratio
S5161-U2 1:2 ratio
S5161-U3 1:3 ratio
S5161-U4 1:4 ratio

Service Units: Unit = 1 Hour

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the adult member's family residence, a licensed group home and in any ISS.

Definition of Service:

Electronic Monitoring/Surveillance System and On-Site Response services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated I/DD Waiver agency stand-by intervention staff prepared for prompt engagement with the member(s) and/or immediate deployment to the residential setting. The use of this service must be designed and implemented to ensure the need for independence and privacy of the member in their own home/apartment.

All of the following requirements must be met.

- This service is only to be utilized when there is no paid staff in the member's home.
- This service may be installed in residential settings in which residing adult members, their legal representatives (if applicable) and their IDT teams request such surveillance and monitoring in place of paid staff.
- All electronic monitoring systems or companies used or contracted by the I/DD Waiver provider meet the standards set by Bureau for Medical Services (BMS) and must be pre-approved by the BMS before providing any services and approved annual thereafter.
- The I/DD Waiver provider must have written policies and procedures approved by BMS that define emergency situations and details how remote and stand-by staff will respond to each (Ex. Fire, prolonged power outage, medical crisis, stranger in the home, violence between members, any situation that appears to threaten the health and welfare of the member).

- The electronic monitoring system or company must receive notification of smoke/heat activation at each member's home.
- The electronic monitoring system or company must have 2-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of the members in each home, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the member's home deemed necessary by the IDT.
- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of members at the remote living site.
- The monitoring base staff will assess any urgent situation at a member's living site and call 911 emergency personal first if that is deemed necessary, then call the stand-by staff.
- The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the stand-by staff or emergency personnel arrive.
- Any member wishing to access this service must first be assessed and approved by the I/DD Waiver provider's Human Rights Committee (HRC) to ensure that the member's health and welfare would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the member's IPP.
- After the approval of the HRC is obtained, the member and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the member's IPP.
    - The member, their legal representative and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may include increased independence and privacy and risks may include not having on-site staff in case of an emergency.
- The Service Coordinator conducts a home visit that includes a programmatic review of the system as well as a drill at 7 days of implementation, again at 14 days and at least quarterly thereafter. The drill will consist of testing the equipment and response time.
- The Service Coordinator reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns encountered with the use of this system, all of which is documented on the IPP.
- The number of members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the members being served in specifically identified locations.
- The I/DD Waiver provider has stand-by intervention staff who meet the following standards:
    - Responds by being at the member's residential living site within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual member need.

- Assists the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved.
- Each time an emergency response is generated, an incident report must be submitted to the West Virginia Incident Management System by the I/DD Waiver provider.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The electronic monitoring/surveillance to member ratios for this service are 1:1, 1:2, 1:3 and 1:4 and authorizations will be based on the number of I/DD Waiver members residing within the residence.
- 5,840 units (Average 16 hours per day) per member's annual IPP year.
- Only electronic monitoring/surveillance systems approved by BMS will be used.
- The member will not be charged for installation costs related to video and/or audio equipment.
- The electronic monitoring/surveillance system may not be used in Specialized Family Care Homes.
- The electronic monitoring/surveillance system may not be used to monitor direct care staff.
- The electronic monitoring/surveillance system serves as a replacement for direct care staff, thus no other direct care service may not be billed at the same for a member.

Provider Qualifications:

All stand-by intervention staff must meet all of the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3.

513.9.1.5 Environmental Accessibility Adaptations: Traditional Option

513.9.1.5.1 Environmental Accessibility Adaptations: Home: Traditional Option

Procedure Code: S5165

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home or any unlicensed ISS.

Definition of Service:

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to the private residence of the member or the member's family home which maximize the member's physical accessibility to the home and within the home. EAA-Home must be documented in the member's IPP. Additionally, these adaptations enable the member to function with greater independence in the home.. This service is used only after all other non-family funding sources have been exhausted.

All EAA requests must be submitted by the Service Coordination provider to the ASO for approval. If approved, the Service Coordination provider is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the Service Coordination provider.

Documentation:

I/DD Waiver provider must maintain all of the following documentation in the member's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-I/DD-08).
- Any assessments detailing the need for the EAA.
- The member's IPP which details the need for the EAA, and indicates the IDT approved the request.
- Proof of purchase including any receipts or invoices pertinent to the EAA.
- Verification by the I/DD Waiver provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- EAA-Home is not intended to replace the member's, member's family or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing and electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation. (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences must be portable.

- $1000 available per member's annual IPP year in combination with Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.
- The service coordination agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.9.1.5.2 Environmental Accessibility Adaptations: Vehicle: Traditional Option

Procedure Code: T2039

Service Units: Unit = $1.00

Payment Limits: The amount of service is limited by the member's individualized budget.

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided to a vehicle owned or leased by the member or the member's family. The vehicle must be the member's primary means of transportation and the adaptations are to maximize the member's accessibility to the vehicle.

Definition of Service:

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to the vehicle including paying for accessibility adaptations if the member has the capacity to drive the vehicle EAA-Vehicle is documented on the member's IPP. The purpose of this service is to maximize the member's accessibility to the vehicle only.

All EAA requests must be submitted by the Service Coordination provider to the ASO for approval. If approved, the Service Coordination provider is responsible for ensuring the adaptation to the vehicle is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the Service Coordination provider.

Documentation:

I/DD Waiver provider must maintain all of the following documentation in the member's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-I/DD-08).
- Any assessments detailing the need for the EAA.

- The member's IPP which details the need for the EAA, and indicates the IDT approved the request.
- Proof of purchase, including any receipts or invoices pertinent to the EAA.
- Verification by the I/DD Waiver provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- $1000 available per member's annual IPP year in combination with Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance and repairs of a vehicle except upkeep and maintenance of the modifications.
- The service coordination agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.9.1.6 Facility-Based Day Habilitation: Traditional Option

Procedure Code: T2021-U5 1:1-2 ratio
T2021-U6 1:3-4 ratio
T2021-U7 1:5-6 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in a licensed I/DD Facility-based Day Program facility.

Definition of Service:

Facility-Based Day Habilitation is a structured program that use meaningful and productive activities designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. The services must be provided by awake and alert staff and based on assessment, be person-centered/goal oriented, and be meaningful/productive activities that are guided by the member's strengths, needs, wishes, desires, and goals.

Facility-Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the member. Activities must consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant or BSP (if applicable).

Facility-Based Day Habilitation activities must be based at the licensed site, but the member may access community services and activities from the licensed site.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Facility-Based Day Habilitation Program services include, but are not limited to:

- Development of self-care skills;
- Use of community services and businesses;
- Emergency skills training;
- Mobility skills training;
- Nutritional skills training;
- Social skills training;
- Communication and speech instruction (prescribed by a Speech Language Pathologist ;)
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
- Interpersonal skills instruction;
- Functional academic training such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, voting training;
- Self-administration of medication training;
- Independent living skills training;
- Training the individual to follow directions and carry out assigned duties;
- Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site;
- Assistance to adjust to the production and performance standards of the workplace;
- Compliance training in workplace rules or procedures;
- Compliance with attendance to work activity training;
- Assistance with workplace problem solving; and
- Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas.).

Facility-based Day Habilitation staff may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO and IDT meetings if requested by the member or their legal representative.

Documentation:

Documentation must be completed on a Direct Support Service Log (WV-BMS-I/DD-7) to include the information listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. As training is always provided in this setting, the agency staff must also complete the task analysis.

- Member's Name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of Facility-Based Day Habilitation cannot exceed 6.240 units/1560 hours (Average 6 hours/day) per member's IPP year. When the member accesses other direct care services, these units are counted toward the daily cap of all direct care services listed in the Person-Centered Supports sections in the Traditional Option., excluding Respite.
- This service may not be billed concurrently with any other direct care services.
- Up to 48 units/12hours of Facility Day Habilitation services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or Registered Nurses (RN) may bill for providing training to facility-based day habilitation staff.
- Agency staff to member ratios for this service are 1:1-2, 1:3-4, and 1:5-6.
- Agency staff providing Facility-Based Day Habilitation services may not be an individual who lives in the member's home.
- Only members 18 years of age and over may access this service.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.7 Occupational Therapy: Traditional Option

Procedure Code: 97530-GO

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Occupational Therapy is provided directly to the member by an agency staff that is a licensed/certified occupational therapist and may include:

- Evaluation and training services in the areas of gross and fine motor function;
- self-care; sensory and perceptual motor function;
- screening; assessments;
- planning and reporting;
- direct therapeutic intervention;
- design, fabrication, training and assistance with adaptive aids and devices; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from Occupational Therapy services furnished under the State Plan. Occupational Therapy services provided under the Waiver are for chronic conditions and maintenance while the Occupational Therapy services furnished under the State Plan are short-term and restorative in nature.

The occupational therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the ASO if requested by the member or their legal representative.

Direct care services provided by the occupational therapist must be billed utilizing the appropriate direct care service code.

Documentation:

A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 416 units/104 hours per member's annual IPP year in combination with Physical Therapy and Dietary Therapy.
- The agency staff to member ratio for this service is 1:1.
- Agency staff providing Occupational Therapy services may not be an individual who lives in the member's home.
- Agency staff providing Occupational Therapy services may not bill for administrative activities.

Agency Staff Qualifications:

All the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a Licensed Occupational Therapist in the State of WV.

If the Occupational Therapist is contracted by the I/DD Waiver provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Occupational Therapist only needs to be licensed to practice in the State of WV.

513.9.1.8 Person-Centered Support: Traditional Option

Two types of Person-Centered Supports (PCS) are available under the Traditional Option. PCS: Agency is available only to agency staff **not living** in the home with the member. PCS: Family is available only to family members or Specialized Family Care Providers **living** in the home with the member. Spouses of members are excluded from providing services. Under both services

the agency staff of the I/DD Waiver provider must meet all the qualifications in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3.

513.9.1.8.1 Person-Centered Support: Agency: Traditional Option

Procedure Code: S5125-U1 1:1 ratio
S5125-U2 1:2 ratio
S5125-U3 1:3 ratio
S5125-U4 1:4 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS and public community locations. This service may not be provided in an agency staff person's home.

Definition of Service:

Person-Centered Support (PCS) services consist of individually tailored training and/or support activities provided by awake and alert staff that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS services may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

Agency staff administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

PCS services may include member specific training. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO is permitted if requested by the member or their legal representative.

PCS staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of member are not compromised.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD 07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. If training was provided the Person-Centered Support worker must also complete the task analysis.

The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Agency services cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child. The IDT must make every effort to meet the member's assessed needs through natural supports.
- PCS: Agency may not substitute for federally mandated educational services.

- Agency staff providing PCS: Agency services may not be any individual who lives in the member's home.
- Up to 48 units/12hours of PCS: Agency services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS staff.
- The agency staff to member ratio codes for this service are 1:1, 1:2, 1:3 and 1:4.
- 1:1 and 1:2 are the only codes available in the member's family residence and in Specialized Family Care Homes.
- This service may not be billed concurrently with any other direct care service.
- 11,680 units/2920 hours (based upon average of 8 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- 35,712 units/8928 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings, to include training. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (when LPN units exceed 2,920 units), PCS: Agency with Choice and PCS: Personal Options.
- PCS: Agency is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.
- PCS: Agency is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.8.2 Person-Centered Support: Family: Traditional Option

Procedure Code: S5125-U5 1:1 ratio
S5125-U6 1:2 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home and public community locations.

Definition of Service:

Person-Centered Support (PCS): Family is provided by awake and alert staff and consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community. PCS: Family may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS: Family services must be assessment based and outlined on the member's IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

PCS: Family services may include member specific training, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

Agency Staff providing PCS: Family must be a family member living in the member's home or a certified Specialized Family Care Provider providing this service in a certified Specialized Family Care Home. PCS: Family may not be provided to a member by the member's spouse.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD 07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. If training was provided the Person-Centered Support worker must also complete the task analysis.
The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Family cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child.
- This service may not be provided by the member's spouse.
- PCS: Family may not substitute for federally mandated educational services.
- The amount of PCS: Family provided must be identified on the member's IPP.
- Up to 48 units/12hours of Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS: Family agency staff.
- Agency staff to member ratio codes for PCS: Family are 1:1 and 1:2.
- This service may not be billed concurrently with any other direct care service.

- 11,680 units/2920 hours (based upon average of 8 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (When LPN units exceed 2,920), PCS: Agency with Choice and PCS: Personal Options excluding Traditional Respite, AwC Respite and *Personal Options* Respite.

PCS: Family is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.

PCS: Family is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.9 Physical Therapy: Traditional Option

Procedure Code: 97530-GP

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Physical Therapy is provided directly to the member by an agency staff that is a licensed physical therapist and may include:

- screening and assessments;
- treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone;
- activities of daily living;
- planning and reporting;
- direct therapeutic intervention;
- training and assistance with adaptive aids and devices; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from Physical Therapy services furnished under the State Plan. Physical Therapy services provided under the I/DD Waiver are for chronic conditions and maintenance while the Physical Therapy services furnished under the State Plan are short-term and restorative in nature.

The physical therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the ASO if requested by the member or their legal representative.

Direct care services provided by the physical therapist must be billed utilizing the appropriate direct care service code.

Documentation:

A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 416 units/104 hours per member's annual IPP year in combination with Occupational Therapy and Dietary Therapy.
- The agency staff to member ratio for this service is 1:1.
- Agency staff providing Physical Therapy services may not be an individual who lives in the member's home.
- Agency staff providing Physical Therapy services may not bill for administrative activities.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a licensed Physical Therapist in the State of WV.

If the Physical Therapist is contracted by the I/DD Waiver provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Physical Therapist only needs to be licensed to practice in the State of WV.

513.9.1.10 Respite: Traditional Option

513.9.1.10.1 Respite: Agency: Traditional Option

Procedure Code: T1005-U1 1:1 ratio
T1005-U5 1:2 ratio
T1005-U6 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed day program facility and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

Respite: Agency services provided by awake and alert staff are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Services consist of temporary care services for an individual who cannot provide for all of their own needs.

Respite Agency services may be used to:

- Allow the primary care-giver to have planned time from the caretaker role;
- Provide assistance to the primary care-giver in crisis and emergency situations; and
- Ensure the physical and/or emotional well-being of the primary care-giver by temporarily relieving them of the responsibility of providing care.
- Support the member while the primary care-giver works outside the home.

Agency staff providing Respite: Agency services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by ASO if requested by the member or their legal representative.

Respite Agency staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of member are not compromised.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided

- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Respite: Agency services are not available to members living in ISS or licensed group home settings.
- Respite: Agency services are not to replace natural supports (which includes a non-custodial parent) available to the member.
- Respite: Agency services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite: Agency is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to staff providing Respite: Agency Services.
- Respite: Agency Services may not be provided in an ICF/IID facility,
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite.
- This service may not be billed concurrently with any other direct care service.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.10.2 Respite: Crisis Site: Traditional Option

Procedure Code: T1005-U7 1:1 ratio
T1005-U8 1:2 ratio
T1005-U9 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on specific assessed needs and services must be within the member's individualized budget.

Under emergent circumstances which place the members or other's health and safety at risk, this service may be immediately implemented without prior authorization up to a maximum of 72 hours.

Site of Service: This service may only be provided in sites designated by the Bureau of Behavioral Health and Health Facilities and licensed by the Office of Health Facility and Licensure as Crisis Sites.

Definition of Service:

Respite: Crisis Site Services provided by awake and alert staff are specifically designed to provide temporary substitute care for an individual who is in need of an alternative residential setting due to behavioral needs or lack of supports. Training programs on the member's IPP may be provided by respite direct care staff.

The services are to be utilized only in licensed crisis sites and used on a short-term basis not to exceed a maximum stay of 30 days per admission without prior authorization from the ASO.

Respite: Crisis Site services usually occur after a critical juncture in treatment and must be approved by the IDT. If Respite: Crisis Site services are utilized due to a member's emergent need there must be a plan to transition the member back into the community developed at the time of admission by the service coordinator and the length of stay in the Crisis Respite site may not exceed 30 days per admission,

Service Coordinators must review the Crisis Respite Directory on the BHHF website and call the contact person listed in the directory or follow after-hours procedures available on the Bureau for Behavioral Health and Health facilities website: http://www.dhhr.wv.gov/bhhf/resources/Pages/DevelopmentalDisabilitiesCrisis.aspx.

The referral packet to the Respite: Crisis Site must include the IPP that identifies the services to be provided and assessments as appropriate.

Crisis Respite Agency staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of member are not compromised.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite.
- PCS cannot be billed in a Crisis Respite Site.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- This service may not be billed concurrently with any other direct care service.
- Respite: Crisis Site must be prior authorized by the ASO. Under emergent circumstances which place the member's or others' health and safety at risk, Respite: Crisis Site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.11 Service Coordination: Traditional Option

Procedure Code: T1016-HI

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in any setting that allows the Service Coordinator to complete all necessary duties for the member.

Definition of Service:

Service Coordination services establish, along with the member, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a member is utilized in making meaningful choices with regard to their life and their inclusion in the community.

Once the member/legal representative has chosen a Service Coordination provider from the available I/DD Waiver providers, the agency assigns a Service Coordinator to the member. The member/legal representative may request the assignment of a specific Service Coordinator (SC) and when possible the agency honors the request. The member/legal representative may choose to transfer to a different SC provider at any time and for any reason.

The Service Coordinator must, at a minimum, perform the following activities listed below.

- Assist the member and/or legal representative with re-determination of financial eligibility as required at the DHHR office in the county where the member lives.
- Verify financial eligibility during monthly home visits.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a member is found to be ineligible for I/DD Waiver Services during annual eligibility or financial redetermination.
- Provide oral and written information about the I/DD Waiver provider agency's rights and grievance procedures for members served by the agency.
- Assist with procurement of all services that are appropriate and necessary for each member within and beyond the scope of the I/DD Waiver Program including annual medical and other evaluations as applicable to the member.
- Inform families or custodians of children less than 3 years of age about the availability of Birth to Three Services.

- Act as an advocate for the member. The I/DD Waiver Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L.99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.
- Provide education, linkage and referral to community resources,
- Promote a valuable and meaningful social role for the member in the community while recognizing the member's unique cultural and personal value system.
- Interface with the ASO on behalf of the member in regard to the assessment process, purchase of services and budget process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs.
- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Notify IDT members 30 days in advance of meeting.
- Support the member as necessary to convene and conduct IDT meetings.
- Coordinate the development of IPPs at least annually. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral and service objectives of the IPP.
- Disseminate copies of all IPPs to the IDT members and Participant-Directed service Option providers (if applicable) within 14 days of the IDT meeting.
- Upload the ISP, the Demographic/cover sheet and signature page into the CareConnection® within 14 days of the IDT meeting.
- Upload into the CareConnection® any additional documentation requested by BMS or the ASO.
- Disseminate copies of the budget sheet from the I/DD Waiver CareConnection® website, once finalized.
- Monitor to ensure that the member's health and safety needs are addressed.
- Comply with reporting requirements of the WV IMS for members on their caseload.
- Personally meet monthly with the member and their paid or natural supports who are present with the member the time of the visit at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented and that the member continues to be financially eligible. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs.

The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-I/DD-03).

- Personally meet at least every other month with the member and their support staff at the member's facility-based day program (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-I/DD-03).
- Provide planning and coordination before, during and after crises, including notifying the ASO if a member is admitted to a crisis site or state institution.
- Process Freedom of Choice forms (WV-BMS-I/DD-2) in the CareConnection® within 2 business days any time a member requests a change of service delivery options.
- Coordinate Transfer/Discharge meetings to ensure the linkage to a new service provider or service delivery option and access to services when transferring services from 1provider agency to another or to another type of service delivery option. Coordination efforts must continue until the transfer of services is finalized.
- Travel as necessary to complete Service Coordination activities related to the IPP.
- Provide information and assistance regarding participant-directed services options during annual IPP meetings and upon request by the member or legal representative.
- Inform the member of their rights at least annually.
- Attend and participate in the annual functional assessment for eligibility conducted by ASO.
- Present member's proposed restrictive measures to the I/DD Waiver provider agency's Human Rights Committee (HRC) if no other professional is presenting the same information.
- Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly and reviewed at least annually by the HRC and by the IDT at every IDT meeting.
- May bill for attendance of and contribution to Futures Planning sessions, including PATHs and MAPs.

Documentation:

A detailed progress note or evaluation report for each service is required, including when any type of IDT meeting is held. Documentation must include all of the following items.

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Type of contact (phone, face-to-face, written)
- Detailed summary of the service provided

- Clinical outcome and/or result of the service provided
- Signature and credentials of the agency staff

Limitations/Caps

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 872 units/218 hours per member's annual IPP year.
- Up to 4 units of Service Coordination per month per member served may be billed to review services provided in order to verify the member receives services as indicated on the IPP.
- Service Coordinators may not provide services for more than 20 people, inclusive of non-I/DD Waiver members served by the agency.
- A member may only have one Service Coordinator assigned at one time. In the event of a transfer from one Service Coordination provider to another Service Coordination provider, the "transfer-from" Service Coordination may have up to 30 days after the effective date of the transfer to complete an agency discharge summary or other documentation related to the transfer.
- Agency staff providing Service Coordination services may not be an individual who lives in the member's home.
- Only one Service Coordinator may bill for this service during an IDT meeting.
- Service Coordination cannot be billed for activities that are an integral component of another covered Medicaid service.
- Service Coordination services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program.
- Service Coordination cannot be billed for activities integral to the administration of foster care programs.
- Service Coordination cannot be billed for activities required of representative payees. Example: writing checks, maintaining bank account, paying the electric bill, compiling a report for Social Security, etc. (Linkage to the payee on behalf of the member is an acceptable Service Coordination activity).
- Service Coordination cannot be billed for Human Resources activities. Example: calling direct care staff to see if they can work with the member, interviewing, etc.
- Service Coordination cannot be billed for evaluation a member's IPP implementation by means of review of "billing or billing documentation" or other auditing activities. (The Service Coordinator may not function as a billing person/auditor. The Service Coordinator may review/monitor implemented services.)
- Service Coordination cannot be billed for leaving voice mail messages.
- Service Coordination cannot be billed for sitting in a waiting room with a member.

- Service Coordination cannot be billed for activities that should be performed by a home manager. Example: fire drills, checking hot water tanks, etc.
- Service Coordination cannot be billed for clinical supervision.
- Service Coordination cannot be billed for administrative activities such as filing.
- Service Coordination cannot be billed for Utilization Management activities.
- Service Coordination cannot be billed for activities that are performed outside of West Virginia unless the Service Coordinator is accompanying the member to a WV Medicaid reimbursable service
- Service Coordination cannot be billed for activities not related to the member.
- Service Coordination cannot be billed for training Agency Staff and Qualified Support Workers.
- Service Coordination cannot be billed for developing goals for a member.
- Service Coordination cannot be billed for the entire calendar month if a home visit did not occur within that calendar month.
- Direct care services provided by the Service Coordinator must be billed utilizing the appropriate direct care service code.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to one of the following requirements listed below.

- Four year degree in a human service field and one or more years' experience in the I/DD field.
- Four year degree in a human service field and less than one year of experience in the I/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of treatment plans for 6 months. This must be verified by supervisory documentation once per month).
- Four year degree in a non-human service field and one year experience in the I/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for 6 months. This must be verified by supervisory documentation once per month).
- No degree or 2 year degree and is a Licensed Social Worker grandfathered in by the West Virginia Board of Social Worker Examiners due to experience in the I/DD field. (Restrictions - none)
- Registered Nurses with a 2 year RN degree employed prior to October 1, 2011.

513.9.1.12 Skilled Nursing: Traditional Option

513.9.1.12.1 Skilled Nursing: Licensed Practical Nurse: Traditional Option:

Procedure Code: T1003-U4 1:1 ratio
T1003-U3 1:2 ratio
T1003-U2 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:
Nursing services listed in the service plan are within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by a LPN under the supervision and monitoring of a RN actively licensed to practice in the State. Nursing services that must be provided by an awake and alert LPN include but are not limited to: (Note: If these services are provided by an RN then the LPN code must be billed for reimbursement)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);
- Reviewing and verifying physician orders are current, properly documented and communicated to direct care staff and others per I/DD Waiver provider policy;
- Direct nursing care including medication/treatment administration;
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Review scheduled medical appointments before occurrence and communicate this information to others per I/DD Waiver provider policy;
- Facilitate procurement of and monitoring of medical equipment;
- Keep emergency contact information updated and accurate;
- Bill for travel time between ISS, licensed group home and licensed day program settings for the purpose of passing medications.
- Train members on individualized medical and health needs, such as wound-care, medically necessary diets, etc.

If a member requires more than 2 hours per day of LPN service, the Request for Nursing Service (WV-BMS-I/DD-09) must be submitted to the ASO for prior authorization.

If the member receives 2 or more hours of skilled nursing services per day, then the LPN is responsible for providing direct care supports and training.

In ISS or licensed group homes, the total number of service units may exceed 24 hours per day when the LPN also passes medication.

The LPN may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO at the request of the member or their legal representative.

In a 3-person home which requires a nurse 24 hours/day, staff may bill LPN 1:3, with no other staff 24 hours/day –or- bill LPN 1:1 plus an additional staff person billing direct supports 1:2. With this option, each member in the home could be considered for authorization for up to 8 hours of LPN 1:1 per day. If the LPN is working with a particular member (such as medication administration) he/she would bill LPN 1:1.

If an LPN is traveling to pass medications at an ISS, licensed group home or licensed facility-based day program, the LPN should bill 1:1 for 1 member during travel time. The time should be disseminated equally among all members receiving medication administration (i.e. bill for member A on day 1, bill for member B on day 2, etc.) so that the travel billing is fairly distributed across member purchase requests and will not disproportionately use 1 member's individualized budget over another's.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of LPN services cannot exceed 11,680 units/2920 hours (Average 8 hours/day) per member's annual IPP year or the monetary equivalent of 8 hours of 1:1 LPN service when alternate LPN service ratios are used.
- When the member accesses other direct care services, any LPN units in excess of 2920 are counted toward the cap listed in the Person-Centered Supports sections in the Traditional Option, excluding Respite
- This service may not be billed concurrently with any other direct care services.
- Agency staff to member ratio codes are 1:1, 1:2 and 1:3.
- Agency staff providing Skilled Nursing LPN services may not be an individual who lives in the member's home.
- LPN services may not be billed for completing administrative activities including these listed below.
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the I/DD Waiver provider but not the I/DD Waiver manual.
    - Waiting at a physician's office.
    - Conducting group training on general medical topics.

- Orientation training that is not member-specific.
- Reviewing incident reports.

Documentation:

A detailed progress note for each service is required. Documentation must include all of the following items.

- Member's Name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Detailed summary of the service provided
- Signature and credentials of the agency staff

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency staff must be a Licensed Practical Nurse in the State of WV or a licensed Registered Nurse in the State of WV.

513.9.1.12.2 Skilled Nursing: Licensed Registered Nurse: Traditional Option

Procedure Code: T1002-HI

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

RN Skilled Nursing services listed in the service plan are within the scope of the West Virginia Nurse Practice Act, ordered by a physician and are provided by a licensed RN licensed to

practice in the State. RN Skilled Nursing services are services which only a licensed RN can perform. The service must be provided by a RN under the direction of a physician. The RN may perform clinical supervision of LPN and AMAP staff.

RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of a LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code.

The RN may also bill for training of staff in the member's home, ISS, licensed group and licensed day program settings on the member's specific medical needs and related interventions as recommended by the member's treatment team.

The RN may travel between ISS, licensed group home and licensed facility day program settings in order to pass medications.

The RN may attend and participate in the IPP and the annual assessment of functioning for eligibility conducted by ASO based upon the member or their legal representative's request.

Direct care services provided by the RN must be billed utilizing the appropriate direct care service code.

The RN may bill to complete assessments if a member's medical need warrant an individualized assessment.

The RN must complete a summary of services provided if necessitated by a change in the member's medical needs, such as Emergency Room visits, medication changes, diagnostic changes, new treatments recommended by physician, etc.

The RN may bill to consult with LPNs who are providing direct care when an urgent, member-specific medical need arises.

Documentation:
A detailed progress note for each service is required. Documentation must include all of the following items.

- Member's Name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Detailed summary of the service provided
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 480 units/120 hours per member's annual IPP year.
- The agency staff to member ratio for this service is 1:1.
- If the RN provides a skilled nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code/rate.
- Agency staff providing Skilled Nursing RN services may not be an individual who lives in the member's home.
- RN services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- RN services may not be billed for completing administrative activities including these listed below.
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the I/DD Waiver provider but not the I/DD Waiver manual.
    - Waiting at a physician's office.
    - Reading LPN notes.
    - Conducting group training on general medical topics.
    - Orientation training that is not member-specific.
    - Reviewing incident reports.
    - Assessing LPN competency and providing support.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency staff must be a licensed Registered Nurse in the State of WV.

513.9.1.12.2.1 Skilled Nursing: Licensed Registered Nurse: Individual Program Planning: Traditional Option

Procedure Code: T2024-TD

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations. The meeting cannot begin at one location and then be continued at another.

Definition of Service:

This is a service that allows the RN to attend a member's IDT meeting in person or by video-conferencing to present assessments or evaluations completed for the purpose of integrating recommendations, training goals and intervention strategies into the member's IPP.

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The RN participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

Documentation:

Documentation must include signature, date of service and the total time spent at the meeting on the member's IPP and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 Events per member's annual IPP year.
- Professional must attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP Planning code, the professional must be physically present for the duration of IPP meeting. IPP cannot be billed for preparation prior or follow-up performed after the IPP meeting.
- Agency staff providing Skilled Nursing RN IPP services may not be an individual who lives in the member's home.
- Only one RN may bill for this service during an IDT meeting.

Agency Staff Qualifications:

All the general requirements in Sections 513.1.12.2, 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency employee must be a licensed Registered Nurse in the State of West Virginia.

513.9.1.13 Speech Therapy: Traditional Option

Procedure Code: 92507-GN

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Speech Therapy is provided directly to the member by an agency staff that is a licensed speech pathologist and may include:

- screening and assessments;
- direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids;
- language stimulation and correction of defects in voice, articulation, rate and rhythm;
- design, fabrication, training and assistance with adaptive aids and devices; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from Speech Therapy services furnished under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance while the Speech Therapy services furnished under the State Plan are short-term and restorative in nature.

The speech therapist may attend and participate in IDT meetings and the annual assessment of functioning eligibility conducted by the ASO if requested by the member or their legal representative.

Direct care services provided by the speech therapist must be billed utilizing the appropriate direct care service code.

Documentation:

A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 96 units/96 events per member's annual IPP year for members below age 24.
- 48 units/48 events per member's annual IPP year for members age 24 and over.
- The agency staff to member ratio for this service is 1:1.
- Agency staff providing Speech Therapy services may not be an individual who lives in the member's home.
- Agency staff may not bill Speech Therapy services for completing administrative activities.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a licensed Speech Therapist in the State of WV.

If the Speech Therapist is contracted by the I/DD Waiver provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Speech Therapist only needs to be licensed to practice in the State of WV.

513.9.1.14 Supported Employment: Traditional Option

Procedure Code: T2019 1:1 ratio
T2019-HQ 1:2-4 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in an integrated community work setting.

Definition of Service:

Supported Employment Services provided by awake and alert staff are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing support based upon the member's level of need.

Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of the member's on-the-job work activities);
- Job development and placement for a specific waiver member with the member present;
- On-the-job training in work and work-related skills;
- Accommodation of work performance task;
- Supervision and monitoring by a job coach;
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors;
- Retraining as jobs change or job tasks change;
- Training in skills essential to obtain and retain employment, such as the effective use of community resources;
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment.

Supported Employment Services must be supervised by a Therapeutic Consultant. In addition to the standard training requirements, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction.

Persons providing supported employment services may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.

Documentation is maintained in the file of each member receiving this service that a referral was made to a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) before this service was provided.

Documentation:

Documentation must include all of the following items.

- Member's Name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Agency staff providing Supported Employment services may not be an individual who lives in the member's home.
- The maximum annual units of supported employment cannot exceed 8,320 units/2080 hours (Average 8 hours/day) per member's annual IPP year. When the member accesses other direct care services, these units are counted toward the cap listed in the Person-Centered Supports section in the Traditional Option, excluding Respite
- This service may not be billed concurrently with any other direct care services.
- Group services for this service have an agency staff to member ratio of 1:2-4.
- Up to 48 units/12hours of Supported Employment services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Supported Employment staff.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.15 Therapeutic Consultant: Traditional Option

Procedure Code: T2025 -HN

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need. Services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Therapeutic Consultant develops training plans and provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., person-centered support workers, facility day habilitation providers and supportive employment providers). Also, the Therapeutic consultant provides training for respite workers (if applicable for —respite-relevant training objectives or health or safety training objectives only). This service is provided to members with the assessed need for adaptive skills training. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. This monitoring is performed and documented at minimum on a monthly basis. The Therapeutic Consultant observes the individual prior to developing a training plan. The Therapeutic Consultant follows up once the plan has been implemented to observe progress and revise the plan, as needed.

The Therapeutic Consultant may perform the following functions:

- Develops task analysis portion of the IHP/ISP and person specific strategy or methodology for development of habilitation plans.
- May develop Interactive Guidelines or Behavior Protocols for individuals who do not meet the criteria for having a Behavior Support Plan developed by a Behavior Support Professional.
- Evaluates environment(s) for implementation of the ISP which creates the optimal environment for habilitation plans.
- Assists members in selecting the most suitable environment for their habilitation needs.
- Trains primary direct workers (i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers) in person-specific aspects habilitation plans or guidelines.
- Provides direct care services when needed and bills the appropriate direct care service code.

- Attends and participates in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO when requested by the member or their legal representative.
- Presents proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.
- May bill for developing/updating the behavioral crisis section of the member's crisis plan if a Behavior Support Professional is not performing this function.
- May verify data compiled by all Person-Centered Support staff for accuracy.

The Therapeutic Consultant may also perform the following functions if they have met the training requirements as a BSP as identified in section 513.9.1.1:

- Train direct care workers in all aspects of PBSPs implementation(i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers).
- Assess, evaluate and monitor the effectiveness of PBSPs.
- Collect and evaluate data and complete a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan or to generate a Positive Behavior Support plan.
- Collaborate with Therapeutic Consultant(s) from other agency(s) to ensure that positive behavior support strategies are consistently applied across all environments.
- Facilitate person-centered planning as a component of the Positive Behavior Support plan.
- Present proposed restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information regarding the member.
- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.
- May provide on-site training to the support staff in behavior/crisis situations.
- May bill for phone consultation during behavioral crisis situations.
- May bill for attendance of and contribution to Futures Planning sessions, including PATHs and MAPs.

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

Documentation:
A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent

- Analysis of the data collected or problem identified
- Clinical outcome of the service provided
- Plan of intervention as the result of the analysis
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with BSP.
- Job Placement activities are limited to 20 units/5 hours per quarter.
- Agency staff providing Therapeutic Consultant services may not be an individual who lives in the member's home.
- Direct care services provided by the TC must be billed utilizing the appropriate direct care service code.
- TC services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- TC services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
    - Filing, collating, writing notes to staff.
    - Phone calls to staff.
    - Observing staff while training individuals without a clinical reason.
    - Administering assessments not warranted or requested by the member.
    - Making plans for a parent for a weekend visit.
    - Working in the home with providing direct care staff coverage.
    - Sitting in the waiting room for a doctor or medical appointment.
    - Conducting a home visit routinely and without justification–only service coordinators are required to make monthly home visits.
    - TC services cannot be billed for traveling to complete TC services.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to 1 of the following requirements:

- Four year degree in a human service field and 1 or more years of professional experience in the I/DD field and completion of the facilitated 3 hour overview of Positive

Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network; or

- Four year degree in a human service field and less than 1 year of professional experience in the I/DD field and completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of habilitation programming for six months. This must be verified by supervisory documentation once per month; or
- Four year degree in a non-human service field and 1 year professional experience in the I/DD field completion of the facilitated 3-hour overview of Positive Behavior Support created by the West Virginia – Association for Positive Behavior Support (WV-APBS) Network. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of habilitation programming for 6 months. This must be verified by supervisory documentation once per month).

A Positive Behavior Support Plan can only be written by an individual who has met the Agency Staff Qualifications as a Behavior Support Professional.

513.9.1.15.1 Therapeutic Consultant: Individual Program Planning: Traditional Option

Procedure Code: T2024-HI

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations. The meeting cannot begin at one location and then continue at another location.

Definition of Service:

This is a service that allows the Therapeutic Consultant to attend a member's IDT meeting to present assessments or evaluations completed for purpose of integrating recommendations, training goals and intervention strategies into the member's IPP.

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The Therapeutic Consultant participates in the IDT

meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

Documentation:

Documentation must include signature, date of service and the total time spent at the meeting on the member's IPP and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 Events per member's annual IPP year.
- Therapeutic Consultant may attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP code, the TC must be physically present for the duration of IPP meeting. IPP cannot be billed for preparation prior or follow-up performed after the IPP meeting.
- Agency staff providing Therapeutic Consultant services may not be an individual who lives in the member's home.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to all of the requirements in Section 513.8.2.15.

513.9.1.16 Transportation: Traditional Option

513.9.1.16.1 Transportation: Miles: Traditional Option

Procedure Code: A0160-U1

Service Units: Unit = 1 mile

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be billed to and from any activity or service outlined in the member's IPP and based on assessed need.

Definition of Service:

Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program or Supported Employment activities, or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

This service may be billed concurrently with Person-Centered Support Services, Respite, LPN, RN, Supported Employment and Facility-Based Day Habilitation services.

Documentation:

Agency staff must complete the transportation log section of the Direct Support Documentation Form (WV-BMS-I/DD-07) to include all of the following items.

- Member's Name
- Service code
- Date of service
- "From" location
- "To" location
- Purpose of trip
- Total number of miles per trip

The member's IPP must specify the number of miles per service (ex. Up to 100 miles per month shall be used for transporting the member to and from his job location).

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 9,600 miles per member's annual IPP year (based on average of 800 miles per month).
- Member must be present in vehicle if mileage is billed. If more than one member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency staff must have a valid driver's license, proof of current vehicle insurance and registration in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

513.9.1.16.2 Transportation: Trips: Traditional Option

Procedure Code: A0120-HI

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be billed to and from any activity or service outlined on the member's IPP and based on assessed need.

Definition of Service:

Transportation services are provided to the I/DD Waiver member in the I/DD Waiver provider's mini-van or mini-bus for trips to and from the member's home, licensed Facility-based Day Habilitation Program or Supported Employment site or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

The agency mini-bus or mini-van must have proof of current vehicle insurance and registration inside the vehicle in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections.

Agency passenger mini-bus or mini-van must have had the original capacity to transport more than 6 passengers but less than 16 passengers.

Documentation:

Agency staff must complete the transportation log section of the Direct Support Documentation Form (WV-BMS-I/DD-07) to include all of the following items.

- Member's Name
- Service code
- Date of service
- "From" location
- "To" location

- Purpose of trip
- Total number of miles per trip

The member's IPP must specify the number of trips per service (ex. Up to 20 trips per month shall be used for transporting the member to and from his job location).

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 one way trips per day or 874 trips annually.
- Member must be present in Agency-owned mini-van or mini-bus if trips are billed.
- A trip must be related to a specific activity or service based on an assessed need and identified in the IPP.
- A trip may be billed concurrently with Person-Centered Support Services, Respite, Supported Employment and Facility-Based Day Habilitation.
- May utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

Agency Staff Qualifications:

All the general requirements in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency employee must have a valid driver's license.

513.9.2 Participant-Directed Services Option

This option provides each eligible member with the opportunity to exercise choice and control over the participant-directed services they receive. The participant-directed services which members may self-direct are:

- Person-Centered Support Services
- Respite
- Transportation
- Participant-directed Goods and Services

Two Financial Management Service (FMS) models are available to members to support their use of participant-directed services. These are the Agency with Choice (AwC) FMS Model and the *Personal Options* FMS Model.

Under the AwC FMS model, the member's chosen I/DD Waiver provider is the Common Law Employer of the Agency Staff employed to provide services to the member. The AwC I/DD Waiver provider is responsible for all payroll functions, including determining wages and benefits to the Agency Staff. The member is a Managing Employer who shares in the responsibility of hiring, training, scheduling, supervising and dismissing the member's Agency Staff. The member may appoint a representative to assist with these functions. The relationship between the AwC I/DD Waiver provider and the member or their representative (when applicable) is that of a Co-Employer.

A member's representative may not be a paid employee providing AwC I/DD Waiver services to the member.

Under the AwC FMS model, no Agency Staff's hourly wage may exceed the Medicaid rate minus all mandatory deductions.

Under the *Personal Options* FMS Model, the member is the Common Law Employer of the Qualified Support Workers hired by the member. The *Personal Options* FMS acts as the fiscal/employer agent to the member and is responsible for managing the receipt and distribution of the member's participant-directed budget funds, processing and paying Qualified Support Workers' payroll and transportation reimbursement as well as payment of vendors' invoices for approved participant-directed goods and services. The *Personal Options* FMS also provides information and assistance to members, their representatives and employees as appropriate. The members and their representatives, if applicable, control the work being performed on the member's behalf by hiring, training, scheduling, supervising and dismissing the member's direct care workers. A member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

A member's representative may not be a paid employee providing *Personal Options* I/DD Waiver services to the member.

The Traditional Service Option, which includes the full array of services, is still available to members who choose AwC or *Personal Options*, however the 4 services mentioned above may be participant-directed. The member who chooses to direct part or all of these services is required to purchase Service Coordination through the Traditional Service Option. Other services chosen by the member that are not part of the 4 participant-directed services also need to be purchased through the Traditional Service Option before any or all of the 4 participant-directed services may be purchased.

The maximum amount of a member's participant-directed budget is the equivalent monetary value of direct care services units, transportation and Participant-Directed Goods and Services units available, based on the age, residential setting, needs of the member and units available. When a member is accessing direct care services, whether in the Traditional or Self Directed Option, the total amount of direct care services in both Options must be added together and may not exceed the caps in both Options combined. Direct care services are defined as PCS:

Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation, LPN, Agency with Choice PCS and *Personal Options* PCS. For example, an adult living at home with his/her parents and his/her IDT has determined the member needs 12 hours of direct care services, his/her budget supports this amount and the team has chosen to utilize 6 hours of Supported Employment and 2 hours of Person-Centered Support: Agency for a total of 8 hours of Traditional direct care services daily. This leaves the monetary equivalent of 4 hours of *Personal Options* PCS that is transferred into the member's self-directed budget. If this adult member has been determined to need 9600 units of transportation by his/her IDT, his/her budget supports this amount and the team chooses to utilize 6000 units of Traditional mileage for the member to be transported to and from their Supported Employment job site then this leaves the monetary equivalent of 3600 units of *Personal Options* Transportation that is transferred into the member's self-directed budget. This member may also have been determined to need 2 hours of respite daily, his team and his budget supports this need and chooses to self-direct this entire service. The monetary equivalent of 2 hours of *Personal Options* Respite Services is transferred to the member's self-directed budget. If the member has been determined to need 1000 units of either EAA/Home or Vehicle and Participant-Directed Goods and Services combined, his team and his budget supports this need and he/she chooses to use 600 units of EAA/Home, then this leaves the monetary equivalent of 400 units of Participant-Directed Goods and Services that is transferred into the member's self-directed budget.

Once all of the equivalent monies are transferred into the member's self-directed budget, the member and/or their legal/non-legal representative, along with their Personal Options Resource Consultant, create a spending plan. At this time, the member and/or their legal/non-legal representative choose the types of services, the amount of services and the wages of the member's employees within the parameters of the entire self-directed budget.

The Participant-Directed Service Option is available to every eligible I/DD Waiver member with the following exception: Members living in OHFLAC licensed residential settings are not eligible for Participant-Directed Services.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s). The Service Coordinator must enter a request into the CareConnection® for these services.

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within 2 days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

The Agency with Choice participant-directed service option is described more fully in section 513.9.2.1. The *Personal Options* participant-directed service option is described more fully in Section 513.9.2.2.

513.9.2.1 Participant-Directed Services Option: Agency with Choice Model

One of the Financial Management Service (FMS) models available to individuals using participant-directed services is the AwC FMS model. Under this FMS model, I/DD Waiver providers may provide FMS to members and their representatives who select the AwC participant-directed service option, once the I/DD Waiver provider is certified as an AwC FMS provider by BMS. Under the AwC FMS model, the AwC FMS provider and the member enter into a Co-Employer arrangement. The AwC FMS provider is the primary or Common Law Employer while the member is the secondary or Managing Employer of the member's Qualified Support Worker(s). The member may appoint a representative to assist with these functions, but the member remains the Managing Employer.

Under the AwC FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

As the Managing Employer, the member and the representative (when applicable):

- Recruit/select and refer their preferred workers for hire to the AwC FMS provider for assignment back to them and
- Select the level of participation in which they are willing and able to engage in employer-related tasks.

As the Common Law Employer, the AwC FMS provider is responsible for:

- Meeting Medicaid program requirements;
- Hiring Agency Staff referred by the Managing Employer for assignment back to the Managing Employer and performing the human resource tasks;
- Verifying that Agency Staff meet criteria in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 as well as each service definition;
- Training Agency Staff in their reporting requirements as stated in Section 513.2.3.
- Verifying citizenship and legal alien status of Agency Staff;

- Processing payroll and managing the related Federal, State, and local tax filings and payments;
- Processing and paying invoices for participant-directed goods and services that are authorized and approved in a member's participant-directed budget;
- Providing employer support as needed and requested by the Managing Employer;
- Providing workers' compensation insurance for Agency Staff; and
- Assisting the Managing Employer, as needed and requested in providing emergency back-up Agency Staff and managing those emergency supports.
- Providing orientation to the Managing Employer on using participant-directed services and AwC FMS; and
- Providing skills training for the Managing Employer to assist them in effectively performing as the Managing Employer of the Agency Staff.

The AwC FMS provider may not impose excessive barriers that discourage Managing Employers from recruiting and referring their preferred staff and/or performing as a Managing Employer. Each AwC FMS provider must be able to respond to inquiries for further information from a Managing Employer as follow-up to the ASO's educational component of the annual functional assessment or interest generated from any other source.

The AwC FMS provider makes available Information and Assistance (I&A) services to Managing Employers to support their use of participant-directed services and to perform effectively as the Managing Employer of the Agency Staff. I&A provided by the AwC FMS include:

(1) Managing Employer orientation sessions once the member and representative (when applicable) chooses to use participant-directed service and chooses an available AwC FMS provider; and,
(2) Skills training to assist Managing Employers to effectively use participant-directed services and FMS and perform the required tasks at the level they choose to participate as the Managing Employer of the Agency Staff.

The Managing Employer orientation provides information on:

(1) The availability for the member and their representative to choose the level of participation they engage in as the Managing Employer of the Agency Staff;
(2) Completion of the Co-Employer agreement between the member and their representative and the AwC FMS;
(3) The roles, responsibilities of and potential liabilities for each of the interested parties related to the delivery and receipt of participant-directed services (i.e., Managing Employer, AwC FMS, ASO, SC, BMS);
(4) How to use the AwC FMS services;
(5) How to effectively perform as a Managing Employer of the Agency Staff;
(6) How to ensure that the Managing Employer is meeting Medicaid requirements and AwC FMS agreements, and,

(7) How a member would stop using participant-directed services and begin receiving traditional waiver services, if they so desire.

Support and/or skills training also would be available for performing the tasks required of a Managing Employer of Agency Staff (i.e., the Managing Employer may be having difficulty supervising an Agency Staff and skills training could be provided to help them improve their performance completing this task).

The AwC FMS provider's performance is monitored in a number of ways.

First, BMS reviews the AwC FMS provider candidate's readiness to perform the required FMS and I&A tasks by having all prospective entities complete an AwC FMS provider Self-Assessment and evaluating the information submitted by the AwC FMS provider. The evaluation of an AwC FMS provider candidate's self-assessment results in the following actions:

- An approval for the agency to immediately provide AwC FMS.
- A request for more information should the information provided in the AwC FMS provider Self-Assessment fall short of the requirements for AwC FMS provider certification. The AwC FMS provider is required to re-submit a full, second self-assessment addressing all areas of correction identified by BMS.

Second, the ASO conducts onsite AwC FMS Provider Performance Reviews on a defined cycle using a Review Protocol that includes all AwC FMS provider requirements as well as the agency's requirements as a I/DD Waiver provider.

With regard to the provision of AwC FMS, the ASO is responsible for:

- Distributing the Managing Employer satisfaction survey, developed by BMS, to AwC FMS providers and receiving and analyzing the survey results and reporting them to BMS annually.
- Conducting on site AwC FMS Provider Performance Reviews on a defined cycle using a Review Protocol based on the AwC FMS provider requirements.
- In conjunction with BMS, ensuring corrective action occurs for significant and recurring failure to perform the AwC FMS provider requirements (i.e., gross over and underutilization (utilization determined by the utilization criteria in the agreements) of services, fraud, and ongoing and unresolved health and safety issues).

If the ASO finds that an AwC FMS provider is not meeting AwC FMS provider requirements as a result of conducting the AwC FMS Provider Performance Review, the ASO may recommend the following actions to BMS for approval and execution.

- Require a Plan of Correction (POC) be completed while continuing to provide AwC FMS.
- Require a POC be completed, as well as, freezing new enrollees to the AwC FMS provider until notified by the BMS otherwise.

- Require a POC be completed, as well as, applying monetary disallowances of noted AwC FMS administrative reimbursements due.
- Recommend decertification of the AwC FMS provider to BMS with a request to initiate transfer support for members and legal/non-legal representatives using the AwC FMS provider.

513.9.2.1.1 Qualifications for Agency with Choice Agency Staff

All Agency Staff who are hired to provide services under the Agency with Choice Model must meet the standards in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3.

Under the AwC FMS model, no Agency Staff's hourly wage may exceed the Medicaid rate minus all mandatory deductions.

513.9.2.1.1.1 Financial Management Services: Participant-Directed Option: Agency with Choice Model

Procedure Code: T2040

Service Units: Unit = Event

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is to be determined following the purchase of Traditional Services.

Definition of Service:

Members choosing to direct their services under the Agency with Choice Model function as a Managing Employer and must obtain Financial Management Services through an I/DD Waiver provider who is a certified Agency with Choice provider that provides the following services:

1) Assists a Managing Employer to exercise budget authority by:
    - Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the member's budget funds (received, disbursed and any balances); and,
    - Processing and paying invoices for goods and services in the member's approved service plan.
2) Assists a Managing Employer to exercise Managing Employer authority by:
    - Assisting the Managing Employer in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the member employs);
    - Collecting and processing support worker's timesheets;
    - Operating a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g.,

income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums); and,
- Distributing payroll checks on the member's behalf.

3) Assists with additional functions, including:
   - Providing orientation/skills training to a Managing Employer about their responsibilities when they function as the co-employer of the Agency Staff; and
   - Providing ongoing information and assistance to Managing Employers.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Limited to 1event per month/12 events per year.

Provider Qualifications:

- Each Agency with Choice FMS provider is verified initially and annually by BMS.

513.9.2.1.1.2 Goods and Services: Participant-Directed Option: Agency with Choice Model

Procedure Code: T2028-HI

Service Units: Unit = $1.00

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget.

Site of Service: The goods or services are routinely provided at the member's residence or with the member as they participate in community activities.

Definition of Service:

Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

Goods and Services are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment.
- The member does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the Agency with Choice I/DD Waiver agency.
- Participant-directed Goods and Services are purchased from the participant-directed budget.
- The need for PDGS supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the Agency with Choice I/DD Waiver provider and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.
- The need must be documented on the Annual IPP unless it is a new need which must be documented on a Critical Juncture IPP.
    - NOTE: All services must be based on assessed need and within a member's individualized budget. If the need was documented on the Annual IPP, but not incorporated into the budget at that time and the member is over budget, then modifications of the services already purchased must occur before this authorization will be approved. If this is a new need, then it should be presented as a need to increase the budget based on a new need.

Documentation:

- Goods and Services are documented in the IPP.
- Goods and Services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- To access Participant-directed Goods and Services the member must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – *Personal Options* Option.

- The AwC provider must not pay PDGS funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- The following represents a non-inclusive list of non-permissible Goods and Services:
    - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services;
    - Goods, services and supports available through another source;
    - Goods, services or supports provided to or benefiting persons other than the individual member;
    - Room and board;
    - Personal items and services not related to the qualifying disability;
    - Gifts for workers/family/friends, payments to someone to serve as a representative,
    - Clothing, food and beverages;
    - Electronic entertainment equipment;
    - Utility payments;
    - Swimming pools, hot tubs and spas;
    - Costs associated with travel;
    - Household furnishings such as comforters, linens, drapes and furniture
    - Vehicle expenses including routine maintenance and repairs, insurance and gas money;
    - Medications, vitamins and herbal supplements;
    - Illegal drugs or alcohol;
    - Experimental or investigational treatments
    - Printers;
    - Monthly internet service;
    - Yard work;
    - Household cleaning supplies;
    - Home maintenance;
    - Pet care;
    - Respite services;
    - Spa services;
    - Education;
    - Personal hygiene items;
    - Day care; and
    - Discretionary cash.

Provider Qualifications:

All goods and services must be purchased from an established business or otherwise qualified entity or individual and prior approved by the ASO. The AwC is responsible for maintaining on file receipts and other approved documentation.

513.9.2.1.1.3 Person-Centered Support: Participant-Directed Option: Agency with Choice Model

Procedure Code: S5125-U7 1:1 ratio
S5125-U8 1:2 ratio
S5125-U9 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, an unlicensed ISS and public community locations. This service may not be provided in the Agency Staff's home unless the Agency Staff's home is also the member's home.

Definition of Service:

AwC Person-Centered Support (PCS) provided by awake and alert staff consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS services must be assessment-based, outlined on the member's IPP and may not exceed the annual individualized participant-directed budget allocation.

Agency staff passing medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Agency Staff who provide Person-Centered Support may not be the member's spouse.

Agency staff providing PCS services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

AwC PSC staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the Agency Staff should complete the accompanying Direct Care Progress Note to detail the issue. If training was provided the Person-Centered Support worker must also complete the task analysis documentation.

The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate Agency Staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the Agency Staff

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget. The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.

- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- AwC: Personal Options services are limited to the equivalent monetary value of 11,680 units/2920 hours (based upon average of 8 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920), AwC: PCS and *Personal Options:* PCS excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- AwC: Personal Options services are limited to the equivalent monetary value of 17,520 units/4380 hours (based upon average of 12 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920 units), AwC : PCS and *Personal Options: PCS* excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- AwC: Personal Options services are limited to the monetary equivalent value of 35,712 units/8928 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings, to include training. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility-Based Day Habilitation and LPN (when LPN units exceed 2,920 units) and PCS: Agency with Choice.
- This service may not be billed concurrently with any other direct care service.
- AwC: PCS cannot replace the routine care, and supervision which is expected to be provided by the parent of a minor member or by a Specialized Family Care Provider providing care to a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- The member's appointed representative may not be employed by the member for providing AwC I/DD Waiver services.
- AwC: PCS may not substitute for federally mandated educational services.
- AwC: PCS must be based upon assessed needs, address identified health and safety issues and be outlined in the member's IPP.
- AwC: PCS is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary change in environment.
- AwC: PCS is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of AwC: Person-Centered Support services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional

activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.2.1.1.4 Respite: Participant-Directed Option: Agency with Choice Model

Procedure Code: T1005-UA 1:1 ratio
T1005-UB 1:2 ratio
T1005-UC 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be provided in the member's home, a Specialized Family Care Home and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

Respite Services provided by awake and alert staff are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the primary care-giver for temporary relief and to help prevent the breakdown of the primary care-giver due to the physical burden and emotional stress of providing continuous support and care to the member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite Care may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members

- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- Support the member while the primary care-giver works outside the home.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Respite staff.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.
- AwC PSC staff may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the Agency Staff should complete the accompanying Direct Care Progress Note to detail the issue.
The Direct Care Service Log must include the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate Agency Staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the Agency Staff

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.

- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- AwC: Respite services are limited to the equivalent monetary value of 6,912 units/1728 hours (Average of 144 hours a month or 4.73 hours a day) AwC Respite per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- AwC: Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite services may not be used to replace natural supports (which includes non-custodial parents) available to the member.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.2.1.5 Transportation: Miles – Participant-Directed Option: Agency with Choice Model

Procedure Code: A0160-U1

Service Units: Unit = 1 mile

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be billed to and from any activity or service outlined on the member's IPP and based on assessed need.

Definition of Service:

- Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program or Supported Employment activities, or to the site of a planned community-based activity or service which is addressed on the IPP and based on assessed need.

- This service may be billed concurrently with Person-Centered Support Services: Agency with Choice or, Respite: Agency with Choice.

Documentation:

Agency staff must complete the transportation log section of the Direct Support Documentation Form (WV-BMS-I/DD07) to include all of the following items.

- Member's Name
- Service code
- Date of service
- "From" location
- "To" location
- Purpose of trip
- Total number of miles per trip

The member's IPP must specify the number of miles per service (ex. Up to 100 miles per month shall be used for transporting the member to and from his job location).

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed. If more than 1 member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must have a valid driver's license, proof of current vehicle insurance and registration in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

513.9.2.2 Participant-Directed Services: *Personal Options* Financial Management Service Option

Another Financial Management Service (FMS) model available to members to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the member is the Common Law Employer of the Qualified Support Workers they hire directly. The member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

A member's representative may not be a member's employee providing *Personal Options* I/DD Waiver services to the member.

No Qualified Support Worker's hourly wage may exceed the Medicaid rate minus all mandatory deductions. All Qualified Support Worker's hired by the member must meet the requirements in Sections 513.9.2.1, 513.9.2.1.1 and 513.9.2.1.2.

The *Personal Options* Fiscal/Employer Agent is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying Qualified Support Workers' payroll and reimbursements for transportation as well as vendors' invoices for approved participant-directed goods and services. The Personal Options Fiscal/Employer Agent is also required to provide information and assistance to members and their representatives as appropriate.

Under *Personal Options* FMS option, the member is the Common Law Employer of the Qualified Support Workers they hire directly.

The Common Law Employer is responsible to:

- Elect the participant-directed option.
- Work with their Resource Consultant (RC) to become oriented and enrolled in the Participant-Directed Option, enroll Qualified Support Workers, develop a spending plan for the participant-directed budget, and create an emergency Qualified Support Worker back-up plan to ensure staffing, as needed.
- Recruit and hire their Qualified Support Worker(s).
- Provide required and member-specific training to Qualified Support Worker(s).

- Determine Qualified Support Workers' work schedule and how and when the Qualified Support Worker should perform the required tasks.
- Supervise Qualified Support Workers' daily activities.
- Evaluate their qualified support worker's performance.
- Review, sign and submit qualified support workers' time sheets to the *Personal Options* Fiscal/Employer Agent.
- Maintain documentation in a secure location and ensure employee confidentiality.
- Discharge their Qualified Support Worker, when necessary.
- Notify their SC of any changes in service need.

Personal Options fiscal/employer agent is responsible for:

1) Assisting Common Law Employers exercising budget authority;
2) Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the member's budget funds (received, disbursed and any balances);
3) Monitoring members' spending of budget funds in accordance with members' approved spending plans;
4) Submitting claims the state's claim processing agent on behalf of the member/employer;
5) Processing and paying invoices for transportation and goods and services in the member's approved participant-directed spending plan
6) Assisting members exercising employer authority;
7) Assisting the member in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the USCIS Form I-9 for each support service worker the member employs);
8) Assisting in submitting criminal background checks of prospective Qualified Support Workers;
9) Collecting and processing support worker's timesheets;
10) Operating a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums);
11) Distributing payroll checks on the member's behalf;
12) Executing Simplified Medicaid provider agreements on behalf of the Medicaid agency;
13) Providing orientation/skills training to members about their responsibilities when they function as the employer of record of their direct support workers; and
14) Providing ongoing information and assistance to Common Law Employers.
15) Monitoring and reporting data pertaining to quality and utilization of the *Personal Options* FMS as required to BMS.

The *Personal Options* Fiscal/Employer Agent is not the Common Law Employer of the member's Qualified Support Worker(s). Rather, the *Personal Options* Fiscal/Employer Agent assists the member/Common Law Employer in performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. The *Personal Options* fiscal/employer agent operates under §3504

of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and Medicaid program rules, as required.

Personal Options makes available Information and Assistance (I&A) services to Common Law Employers to support their use of participant-directed services and to perform effectively as the Common Law Employer of their Qualified Support Workers. I&A provided by *Personal Options* include:

- Common Law Employer orientation sessions once the member chooses to use participant-directed services and enrolls with *Personal Options*, and,
- Skills training to assist Common Law Employers to effectively use participant-directed services and FMS and perform the required tasks of an employer of record of Qualified Support Workers. Common Law Employer orientation provides information on:
    (1) The roles, responsibilities of and potential liabilities for each of the interested parties related to the delivery and receipt of participant-directed services (i.e., Common Law Employer, *Personal Options,*, ASO, SC, BMS),
    (2) How to use *Personal Options*,
    (3) How to effectively perform as a Common Law Employer of their Qualified Support Workers,
    (4) How to ensure that the Common Law Employer is meeting Medicaid and *Personal Options* requirements, and
    (5) How a member would stop using participant-directed services and begin to receive traditional waiver services, if they so desire. Skills training curricula reinforce Medicaid, *Personal Options*, federal and state labor, tax and citizenship and legal alien status requirements and provide a review of best practices for performing the tasks required of a Common Law Employer of a Qualified Support Worker (i.e., the Common Law Employer may be having difficulty reviewing, signing and submitting Qualified Support Workers' time sheets and skills training could be provided to help them improve their performance completing this task).

Personal Options provides I&A supports to members and their representatives (when applicable) who wish to function as Common Law Employers. The educational presentations provide interested members with information on the role and responsibilities of *Personal Options* and each of the other interested parties (i.e., member, representative, Qualified Support Worker, vendors of participant-directed goods and services and BMS) and what it is required of the member to be a Common Law Employer to his or her Qualified Support Worker(s). These presentations provide the venue through which a member may enroll in the participant-directed option. *Personal Options* makes available I&A supports to members and their representatives (when applicable), to implement and support their use of participant-directed services and performing as an employer of record.

If *Personal Options* is selected by the member, *Personal Options*, rather than the Service Coordinator provides Information & Assistance (I&A) service that includes:

1. Providing or linking Common Law Employers with program materials in a format that they can use and understand.
2. Providing and assisting with the completion of enrollment packets for Common Law Employers.
3. Providing and assisting the Common Law Employer with employment packets.
4. Discussing and/or helping determine the participant-directed budget with the Common Law Employer.
5. Presenting the Common Law Employer with the *Personal Options* fiscal/employer agent's role in regards to payment for services, goods, etc.
6. Assisting Common Law Employers with determining participant-directed budget expenditures (hiring, or purchasing participant-directed goods and services).
7. Providing Common Law Employers with a list of approved purchases or criteria for selection of participant-directed goods and services.
8. Assisting with the development of an individualized spending plan based upon the member's annual participant-directed budget.
9. Making available to the member/representative a process for voicing complaints/grievances pertaining to the *Personal Options* fiscal/employer agent's performance.
10. Providing additional oversight to the Common Law Employer as requested or needed.
11. Monitoring and reporting information about the member's utilization of the participant-directed budget to the member, representative, SC and BMS.
12. Explaining all costs/fees associated with the member directing their own services.

With regard to the provision of *Personal Options* FMS, the ASO is responsible for:

- Distributing the *Personal Options* FMS satisfaction survey, developed by BMS, to Personal Options members or their representatives (when applicable) and receiving and analyzing the survey results and reporting them to BMS annually.
- Conducting *Personal Options* FMS Performance Reviews on a defined cycle using a Review Protocol based on the Personal Options FMS requirements

513.9.2.2.1 Qualifications for Qualified Support Workers

All Qualified Support Workers must meet the qualifications listed below. For all trainings but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires. These trainings include:

- Must be 18 years of age or over;
- Have the ability to perform the participant-specific required tasks;
- Have documentation of initial and renewal of training requirements:
    - Documented training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and annually thereafter;

- Documented training on Emergency Care such as a Crisis Plan, Emergency Worker Back-up Plan and Emergency Disaster Plan upon hire and on an as needed basis thereafter;
- Documented training on Infectious Disease Control upon hire and annually thereafter;
- Documented training on First Aid by a certified trainer from an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current First Aid Certification upon hire and as indicated per expiration date on the card;
- Documented training in Cardiopulmonary resuscitation (CPR) by an approved agency listed on the BMS I/DD Waiver website (http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx) to include always having current CPR certification upon hire and as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the QSW);
- Documented training on Member-specific needs (including special needs, health and behavioral health needs) upon hire and on an as needed basis thereafter; and
- Documented training in Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation upon hire and annually thereafter.

- Qualifications must be verified initially upon hire as current and updated as necessary.
- The QSW may be responsible for the certain costs, i.e. CPR and First Aid certifications, CIB/NCIC background checks.

513.9.2.2.1.2 Criminal Investigation Background (CIB) Check Requirements for Qualified Support Workers

All Qualified Support Workers having direct contact with members must, at a minimum, have a state level CIB check initiated upon hire which includes fingerprints. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the employer of record must require an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also upon hire and every 3 years of employment. The employer of record or Personal Options may choose to do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received, however, only on-line companies that check counties in which the applicant has lived and worked within the last 5 years may be utilized. An individual cannot be employed or continue to be employed by a member/Employer who is directing their own services if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;

- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be made available to the member before continuing the employment of the Qualified Support Worker.

513.9.2.2.1.3 Federal Office of the Inspector General (OIG) Medicaid Exclusion List Requirements for Qualified Support Workers

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities must be checked by the Fiscal/Employer agent (Personal Options) for every employee who provides Medicaid services prior to employment and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

513.9.2.2.1.4 Protective Services Record Check for Qualified Support Workers

All Qualified Support Workers hired after July 1, 2012 having direct contact with members must have a WVDHHR Protective Services Record Checks. These must be initiated on each individual upon hire. The results must be considered by the Fiscal/Employer Agent (Personal Options) before continuing employment. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for

Children and Families, Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the Qualified Support Worker's personnel file.

513.9.2.3 Services Available under the *Personal Options* Participant-Directed Option

513.9.2.3.1 Goods and Services: *Personal Options* Participant-Directed Option:

Procedure Code: T2021-SC

Service Units: Unit = $1.00

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget.

Site of Service: The goods or services are routinely provided at the member's residence or to the member as they participate in community activities.

Definition of Service:

Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment.
- The member does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the *Personal Options* F/EA
- Participant-directed Goods and Services are purchased from the participant-directed budget.
- The need for PDGS supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the *Personal Options* F/EA and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.
- The need must be documented on the Annual IPP unless it is a new need which must be documented on a Critical Juncture IPP.

- NOTE: All services must be based on assessed need and within a member's individualized budget. If the need was documented on the Annual IPP, but not incorporated into the budget at that time and the member is over budget, then modifications of the services already purchased must occur before this authorization will be approved. If this is a new need, then it should be presented as a need to increase the budget based on a new need.

Documentation:

- Goods and Services are documented in the IPP.
- Goods and Services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – Agency with Choice.
- The *Personal Options* provider must not pay PDGS funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- To access Participant-directed Goods and Services the member must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- The following represents non-permissible Goods and Services:
  - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services;
  - Goods, services and supports available through another source;
  - Goods, services or supports provided to or benefiting persons other than the individual member;
  - Room and board;
  - Personal items and services not related to the qualifying disability;
  - Gifts for workers/family/friends, payments to someone to serve as a representative,
  - Clothing, food and beverages;
  - Electronic entertainment equipment;
  - Utility payments;
  - Swimming pools, hot tubs and spas;
  - Costs associated with travel;

- Household furnishings such as comforters, linens, drapes and furniture
- Vehicle expenses including routine maintenance and repairs, insurance and gas money;
- Medications, vitamins and herbal supplements;
- Illegal drugs or alcohol;
- Experimental or investigational treatments
- Printers;
- Monthly internet service;
- Yard work;
- Household cleaning supplies;
- Home maintenance;
- Pet care;
- Respite services;
- Spa services;
- Education;
- Personal hygiene items;
- Day care; and
- Discretionary cash.

Provider Qualifications:

All Goods and Services must be purchased from an established business or other qualified entity or individual and prior approved by the *Personal Options* F/EA. The *Personal Options* F/EA is responsible for maintaining on file receipts and other approved documentation.

513.9.2.3.2 Person-Centered Support: *Personal Options* Participant-Directed Option:

Procedure Code: S5125-UA

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, an unlicensed ISS and public community locations. This service may not be provided in the Qualified Support Worker's home unless the worker's home is also the member's home.

Definition of Service:

Person-Centered Support (PCS) provided by awake and alert staff consists of individually tailored training and/or support activities that enable the member to live and inclusively

participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care
- Receptive or expressive language
- Learning
- Mobility
- Self-direction
- Capacity for Independent Living

PCS services must be assessment based and outlined on the member's spending plan. PCS activities may be completed in the member's residence or in public community settings. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs. Qualified Support Workers (QSW) Staff providing PCS services may participate in person-centered planning, IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

The QSW may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Documentation:

The Qualified Support Worker must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Member's Name
- Month of Service
- Year of Service
- Day of Service
- Total time spent
- Transportation Log including beginning location (from), end location (to) and total number of miles for the trip
- Signature of the QSW and the member and representative (when applicable)

If a Therapeutic Consultant or a Behavior Support Professional is involved in training plans carried out by the QSW, documentation is completed through those training plans per the

member's IPP. This documentation must be maintained by the member/employer and provided to the TC or BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Personal Options services are available to members living in the following types of residential settings: the member's family residence, Specialized Family Care Homes and unlicensed ISS.
- PCS: Personal Options services are limited to the equivalent monetary value of 11,680 units/2920 hours (based upon average of 8 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920 units), AwC: PCS and *Personal Options:* PCS excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- PCS: Personal Options services are limited to the equivalent monetary value of 17,520 units/4380 hours (based upon average of 12 hours per day) of PCS: Traditional Family per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services: PCS: Agency, PCS: Family, Supported Employment, Facility Based Day Habilitation, LPN (When LPN units exceed 2,920 units), AwC: PCS, *Personal Options:* PCS excluding Traditional Respite, AwC Respite and *Personal Options* Respite.
- PCS: Personal Options services are limited to the equivalent monetary value of 35,712 units/8928 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings, to include training. This is in combination with all direct care services available: PCS: Agency, Supported Employment, Facility-Based Day Habilitation and LPN (when LPN units exceed 2,920 units) and PCS: Agency with Choice.
- This service may not be billed concurrently with any other direct care service.
- PCS: Personal Options cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor member or a Specialized Family Care Provider caring for a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- A member's representative may not be a paid employee providing *Personal Options* I/DD Waiver services to the member.
- PCS: Personal Options may not substitute for federally mandated educational services.

- PCS: Personal Options is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.
- PCS: Personal Options is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- PCS: Personal Options may not be provided by the member's spouse.
- Up to 48 units/12hours of *Personal Options: PCS* services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

Qualified Support Worker Qualifications:

All of the requirements in sections, 513.9.2.2.1.1, 513.9.2.2.1.2, 513.9.2.2.1.3 and 513.9.2.2.1.4 must be met .

513.9.2.3.3 Respite: Participant-Directed Option: *Personal Options* Model

Procedure Code: T1005-UD

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be provided in the member's home, a Specialized Family Care Home and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

Respite Services provided by awake and alert staff are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- Support the member while the primary care-giver works outside the home.
- This service may not be billed concurrently with any other direct care service.
- Up to 48 units/12hours of Respite services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may provide training to Respite staff.
- Allow the QSW to attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.
- The QSW may compile data collected in daily documentation during their shift for later review by the member's TC or BSP, as long as safety/health and oversight of the member are not compromised.

Documentation:

The Qualified Support Worker must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Member's Name
- Month of Service
- Year of Service
- Day of Service
- Total time spent
- Transportation Log (when applicable) including beginning location (from), end location (to) and total number of miles for the trip
- Signature of the QSW and the member and representative (when applicable)

If a Therapeutic Consultant or a Behavior Support Professional is involved in training plans carried out by the Respite worker, documentation is completed through those training plans per the member's IPP. This documentation must be maintained by the member/employer and provided to the TC or BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.

- *Personal Options*: Respite services are limited to the equivalent monetary value of 6,912 units/1728 (Average of 144 hours a month or 4.73 hours a day) AwC Respite per member's annual IPP year. This is in combination with all other respite services: Traditional Respite, Traditional Crisis Site Respite, AwC Respite and *Personal Options* Respite. The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- *Personal Options:* Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite services may not be used to replace natural supports (which includes non-custodial parents) available to the member..
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- *Personal Options*: Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite services may not be used to replace natural supports (which include non-custodial parents) available to the member.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- *Personal Options*: Respite services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.

Qualified Support Worker Qualifications:

All of the requirements in sections, 513.9.2.2.1.1, 513.9.2.2.1.2, 513.9.2.2.1.3 and 513.9.2.2.1.4 must be met.

513.9.2.3.4 Transportation: Miles: *Personal Options* Participant-Directed Option:

Procedure Code: A1060-U3

Service Units: Unit = 1 mile

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be billed to and from any activity or service outlined on the member's IPP and based on assessed need.

Definition of Service:

- Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program or Supported Employment activities, or to a community-based planned activity or service which is based on assessed need.
- This service may be billed concurrently with Person-Centered Support Services: *Personal Options* option or Respite: *Personal Options* option.
- The number of miles per service must be included on the member's IPP.

Documentation:

The member's spending plan must specify the number of miles to be provided and Qualified Support Workers must document the provision of transportation on a transportation log that includes:

- Member's Name
- Date of Service
- "From" location
- "To" location
- Purpose of trip

Total number of miles for the trip

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed. If more than 1 member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to an assessed need in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of Wes Virginia.

- The amount of transportation provided to a member directing their services must be identified on their spending plan and may not exceed the annual participant-directed budget allocation.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

Qualified Support Worker Qualifications:

All of the requirements in sections, 513.9.2.2.1.1, 513.9.2.2.1.2, 513.9.2.2.1.3 and 513.9.2.2.1.4 must be met in addition to the following requirement:

- The Qualified Support Worker must have a valid driver's license, proof of current vehicle insurance and registration in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

513.10 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

GENERAL REQUIREMENTS

- I/DD Waiver Program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information*; *Chapter 300, Provider Participation; and Chapter 800, General Administration* of the Provider Manual. This can be found at the BMS Web Site (www.dhhr.wv.gov/bms).
- I/DD Waiver Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the I/DD Waiver provider for at least 5 years in the member's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or 5 years whichever is greater.
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes.
- Failure to maintain all required documentation and in the manner required by BMS, may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.

SPECIFIC REQUIREMENTS

I/DD Waiver Program provider agencies must maintain a specific record for all services received for each I/DD Waiver Program member including, but not limited to:

- Each I/DD Waiver provider who provides Service Coordination services is required to maintain all required I/DD Waiver documentation on behalf of the State of West Virginia and for state and federal monitors.
- All I/DD Waiver Program forms as applicable to the policy requirement or service code requirement.
- Agencies that wish to computerize any of the forms, may do so, however once the automated IPP becomes available through the CareConnection®, it must be used by all agencies. All basic components must be included and the name/number indicated on the form (refer to *Chapter 300, Provider Participation Requirements,* for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS web site (www.dhhr.wv.gov/bms).
- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the I/DD Waiver Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation requirements are detailed in Section 513.9, including all subsections of 513.9, Description of Covered Services.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the Service Coordination provider record. In the course of monitoring of the IPP and services, the Service Coordinator may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it. In addition to all documentation required by other state agencies (OHFLAC), the I/DD Waiver provider must disseminate this information to the member when the member resides in their natural family home. The I/DD Waiver provide must ensure that the following is maintained in the member's home when the member resides in an ISS or group home setting:
    - Personal demographic/emergency contact information. If community activities are planned, a copy will be taken in a sealed envelope for emergency use only.
    - Current complete IPP including current psychological, social and physical evaluations (if applicable), current behavior support plan, activity schedule, Crisis Plan, IHP and IEP.
    - (ISS/GH) Current doctor's orders for every medication administered at that site, even if the client self-administers
    - Current daily direct support documentation, task analysis and/or staff notes

- (ISS/GH) Current MARs
- Copies of other pertinent medical or evaluative information relevant to treatment

513.11 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual.

In order to receive payment from BMS, a provider must comply with all prior authorization requirements. BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met**.** All services provided within the I/DD Waiver program must be authorized with the ASO. Services requiring prior authorization (refer to Section 513.10) must be submitted to the ASO within 10 working days of the IDT meeting at which the services were chosen. The Service Coordinator is responsible for ensuring that all prior authorizations for all chosen I/DD Waiver providers are forwarded to the ASO.

513.12 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing must take place on the last date in the service range. Billing cannot be rounded more than once within a calendar month. **The billing period cannot overlap calendar months.**

- Medicaid is the payer of last resort. I/DD Waiver Program providers must bill all third party liabilities such as a member's private insurance for those services that are covered by both private insurance and the Medicaid waiver program prior to billing Medicaid. Medicaid is considered a secondary insurance to an individual's private insurance. The Service Coordinator must inform the member, their family and/or legal representative of this requirement.
- Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of *Chapter 513* of the I/DD Waiver policy manual or outside of the scope of federal regulations.

513.13 PAYMENTS AND PAYMENT LIMITATIONS

I/DD Waiver providers must comply with the payment and billing procedures and requirements described in *Chapter 600, Reimbursement Methodologies* of the Provider Manual.

When a member is an inpatient in a West Virginia medical hospital and the member's behavioral needs require additional support staff, then the member may receive Person-Centered Support

services on a short-term basis. The services provided by PCS may not duplicate services provided by the medical hospital.

No I/DD Waiver services may be charged while an individual is receiving services as an inpatient in an ICF/IID facility, a state institution, nursing facility, rehabilitation facility, psychiatric facility, or as a member of another other waiver program. Thirty days prior to discharge from 1 of these programs, Service Coordination, Therapeutic Consultant, Behavior Support Professional and Registered Nurse may be billed to plan the member's discharge.

Reimbursement via the Resource Based Relative Value Scale (RBRVS) is described in *Chapter 600, Reimbursement Methodologies*. CPT codes referenced in this manual are reimbursed by using the Resource Based Relative Scale (RBRVS). RBRVS rates are subject to change on an annual basis. It is also necessary to include a location code for CPT codes.

513.14 HOW TO OBTAIN INFORMATION

For information concerning procedure codes and diagnosis codes, refer to *Chapter 100, General Information.*

SERVICE	PERSON OR COMPANY	PHONE NUMBER	FAX NUMBER
I/DD Program Manager	Bureau for Medical Services	304-356-4904	304-558-4398
Claims Processing	Molina Medicaid Solutions	304-888-483-0793 (for Providers) 304-348-3380 (for Members)	304-348-3380
Medical Eligibility Contracted Agent (MECA)	Psychological Consultation & Assessment	304-776-7230	304-776-7247
Administrative Services Organization (ASO)	Innovative Research Group (IRG) d/b/a APS Healthcare, Inc.	1-866-385-8920	304-866-521-6882
Personal Options Fiscal Employer Agent (F/EA)	Public Partnerships, LLC (PPL)	1-877-908-1757	304-296-1932

CHAPTER 514 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR NURSING FACILITY SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	XXXXX	January 1, 2013
Section 514.13.23	Transportation Services	January 4, 2013	January 1, 2013

CHAPTER 514 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR NURSING FACILITY SERVICES
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CHAPTER 514–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS, FOR NURSING FACILITY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State Agency responsible for administering the program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and complete documentation to justify medical necessity for service provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for payment of services provided by nursing facilities to eligible West Virginia Medicaid resident.

514.1 DEFINITIONS

Definitions governing the provisions of all West Virginia Medicaid services will apply pursuant to Provider Manual *Common Chapter 200, Acronyms and Definitions*. The following definitions apply to the requirements for payment of nursing facility services described in this chapter.

Administrator - a person licensed by the West Virginia Nursing Home Administrators Licensing Board as a "Nursing Home Administrator" who is responsible and accountable for the day-to-day operations of the nursing facility.

Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Ancillary Service - a required service necessary to support the primary activities of the nursing facility to meet the resident's needs. However, these services are not included in the per diem rate.

Capacity - the ability to comprehend and retain information which is material to a decision, especially as to the likely consequences; the person is able to use the information and weigh it

in the balance as part of the process of arriving at a decision and is able to communicate the decision in an unambiguous manner.

Case Mix Reimbursement System - a payment system that measures the intensity of care and services required for each resident. This translates into the amount of reimbursement given to the facility for care provided to each resident.

Care Area Assessment (CAAs) - a problem-oriented framework for organizing MDS information and additional clinically relevant information about an individual's health problems or functional status.

Care Plan - a document based on a comprehensive assessment prepared by the interdisciplinary team. This is coordinated with the resident/representative and identifies measurable objectives for attaining the highest level of physical, mental and psychosocial functioning.

Centers for Medicare and Medicaid Services (CMS) - the Federal Agency which administers the Health Care Programs within the United States Department of Health and Human Services (USDHHS).

Certificate of Need (CON) - a process often associated with cost containment measures. Additionally, the Legislative findings in the CON law declare the need for health services to be provided in an orderly, economical manner that discourages unnecessary duplication. The CON is to be submitted to the Health Care Authority.

Change of Ownership - any transaction that results in change of control over the capital assets of a nursing facility including, but not limited to, a conditional sale, a sale, a lease or a transfer of title or controlling stock. The two most common types of change of ownership are asset purchase and stock transfer.

Civil Money Penalty (CMP) - a punitive fine imposed on a nursing facility when the nursing facility has demonstrated deficient practices.

Cost Average Point (CAP) – a calculation used in the reimbursement methodology for establishing rates in nursing facilities.

Cost Report - the instrument used in the reimbursement system for nursing facilities with semi-annual rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. In order to be equitable, complete and accurate cost data must be maintained by each facility with cost reports accurately prepared and submitted on a timely basis and in an approved format.

Deficiency - an entry on the federally mandated form provided by the State survey agency, the Office of Health Facility Licensure and Certification (OHFLAC), which describes the specific requirements of the regulations with which the nursing facility failed to comply, an explicit

statement that the requirement was not met, and the evidence to support the determination of noncompliance.

Denial of Payment for New Admissions (DPNA) - the denial of Medicaid payment for new admissions when the nursing facility no longer meets the standards of facility certification.

Discharge - the termination of a resident's affiliation with the nursing facility, achieved through the permanent move of a resident to another facility or setting that operates independently from the nursing facility.

Discharge Planning - the organized process of identifying the approximate length of stay and the criteria for exit of a resident from the current service to an appropriate setting to meet the individual's needs. Discharge planning begins upon the day of admission to the nursing facility and includes provision for appropriate follow-up services.

Dually Certified Facility - a facility which is certified to participate in both the Medicare and Medicaid programs.

Facility Certification - the official designation by BMS, based on recommendation from the Office of Health Facility Licensure and Certification (OHFLAC), that the nursing facility meets Medicaid standards and regulations.

Governing Body - the person or group of persons with the ultimate responsibility and authority for the operation of the nursing facility.

Health Care Authority (HCA) - an organization which administers programs that help contain the rising cost of health care and assure reasonable access to necessary health care services. HCA assures public access to the information compiled under the Rural Health Systems Program, the Planning Division, and Certificate of Need Program.

Immediate Jeopardy (IJ) - a situation in which the nursing facility's noncompliance with one or more certification requirements has caused, or is likely to cause, serious injury, harm, impairment or death of a resident.

Interdisciplinary Team (IDT) - a group of professionals, paraprofessionals, non-professionals and the resident who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the resident's needs and who design specialized programs responsive to the needs of the resident which are to be documented in the care plan.

Licensed Nursing Home - any institution, residence, place or any part or unit thereof, licensed in accordance with the requirements specified in W. Va. 16-5c et al, in which an accommodation of four or more beds is maintained for the purpose of providing accommodations and care for a period of more than twenty-four hours, to persons who are ill or otherwise incapacitated and in need of extensive, ongoing nursing care due to physical or mental impairment, or provides services for the rehabilitation of persons who are convalescing from illness or incapacitation.

Minimum Data Set (MDS) - a core set of screening, clinical, and functional status elements completed by an IDT of which the resident is the principal member. It also includes common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.

Misappropriation of Property - the deliberate misplacement, exploitation, or wrongful misuse of a resident's belongings or money.

Neglect - the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Nursing Facility - defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases and has in effect a transfer agreement (meeting the requirements of §1861(1)) with one or more hospitals having agreements in effect under §1866.

Patient Resource (or Resident Resource) Amount - the amount calculated by the WVDHHR which the resident must contribute to the cost of care every month by which the monthly Medicaid payment is reduced.

Personal Needs Allowance - the amount deducted from the member's monthly income which allows for personal needs of the nursing facility member.

Pre-Admission Screen - the preliminary screen conducted on all persons seeking admission to a nursing facility in order to identify persons with major mental illness or developmental disability.

Representative - the spokesperson acting in the best interest of the resident. Representatives may be designated by the residents themselves, court appointed, or physician appointed, in accordance with state law.

Resident - any individual residing in a nursing facility (NF), skilled nursing facility (SNF), or dually certified skilled nursing facility/nursing facility (SNF/NF). For the purpose of Medicaid reimbursement only, the resident may be identified as a Member of the Medicaid program.

Resident Council - a group of residents residing in the nursing facility having the right to meet to express grievances in relation to the residents' general well-being and to make recommendations concerning nursing facility policies and procedures.

Substantial Compliance - a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

514.2 PROVIDER PARTICIPATION REQUIREMENTS

The governing body or designee of a nursing facility participating in the Medicaid Program must fully meet the standards established by the West Virginia Secretary of the Department of Health and Human Resources (WVDHHR); all applicable State and Federal laws governing the provision of these services as currently promulgated or amended in the future; and all regulations contained herein or issued as Medicaid Policy. The Federal standards take precedence over State requirements except where State requirements are more restrictive.

A nursing facility may be a freestanding entity qualifying and serving as a long-term-care provider or it may be a distinct part of a larger institution. If the distinct part is operating as another part of an institution, the distinct part must be an identifiable unit and meet all of the requirements for a nursing facility.

514.2.1 State Licensure

As a condition of participation as a nursing facility in the West Virginia Title XIX Medicaid Program, a free-standing nursing home or distinct part of a hospital must be currently licensed in accordance with the applicable State Code and Legislative Rule. The nursing home or hospital must meet and maintain the standards for licensure on a continuing basis. When required by the nursing home or hospital licensure rule, the nursing facility must be administered by a licensed nursing home administrator, who is legally responsible for establishing and implementing policies regarding the management and operations of the facility and who holds an approved, current license, as required by State law. The nursing facility must also meet all Federal and State standards for participation in the Title XIX Medicaid Program and remain in compliance with all other applicable Federal, State, and Local laws, rules, and regulations affecting the health and safety of all residents.

514.2.2 Provider Enrollment

The nursing home or hospital distinct part must submit a completed, signed and dated provider enrollment application and a nursing facility agreement in order to apply with the Bureau for Medical Services for approval to participate in the Title XIX Medicaid Program. Prior to approval as a provider, a Certificate of Need (CON) must be approved by HCA. The nursing home or hospital distinct part must meet Medicaid certification requirements. Upon approval of the application and the agreement by BMS, a provider number will be assigned by BMS' fiscal agent. See *Common Chapter 300*, *Provider Participation Requirements*.

514.2.3 Nursing Facility Provider Agreement

A nursing facility provider agreement must be approved by BMS prior to eligibility for

reimbursement and annually thereafter. The nursing facility provider agreement will certify that the nursing facility agrees to follow the Code of Federal Regulations, (42 CFR, Part 483, the requirements for States and long term care facilities) and West Virginia Legislative Rule Title 64, Series 13 (the Nursing Home Licensure Rule) as updated. Upon acceptance for participation as a nursing facility in the Medicaid program, the administrator of the facility, under the delegated authority of the facility's governing body becomes responsible for ensuring the nursing facility remains in compliance with the terms of the agreement and Medicaid rules and regulations. It is the responsibility of each nursing facility's administrator to stay apprised of any revisions to the Medicaid Provider Manual. Payment to the nursing facility, for covered items and services it furnishes on or after the approval date of the agreement, will require that the facility have a record keeping capability sufficient for determining the cost of medically necessary services furnished to any Medicaid resident. (See Appendix 1)

As a provider participating in the Medicaid program, the governing body/designee must agree to admit and provide care and services equitably to all individuals, no matter the payment source of the individual seeking care.

The agreement for participation in the Medicaid program by a governing body/designee is limited by compliance with Federal and State laws, certification rules and regulations. OHFLAC determines whether a prospective provider is in compliance with the nursing home requirements. When the facility is in compliance, OHFLAC certifies and recommends that BMS enter into an agreement with the facility. If the facility is determined not be to be in compliance, OHFLAC recommends that BMS deny participation.

If OHFLAC recommends that BMS deny participation and BMS accepts that recommendation, BMS will notify the facility in writing of the denial of participation in the Medicaid program, and include, in the letter the appeal rights available under 42 CFR 431.153 and 42 CFR 498.3 (b).

514.2.4 Enforcement

BMS is required by Federal regulations to impose certain enforcement actions on nursing facilities which are not in compliance with certification rules and regulations. Enforcement action may include but is not limited to: termination of the provider agreement; temporary management of the nursing facility by a designee appointed by the Department of Health and Human Resources; denial of payment for new admissions; civil money penalty; state monitoring; transfer of resident; transfer of resident with closure of a facility; and/or reduction of bed quota without reduction of staff. (See 42 CFR 488 Subpart F and WV Legislative Rule 64CSR 13). CMS is responsible for enforcement of dually certified facilities.

514.2.5 Ownership

Owners include any individual, organization, partner and all stockholders of organizations which have a financial interest in the facility's operations.

Nursing facilities that are in compliance with all applicable requirements may participate in the Medicaid program and receive payments regardless of the ownership category**,** i.e., proprietary,

voluntary, non-profit, etc. The governing body/designee of each nursing facility must provide BMS and OHFLAC with full and complete information and documentation as to the identity of the owner(s) in the enrollment packet as follows:

- The name and address of each person with an ownership or five percent controlling interest in the facility or disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership;
- The name and address of each officer and director, when a nursing facility is organized as a corporation, must be declared and verified if it is organized as a for-profit entity;
- The name and address of each partner when a nursing facility is organized as a partnership.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative or other function required to operate the facility, but who do not actually provide said services. Functions claimed to be provided by owners, operators, or their relatives which are merely a duplication of services that are already provided by other employees, or are functions which should reasonably be expected to be performed by other employees, are not reimbursable.

When owners, operators, or their relatives are on salary at a facility, the Medicaid program will reimburse the facility to the extent that said individuals salaries are not excessive (*See* 514.13.27 OWNERS) compared to other individuals who perform the same or similar functions but are not owners, operators or their relatives.

514.2.6 Change of Ownership

The following events constitute a change of ownership:

1. The removal, addition or substitution of a partner. (Stock Transfer)
2. Transfer of title and property to another party by as sole proprietor. (Asset Transfer)
3. The merger of a provider corporation into another corporation, or the consolidation of two or more corporations resulting in the creation of a new corporation. (Asset Transfer)
4. Leasing all or part of a provider facility. (Stock Transfer) See 42 CFR 489.18; 42 CFR 431.108; WV Code 31D-11-1101 et seq.; WV Code 47B-1-1 et seq.

When there is a change of ownership, the governing body must acquire a Certificate of Need or an exemption as required under West Virginia State law. Refer to WV Code 16-2D-01 et seq. and WV Legislative Rule 65CSR7 for direction on complying with Certificate of Need requirements in West Virginia. Note that Certificates of Need are nontransferable. The nursing facility may not bill Medicaid for any health service without first obtaining an approved Certificate of Need.

West Virginia Medicaid recognizes two types of changes in ownership, stock transfer and asset transfer.

A change in ownership of a nursing facility as a result of an asset transfer requires the execution of a new Provider Agreement, new enrollment application and assignment of a new provider number. Notification of the change is required to be submitted, in writing, to BMS 90 days prior to the effective date of the change of ownership.

A change of ownership as a result of a transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership for a corporation. A stock transfer of a nursing facility without a change in administrative personnel of that facility does not require the execution of a new Provider Agreement; however, the enrollment packet must be updated to identify all interested parties for the exclusions list.

The governing body must comply with West Virginia law when changing ownership, merging corporations or transferring corporate stock. Partnerships are governed in West Virginia by the West Virginia Uniform Partnership Act. This act is codified at WV Code 47B-1-1et seq.

Effect on the provider agreement of a change of ownership:

An agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

1. Any existing plan of correction.
2. Compliance with applicable health and safety standards.
3. Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C of Title 42, Chapter IF of the Code of Federal Regulations and;
4. Compliance with Civil Rights requirements set forth in 45 CFR parts 80, 84, and 90 of the Code of Federal Regulations See 42 CFR 489,18 (d)

Enrollment of a new provider as a result from an asset transfer:

A new provider must enroll in Medicaid. Providers are required to submit a complete and accurate enrollment packet. A change of ownership requires that all parties involved shall collaborate to ensure that services are billed and paid to the correct owner using the correct provider number. The effective date of the new owner's enrollment is determined when the enrollment application is approved by BMS. Providers are required to submit a complete and accurate enrollment packet and inform The Office of Facility Based and Residential Care unit within BMS and BMS's fiscal agent's Provider Enrollment Unit of the proposed date of the change in ownership to ensure a seamless transition. It is recommended that changes of ownership occur at the first of the month. Services rendered prior to the effective date of the change in ownership will not be payable through Medicaid. However, in cases of a change of ownership of a nursing facility that is dually certified for participation in both Medicare and Medicaid, BMS will follow Medicare policy regarding effective dates of the actual change of ownership

A provider agreement shall not be approved if the owner fails to comply with 42 CFR 455.104 and 42 CFR 455.105, which requires the owner to provide information to the BMS fiscal agent on ownership interests and certain business transactions. See also 514.2.6 of this manual.

If a partnership purchases a dissociated partner's interest in the partnership and the partnership is not winding up business, under WV Code 47B-7-1(d), the partnership "shall indemnify a dissociated partner whose interest is being purchased against all partnership liabilities, whether incurred before or after the dissociation, except liabilities incurred by an act of the dissociated partner under section two 47B-7-2, article seven of this chapter." Whenever a partnership purchases a dissociated partner's interest in the partnership, it shall send to the Office of Accountability and Management Reporting (OAMR) a copy of the indemnification agreement.

When there is a change of ownership, the provider shall supply the Office of Accountability and Management Reporting (OAMR) a copy of the executed contract or other agreement effecting the transfer between the buyer and seller, and shall also include with the transmittal a separate statement, signed by authorized representatives of both the buyer and seller, stating whether the prior owner or new owner retains the liability for any over/under payment related to cost reporting periods that have not been audited by the Department at the time of the transfer.

A provider may request a final audit, in writing prior to the change in ownership, resulting from an asset purchase. Requests should be submitted to the following address: WVDHHR Office of Accountability and Management Reporting; Attention: Division of Audit; 1 Davis Square, Suite 304, Charleston, WV 25301.

514.2.7 Bed Configuration

BED TRANSFER:
A licensed nursing facility or hospital based distinct part may not add any beds to its license without first obtaining certificate of need approval (CON) from the West Virginia Health Care Authority. If the transfer is authorized by the Health Care Authority, the governing body or designee of a licensed nursing home or hospital distinct part must submit a written request for Medicaid reimbursement on transferred beds to the Commissioner of the Bureau for Medical Services. The request that is to be submitted to the Commissioner must detail need for the additional transferred beds by indicating the overall census, using the past two most recent cost reporting periods, of the transferring from facility and transferring to facility. The overall census of the transferring to facility must be at 95% or greater on average for each cost reporting period and the Medicaid census must be at 85% or higher for each cost reporting period.

DUAL CERTIFICATION:
When the request is to gain dual certification on beds that are currently licensed however do not have Medicaid certification; the CON process is not needed. The facility asking for dual certification must submit a written request to the Commissioner of the Bureau for Medical Services and the request must show the need for the Medicaid certification on the current licensed beds in the facility. The need must be proven by indicating the overall census, using the most recent two cost reporting periods. The overall census must be at least 95% or greater on average for each cost reporting period and the Medicaid census must be at 85% or higher for each cost reporting period.

The Commissioner, in his or her discretion, shall determine whether to approve or deny the request of Medicaid reimbursement for the transfer or dual certification of currently licensed beds. In determining whether or not to approve the requests for dual certification or on transferred beds, the Commissioner shall take into consideration the fiscal impact of the request as well as the need for the transferred or dual certified beds as stated by the request.

514.2.8 Non-Compliance of Nursing Facilities

OHFLAC conducts surveys on all nursing facilities for compliance or noncompliance with the requirements for long term care nursing facilities. When OHFLAC completes a survey, CMS may follow up with a validation survey. A determination is final except in the case of a complaint or validation survey conducted by the CMS.

Under Federal guidelines, OHFLAC certifies the compliance or noncompliance of a non-State operated skilled nursing facility. OHFLAC also certifies compliance or noncompliance for a dually participating skilled nursing facility/nursing facility. If there is a disagreement between CMS and OHFLAC, CMS's determination as to the facility's noncompliance is binding and takes precedence over a determination of compliance by OHFLAC (see 42 CFR 488.330 (a)).

A certification of compliance constitutes a determination that the facility is in substantial compliance and is eligible to participate in Medicaid as a Nursing Facility, or in Medicare as a Skilled Nursing Facility, or in Medicare and Medicaid as a dually participating facility.

A certification of noncompliance requires denial of participation for prospective providers and enforcement action for current providers in accordance with Federal guidelines. Enforcement action must include either termination of the Medicaid provider agreement or the application of alternative remedies instead of, or in addition to, termination procedures. In cases where either BMS or CMS is taking action, notice of noncompliance resulting in action will be sent in accordance with 42 CFR 488.402 (f).

Termination of a provider agreement with a nursing facility may result from, but not be limited to, any of the following:

1. Failure to comply with licensure and certification standards as identified by OHFLAC and CMS;
2. Failure to implement the corrective action plan accepted by OHFLAC and CMS for correction of non-compliance with license and certification standards; or
3. Failure to comply with all of the provisions of the provider agreement executed with BMS.
4. Exclusion Proceedings – See *Common Chapter 300, Provider Participation Requirements*.

When an agreement is terminated, Medicaid may continue reimbursement to the nursing facility for a period not to exceed 30 days from the date of termination. The 30 day continuation is only for Medicaid members admitted to the nursing facility prior to the date of termination of the provider agreement. It is the responsibility of the governing body or designee of the nursing

facility to provide a safe and orderly transfer and quality of care for all residents of the facility affected by the termination of the provider agreement.

The termination of participation in the Medicaid program does not immediately release the governing body or designee of a nursing facility from all of the nursing facility's statutory and regulatory responsibilities of its agreement for participation. The nursing facility's governing body or designee remains responsible for the repayment of any overpayment or debt related to the final program cost settlement as well as any other Federal and/or State statutory and/or regulatory mandates.

514.3 PROVIDER CERTIFICATION

OHFLAC and CMS will conduct periodic and timely evaluations of nursing facilities for the purpose of certifying nursing facilities for participation in the Medicaid program. Prior to entering into an agreement of participation in the Title XIX (Medicaid) Program with a nursing facility, BMS will obtain certification recommendations from OHFLAC to ensure the nursing facility is in compliance with both State and Federal statutes and regulations.

A nursing facility may be certified with correctable deficiencies if the deficiencies, as determined by OHFLAC, individually or in combination, do not jeopardize resident health, safety, quality of life and/or quality of care.

The governing body or designee of a nursing facility with deficiencies must submit to OHFLAC a written plan for correcting the deficiencies with credible evidence, when requested, per the written instructions from OHFLAC. This plan of correction may either be accepted with credible evidence of compliance; or one or more subsequent surveys may be necessary to verify compliance with applicable rules and regulations.

A CMP and/or DPNA may be imposed upon the nursing facility until compliance is demonstrated and an acceptable plan of correction is approved.

State remedies are found in 42 CFR 488.406 and include termination of the provider agreement, temporary management, denial of payment for all individuals when imposed by CMS, DPNA, CMP, State monitoring, transfer of residents, closure of the facility and transfer of residents, a directed plan of correction, a directed in-service training and many alternative remedies that have been approved by CMS in the State plan.

514.3.1 Denial of Payment for New Admission (DPNA)

A governing body or designee of a nursing facility that no longer meets standards of certification as determined by OHFLAC, in conjunction with CMS, may be denied Medicaid payment for new admissions. If the nursing facility's deficiencies pose IJ to the resident's health and safety, the provider agreement may be terminated and denial of payment for Medicaid members currently residing in the nursing facility may also be imposed. However, if a current resident of the NF who is under a DPNA gets transferred to the acute care hospital, they may be re-admitted to the original NF when re-admission is appropriate and reimbursement will resume.

514.3.2 Civil Money Penalty (CMP)

A governing body or designee of a nursing facility may have imposed upon it a CMP, when OHFLAC recommends and BMS agrees that one or more deficient practices are of such a nature that the potential for more than minimal harm to one or more residents exists or actual harm has occurred.

514.3.3 Temporary Management/Administrator

A temporary manager may be imposed by BMS, CMS or the court system any time a nursing facility is not in compliance with Federal and State regulations. However, when a nursing facility's deficiencies constitute IJ and a decision is made to impose an alternative remedy to termination, the imposition of a temporary manager is required, in accordance with State code.

It is the temporary manager's responsibility to oversee correction of the deficiencies and to assure the health and safety of the nursing facility's resident while the corrections are being made. A temporary manager/administrator may also be imposed to oversee orderly closure of a nursing facility.

Any temporary manager, whether imposed by BMS, CMS or the court system, must be licensed by the West Virginia State Board of Nursing Home Administrators.

514.4 STANDARDS FOR NURSING FACILITIES

All providers participating as a nursing facility in the Title XIX, Medicaid Program must comply with Federal standards as published in the Code of Federal Regulations and as later amended; as well as State Laws and Program Regulations governing BMS.

Any nursing facility participating in both the Medicaid program and the Medicare program must comply with the higher standards of either program. Additional requirements may be found in Chapter 42 of the Code of Federal Regulations.

OHFLAC is responsible for conducting a periodic survey in each nursing facility to ascertain compliance with standards of participation in the Medicaid program. Based on OHFLAC's recommendations, the authority to approve or terminate a nursing facility provider agreement rests with either the Secretary of the Federal Department of Health and Human Services (USDHHS) or the Secretary of the State Department of Health and Human Resources (WVDHHR) or his/her delegated representative.

Determinations made on behalf of either of these Secretaries/or his/her Representative are final with respect to compliance of nursing facility standards for participation in both programs. The determinations by OHFLAC are generally the basis for acceptance of an agreement of participation in the West Virginia Medicaid Title XIX Program; however, Federal and State laws may also impact the agreement for participation.

514.4.1 Employment Restrictions

Criminal Investigation Background Check (CIB) results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the nursing facility before placing an individual in a position to provide services to the member. At a minimum, a fingerprint-based State level criminal investigation background check must be conducted initially by the employer prior to hire and every three years thereafter throughout the remainder of the employment. If the prospective employee has lived out of state within the last five years, the agency must also conduct a federal background check utilizing fingerprints through the national crime information database (NCID). It is the responsibility of the employer to assure that the exclusion lists are checked monthly. The facility may employ an individual for a maximum of 60 days if a preliminary check is completed. The facility may choose to contract with a company that completes internet background checks use these results until the fingerprint results are received.

An individual cannot be considered to provide services nor can be employed by the nursing facility if ever convicted of:

- Abduction
- Any violent felony crime including but not limited to rape, sexual assault, homicide , felonious physical assault or felonious battery
- Child/adult abuse or neglect
- Crimes which involve the exploitation of a child or an incapacitated adult
- Felony domestic battery or domestic assault
- Felony arson
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- Felony drug related offenses within the last 10 years from release of incarceration, if applicable or date of conviction if not incarcerated
- Felony DUI within the last 10 years from release of incarceration, if applicable or date of conviction if not incarcerated
- Hate crimes
- Kidnapping
- Murder/ or manslaughter
- Neglect or abuse by a caregiver
- Pornography crimes involving children or incapacitated adults including, but not limited to, use of minors or incapacitated adults in filming sexual explicit conduct, distribution and exhibition of material depicting minors or incapacitated adults in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a minor or incapacitated adult engaged in sexually explicit conduct.
- Purchase or sale of a child
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure. Providers must check the list of excluded individuals/entities
- (LEIE) at: http://exclusions.oig.hhs.gov/; https://www.epls.gov
- National Practitioner Data Bank at: http://www.npdb-hipdb.hrsa.gov/

Employment of an individual with one or more of the above listed convictions will result in recoupment of monies paid for services provided.

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and contiguous states;

West Virginia's state police offender registry is at www.statepolice.wv.gov

Ohio's sex offender registry is at www.drc.ohio.gov

Kentucky's sex offender registry is at http://kspsor.state.ky.us/sor/html/SORSearch.htm

Virginia's sex offender registry is at http://sex-offender.vsp.virginia.gov/sor/

Maryland's sex offender registry is at www.dpscs.state.md.us

Pennsylvania's sex offender registry is at http://www.pameganslaw.state.pa.us/

Current Federal requirements dictate that all States must check for exclusions. Check the fiscal agent's website at www.wvmmis.com for state updates. If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified of the change as services cannot be reimbursed for any Medicaid covered services if the facility identified or becomes aware of a disqualifying conviction.

514.4.2 Staffing Requirements

In order to participate in the West Virginia Medicaid Title XIX Program, a nursing facility must have sufficient nursing staff (including licensed nurses and certified nurse aides) on a 24 hour basis to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Federal and State requirements for sufficient nursing staff can be found at 42 CFR 483, 42 CFR 488, and WV Legislative Rule 64CSR13. Where there are differences between the specific Federal and State staffing requirements, the NF will be required to comply with the more restrictive requirements.

514.4.3 General Staffing Information

Only qualified staff shall provide services in a nursing facility. The nursing facility must employ staff sufficient in number and in qualifications as required to meet the needs of each resident pursuant to their care plans and to protect their health and safety.

- There must be on duty at all hours of each day sufficient staff in number and qualifications to carry out the policies, responsibilities, and programs of the facility. The nursing facility must employ and maintain sufficient staff on duty, awake and accessible.

- The nursing facility administrator or designee assumes responsibility for the provision of services directly or through outside resources to meet the needs of each resident. The residents and their representatives or volunteers may not perform direct care services for individuals. At a minimum, the administrator or designee of the nursing facility is required to ensure the facility complies with WV Legislative Rule 64 CSR 13 for services to be provided in a licensed nursing home or an extended care unit of a licensed hospital.
- The nursing facility must assure that all staff are properly licensed and competent to provide appropriate care.

514.4.4 General Administration

The governing body is responsible to ensure the nursing facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Policies must be documented as to the provision of services to residents in order to address quality of life, quality of care, resident rights and any other services within the scope of nursing facility services.

514.4.5 Governing Body and Management

The management of the nursing facility must identify an individual or individuals as the governing authority of the facility in accordance with 42 CFR 483.410 and WV Legislative Rule 64CSR13.

514.4.6 Physical Environment Requirements

In order to participate in the West Virginia Medicaid Title XIX Program nursing facilities must be equipped and maintained to provide a functional, sanitary and comfortable environment for all residents admitted for care.

The nursing facility must be in compliance with the 2005 Edition of the National Fire Protection Association (NFPA) of “NFPA 99 Standards for Health Care Facilities” as promulgated and mandatory references issued by CMS as currently published or modified in the future. Additionally, BMS requires adherence to the Guidelines for Design and Construction of Hospital and Health Care Facilities in establishing the Standard Appraised Value (SAV) for the capital component of the nursing facility rate.

BMS pays for an annual SAV inspection. If the first SAV inspection has been completed and the nursing facility requests an additional SAV inspection, the nursing facility is responsible for payment to the appraisal company approved by BMS, who completes the additional SAV inspection.

When the nursing facility has proposed changes to the physical plant, the governing body or designee of the nursing facility is responsible to notify BMS, in writing.

514.4.7 Administrative Policies

The governing body of a nursing facility must ensure the development of policies and procedures regarding all aspects of the operation of the facility, including policies and procedures regarding the provision of care and services to residents. These policies must be available to each resident and his/her representative.

All policies and procedures regarding the provision of care and services to residents must reflect current accepted standards and practices and must be reviewed and approved by the governing body or designee at least annually. All of these policies must be written or presented in a language/method of communication that can be understood by any individual admitted to the facility.

Additionally, all individuals residing within the facility must be informed in a language/method of communication which the individual or legal representative can understand regarding all rights and policies affecting their acceptance of services provided by the facility.

514.4.8 Emergency/Disaster Preparedness Procedure

The nursing facility's governing body or designee must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents and must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

The nursing facility's emergency / disaster preparedness procedures must include at a minimum:

- How to shelter in place when indicated and how to care for residents when sheltering in place;
- How to evacuate all or part of the facility when indicated and how to care for residents in an emergency shelter when evacuation of the NF is indicated;
- Notification of the attending physician, EMS, law enforcement and other persons responsible for the residents;
- Arrangements for transportation;
- Arrangements for hospitalization;
- Arrangements for other appropriate services;
- Arrangements for emergency physician services, if the attending physician is not immediately available;

- Arrangements for securing the residents' medical records and;
- Actions to be taken to locate a missing resident.

The nursing facility's governing body or designee must ensure that staff rehearses and document, at least annually, actions to be taken in the event of a missing resident.

514.4.9 Resident Rights

The NF's governing body or designee must:

- Establish a policy statement setting forth the rights of residents prohibiting the mistreatment, neglect, misappropriation of resident property or abuse of resident;
- Post the written resident rights policy for staff, resident, families or representatives and all interested parties to view; and
- Provide policies and procedures and ensure that each resident admitted to the facility is fully informed of his/her rights and responsibilities as a resident in the facility.

514.4.10 Hospital Transfer Agreement

Each nursing facility's governing body or designee must show documentation of a written transfer agreement that must be in effect with one or more hospitals approved for participation under the Medicare and Medicaid programs in accordance with 42 CFR 483.75 (n). The agreement must include information necessary to provide quality care and continuation of services by either the hospital or the nursing facility.

The hospital transfer must include information regarding the resident and must include a copy of the Advanced Directives and the most current evaluations including a list of current medications and most recent PASRR Level II evaluation, if applicable.

514.4.11 Services Provided by Outside Sources

If a nursing facility does not provide a required service to meet the needs of one or more residents, the governing body or designee may enter into a written agreement / contract with an outside service, program, or resource to provide this service which is to be paid by the facility under the all-inclusive rate. The administrator or designee is responsible and accountable for assuring that outside sources meet the standards for quality of services and the timeliness of providing those services.

The administrator or designee must assure that the vendor and their staff is able to meet all mandatory educational, licensing, certification and criminal investigation background check requirements for the specific area of service(s) furnished and follow the policies and procedure of the nursing facility.

The agreement / contract must clearly state the responsibilities, functions, objectives, and the terms of the agreement and be signed and dated by both parties. See Section 514.8 – 514.8.9 for specific information regarding the all-inclusive rate.

514.5 QUALIFIED STAFF

514.5.1 Administrator

The day-to-day operations of each nursing facility must be directed by an individual identified as an administrator who is licensed by the West Virginia Nursing Home Administrators Licensing Board (WVNHALB). The WVNHALB may approve the director of nursing or another qualified individual to serve as the "Person in Charge" if a licensed nursing home administrator is not available. It is the responsibility of the Person in Charge to notify BMS directly of their designation as a temporary administrator.

In accordance with the Administrators licensure Rule 5.3.1.A. an administrator shall not administer or be the administrator of more than two nursing facilities at the same time, except that an administrator may oversee the operations of two nursing facilities which are within reasonable proximity (30 minutes or less), provided that such administrator is not administering more than a total combined one hundred twenty beds. The administrator of two facilities shall spend not less than an average of twenty hours per week at each nursing facility, and the administrator must employ the services of a full-time competent assistant at each nursing facility.

If an administrator oversees the operations of two NFs, the amount of time spent each week by the administrator at each of the two NF is to be documented. Documentation consists of weekly or monthly time cards, time sheets or work logs that are signed and maintained on file at the facility. Documentation must be made available immediately upon the request of BMS. If the documentation is not produced immediately, the records will be considered non-existent. "On-Call" time is not to be used in determining hours of service and will not be accepted.

According to 42 CFR 483.75 (d) (2)(i)(ii), the administrator is responsible for management of the facility.

514.5.2 Medical Director

The administrator shall designate, in writing, a physician (MD or Do) accountable to the governing body to serve as medical director to ensure that medical care provided to all resident is adequate and appropriate.

As a member of the resident care committee, the medical director is responsible and accountable for participating in the development, implementation, evaluation, and revision of resident care policies and procedures, to ensure that such procedures reflect current standards of practice for resident care and quality of life; and coordinating and evaluating medical care in the nursing facility.

514.5.3 Physician Services

According to 42 CFR 483.40, a physician (MD or DO) must personally approve in writing, a recommendation that a person be admitted to a NF. Each resident's care must be supervised by a physician at all times. The administrator or designee shall ensure that the medical care of each resident is supervised by a physician. Another physician must supervise the medical care of residents when their attending physician is unavailable.

The attending physician must review the resident's total program of care, including medications and treatments, and examine the resident personally at each visit. The physician must write, sign and date progress notes at each visit and sign and date all physician orders. Any specialist who is called into the nursing facility must have a physician's order for the service signed prior to the date of service. Standing orders are not allowed and routine screening services are not covered in relation to the specialist.

The resident must be seen within 72 hours following the admission to the nursing facility and at least every 30 days for the first 90 days after the admission and as the resident's condition warrants. After the 90 day requirement been met, the physician must visit every 60 days or more often as the resident's condition warrants.

After the initial visit, and completion of the visits required during the resident's first 90 days in the nursing facility, at the option of the physician, required visits may alternate between personal visits by the physician and visits by a qualified physician extender (a physician's assistant, an advance practice registered nurse or a clinical nurse specialist) who is licensed as such by the State of West Virginia, performing within their scope of practice, and is under the supervision of the physician following the above requirements. If the physician elects to alternate visits with a qualified physician extender, all requests for reimbursement from the Medicaid program must be submitted under the servicing provider's number. Please refer to *Chapter 519 Practitioner Services*

The administrator or designee must provide or arrange for the provision of physician services 24 hours of every day.

514.5.4 Nursing Services

According to 42 CFR 483.30, the nursing facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The administrator and director of nursing at the nursing facility must follow licensure requirements to provide health services which assure that each resident receives treatments, medications, diets and other health services as prescribed and planned all hours of each day.

- The primary duties of certified nurse aides consist of direct resident care and services, as distinguished from the duties of paid feeding assistants and housekeeping, laundry and dietary functions.

- Where residents are in a nursing facility located in a distinct part of a larger institution, each part of the institution must be separately staffed with adequate nursing personnel regardless of size.

- 24-hour health service requires that the number and type of personnel be sufficient to meet the total needs of the residents.

514.5.5 Director of Nursing (DON)

The administrator must designate, in writing, a registered nurse (RN), who is licensed by the West Virginia Board of Examiners for Registered Professional Nurses (RN Licensing Board), to serve as the Director of Nursing (DON) on a full-time basis. The DON must be on duty at least five days a week, eight consecutive hours a day. The administrator and DON are responsible for ensuring the nursing facility has sufficient direct care staff to deploy across all shifts and units to meet the assessed needs of resident on 24-hour basis.

514.5.6 Licensed Nurse

The administrator or designee is responsible for designating a licensed nurse to serve as a charge nurse on each shift. If an RN is not available in the facility, a licensed practical nurse (LPN) may serve in this capacity. All RNs and LPNs are required to follow the policies and procedures of the NF and work within the scope of their individual licenses.

A NF must have an RN on duty, in the facility, for at least eight consecutive hours, seven days a week. In NFs with fewer than sixty beds, the DON may serve to meet this requirement. During periods when there is not an RN on duty, there must be an RN on call.

514.5.7 Certified Nurse Aide (C.N.A)

The administrator or designee must receive registry verification from the West Virginia Nurse Aide Registry that a nurse aide has met training and/or competency evaluation requirements prior to hire into the nursing facility and retain these documents in the individual's personnel file.

514.5.8 Social Services

The administrator or designee is responsible for designating a qualified social worker suited by training or experience, in accordance with WV Legislative Rule 64CSR13 and 42 CFR 483.15(g)(1)(2)(3)(i)(ii), to provide or arrange for the provision of social services as needed by the resident to promote the resident highest physical, mental and psychosocial wellbeing. These services must be integrated with all other elements of the overall plan of care.

The social worker is an individual who is currently licensed by the West Virginia Board of Social Work Examiners as a licensed social worker, (LSW) at entry level or higher and has some background, knowledge or experience related to social service activity in order to perform this function. If the facility's governing body/ designee does not employ an individual qualified by training or experience, arrangements must be made through written agreement/contract with an

outside resource (a person or agency) to provide direct medically-related social services as needed by the resident or to act as a consultant.

The chief function of the social worker is to help with problems which inhibit or prevent the resident's social adjustment and, because of this, affect his/her ability to benefit from their stay in the nursing facility.

Social service activity is not limited to the resident alone, but will usually include contact with the resident's family, close friends, and the coordination of services with other agencies, such as WVDHHR, Social Security Administration (SSA), Veteran's Administration (VA), Aging & Disability Resource Centers, community service organizations, etc. A good working knowledge of community resources is a valuable asset for the social worker.

The social worker is to provide indirect services to the resident through staff education both by participation in the nursing facility's in-service training program and through conferences with staff who are concerned with the resident's care. To carry out this function, the social worker will need to have a thorough knowledge of the nursing facility's method of operation and its practices and policies.

Sales and marketing activities do not constitute medically-related social services.

514.5.9 Activities Director

In compliance with 42 CFR 483.15 (f) (1)(2)(i) (A)(B)(ii)(iii)(iv) the nursing facility administrator or designee must provide for an ongoing program of activities designated to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

The administrator or designee must designate a qualified professional who is a qualified Therapeutic Recreation Specialist or an Activities Professional, who is licensed or registered, by an accrediting body on or after October 1, 1990.

The Activities Director is responsible for developing programs which provide constructive supervision and services directed toward restoring and maintaining each resident at his/her best possible functional level including activities designed to encourage self-care and independence.

The Activities Director shall develop a plan for independent and group activities for each resident in accordance with his/her needs and interests. The plan is incorporated in the overall plan of care and is reviewed with the resident's participation at least quarterly and revised as needed and documented in the care plans and MDS.

The activities director shall provide opportunities for meaningful activities and social relationships. These may include holiday celebrations, parties, indoor and outdoor games, or personal hobbies. Educational or recreational activities sponsored by groups within the community should be encouraged and planned with these community groups or agencies.

514.5.10 Food and Dietary Director

In accordance with 42 CFR 483.35 and WV Legislative Rule 64CSR13, the administrator or designee must employ a qualified dietitian either full-time, part-time or on a consultant basis.

A qualified licensed dietitian is one who is registered by the Commission on Dietetic Registration and licensed by the West Virginia Board of Licensed Dietitians or is qualified by the West Virginia Board of Licensed Dietitians, and is licensed by that board to provide professional nutritional services in West Virginia.

Consultation will be based upon the resident needs and will occur at intervals of no less than every 30 days and for no less than 8 hours.

If a full-time qualified dietitian is not employed, the administrator or designee must, in accordance with WV Legislative Rule 64CSR13, utilize the services of a full-time qualified dietary manager who shall meet one of the following qualifications:

- A dietetic technician registered by the American Dietetic Association; or
- A certified dietary manager as certified by the Dietary Manager's Association; or
- A graduate of an associate or baccalaureate degree program in foods and nutrition or food service management.

The dietary manager, under the direction of the dietitian, is responsible for the daily operation of the dietetic service. A nursing facility must employ sufficient support personnel competent to carry out the functions of the dietary service. The administrator or designee shall ensure the dietary manager utilizes the services of sufficient support personnel competent to carry out the functions of the dietary service.

The dietary manager must ensure the nutritional needs of all residents are met and that preferences are accommodated. Each resident must have a physician's order for the specific type of diet he/she is to receive as set forth in the nursing facility's dietary manual.

Rules regarding the frequency of meals, sanitary conditions and emergency supplies may be found at WV Legislative Rules 64CSR13 (Nursing Homes) and 64CSR17 (Food Establishments).

514.6 ELIGIBILITY REQUIREMENTS

Eligibility requirements for residents are as follows:

514.6.1 Application Procedure

An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:

- The financial application for nursing facility services is made to the local WV DHHR office.
- The medical eligibility determination is based on a physician's assessment of the medical and physical needs of the individual. At the time of application the prospective resident should be informed of the option of receive home and community based long-term. The PAS assessment must have a physician signature dated not more than 60 days prior to admission to the nursing facility.

514.6.2 Pre-Admission Screening and Resident Review (PAS)

Pre-admission screening for medical necessity of nursing facility services is a two-step process. The first step (Level I) identifies the medical need for nursing facility services based on evaluation of identified deficits and screens for the possible presence of a major mental illness, mental retardation, and/or developmental disability. The second step (Level II) identifies if the individual needs specialized services for a major mental illness, mental retardation, and/or developmental disability.

514.6.3 Medical Eligibility Regarding the Pre-Admission Screening

To qualify medically for the nursing facility Medicaid benefit, an individual must need **direct nursing care 24 hours a day, 7 days a week.** BMS has designated a tool known as the Pre-Admission Screening form (PAS) (see appendix II) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit.

An individual must have a minimum of five deficits identified on the PAS. These deficits will be determined based on the review by BMS/designee in order to qualify for the Medicaid nursing facility benefit.

These deficits may be any of the following:

- #24: Decubitus – Stage 3 or 4
- #25: In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) and b) are not considered deficits.
- #26: Functional abilities of the individual in the home.
  Eating: Level 2 or higher (physical assistance to get nourishment, not preparation)
  Bathing: Level 2 or higher (physical assistance or more)
  Grooming: Level 2 or higher (physical assistance or more)
  Dressing: Level 2 or higher (physical assistance or more)
  Continence: Level 3 or higher (must be incontinent)
  Orientation: Level 3 or higher (totally disoriented, comatose)
  Transfer: Level 3 or higher (one person or two persons assist in the home)
  Walking: Level 3 or higher (one person assist in the home)
  Wheeling: Level 3 or higher (must be Level 3 or 4 on walking in the home to use, Level 3 or 4 for wheeling in the home.) **Do not count outside the home.**

- #27: Individual has skilled needs in one these areas – (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
- #28: Individual is not capable of administering his/her own medications.

This assessment tool must be completed, signed and dated by a physician. The physician's signature indicates "to the best of my knowledge, the patient's medical and related needs are essentially as indicated". It is then forwarded to the Bureau or their designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility, regardless of the payment source for services.

PAS' may be submitted to the Bureau's Utilization Management Contractor electronically through a secure website. The faxing option will still be available and is entered into the direct data entry (DDE) by the UMC. When a PAS is submitted electronically, the physician has two options for providing attestation that the patient's medical and related needs are accurate as indicated with their signature.

1. If the physician has the capability for electronic signature (an actual version of their signature, such as when one signs for a credit card or package, the signature is created electronically), not just a typed version of their name; OR,
2. #39 will be checked on the PAS which certifies Dr. Jane Doe has completed this PAS (his or her name will be typed out). Then the PAS MUST be printed off and the physician's physical signature (such as the signature you see when one signs a letter) must be added. The signed page is attached to the electronic record and/or sent to the nursing facility accepting the resident.

On either option for signature, the date is automatically populated and that will be the date for the start of Medicaid reimbursement for services, if the individual meets financial eligibility for the nursing facility benefit. However, the PAS must be signed either electronically or physically by the physician in order for the PAS to be valid.

If an actual written signature either from the resident or responsible party cannot be obtained, verbal consent is necessary. The individuals obtaining verbal consent must sign/date along with the witness who also signs/dates. However, the entity completing the PAS **MUST** obtain an actual signature from the resident or responsible party on the hard copy of the PAS which will be the PAS on file with the nursing facility and available for review upon request.

Each nursing facility must have a signed, original pre-admission screening tool to qualify the individual for Medicaid benefits and to meet the Federal PASRR requirements. Should the receiving nursing facility fail to obtain an approved assessment with an original signature from the resident or responsible party prior to admission of a Medicaid eligible individual, the Medicaid program cannot pay for services rendered at the nursing facility for that individual. The individual cannot be charged for the cost of care during the non-covered period.

A Medicaid member, who had Medicare and reaches the 21st day of Medicare Coverage and will be converting to Medicare Part A coverage with Medicaid as the co-pay, does not need a new PAS as long as the facility has a current PAS that is no more than 60 days old. If the

individual has not been a member of Medicaid upon admission to the nursing facility, a new PAS will need to be completed before the Medicare benefit has ended and the Advanced Beneficiary Notice of Medicare Non-Coverage has been issued. This ensures proper placement if circumstances warrant long-term placement for the individual in the nursing facility after Medicaid becomes the primary payer.

A new medical assessment must be completed for Medicaid Medical Eligibility for the nursing facility resident for all of the following situations:

- Application for the Medicaid nursing facility benefit;
- Resident transfers from one nursing facility to another nursing facility, even if the transfer is within the same corporation;
- Resident returns to the same nursing facility from any healthcare setting other than an acute care hospital;
- Resident transfers to an acute care hospital, then to a hospital-based skilled nursing unit, and then returns to the original nursing facility;
- Resident converts from private pay or any other payer to Medicaid; or
- Expiration of the Current PAS due to time limitation.

514.6.4 Physician Certification

A physician who has knowledge of the individual must certify the need for nursing facility care. Medical eligibility for persons in need of nursing facility services is determined initially from the information supplied by the physician on the specified assessment tool. The information must be current as to the individual's need for nursing facility care. With the physician's signature and date, this is considered the certification for nursing facility services.

514.6.5 Medical Necessity (Level I)

All individuals admitted or requesting admission to a Medicaid certified nursing facility must be screened for the possible presence of a major mental illness, and/or an intellectual/developmental disability (MI/I/DD). This review is identified as the Level I evaluation. Any individual identified with the possible presence of mental health issues must be further evaluated.

514.6.6 Pre-Admission Screening and Resident Review (PASRR) (Level II)

If the Level I evaluation found the possible presence of MI and/or I/DD, further evaluation of the individual must be completed to obtain a definitive diagnosis and the need for specialized services for the mental health condition. This evaluation is identified as a Level II evaluation and must be completed by an individual identified by the BMS as an approved Level II

evaluator. All Level II evaluators are either licensed psychologists or Board certified psychiatrists.

It is the responsibility of the facility in which the PAS is completed, to arrange for the Level II evaluation. This evaluation must be completed, including a report of the mental health status and whether specialized services are needed, within (7 to 9) seven to nine days following the referral. The Level II must be completed prior to the individual's admission into a nursing facility. Upon completion of the evaluation, both the referring entity and the PASARR Level II evaluator must provide the complete mental health evaluation and the original Level I evaluation to the receiving nursing facility. Additionally, the results of the evaluation shall be sent to Psychological Consultants and Associates (PC&A) via mail to 202 Glass Drive, Cross Lanes, West Virginia 25313 or fax to (304) 776-7247 on the applicable forms.

42 CFR 483.106 (ii) states "In cases of transfer of a resident with MI or IDD from a nursing facility to a hospital or to another nursing facility , the transferring nursing facility is responsible for ensuring that copies of the resident's most recent PASARR and resident assessment reports accompany the transferring resident". This regulation applies to all residents of nursing facilities.

Repeat Level II evaluations are necessary when there is an acute exacerbation of the mental illness resulting in an inpatient admission to a psychiatric facility/psychiatric unit. The discharging facility must complete a new PAS, assuring that #31 on the PAS is completed accurately, in which a Level II will be triggered.

514.6.7 Specialized Services for I/DD

Specialized services for an individual identified as I/DD are a continuous program for an individual requiring aggressive, consistent implementation of a program of specialized and generic training, treatment, health and related services developed by an IDT that is directed towards:

- The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and
- The prevention or deceleration of regression or loss of their current optimal functional status.

These services are generally provided in an intermediate care facility for persons with I/DD or a related condition. If the resident is presently residing in a nursing facility when the Level II is completed and specialized services for I/DD is indicated, and the responsible party refuses this recommendation, this refusal must be documented in the resident's record and readdressed with the responsible party on a continuing quarterly basis or until a Level II recommends otherwise.

514.6.8 Specialized Services for Mental Illness

Specialized services for an individual with an acute exacerbation of a major mental illness are the continuous and aggressive implementation of an individualized plan of cares that:

- Is developed under and supervised by a physician in conjunction with an IDT which includes qualified mental health professionals;
- Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of a major mental illness which necessitates supervision by trained mental health professionals; and
- Is directed toward reducing the individual's acute psychotic symptoms that adversely affect the person's ability to perform their activities of daily living. The long term goal of the specific therapies is to improve the individual's level of independent functioning and to achieve a functional level that permits reduction in the intensity of mental health services at the earliest possible time.

These services may only be provided in an acute psychiatric facility. If the resident or responsible party refuse this service, if it is recommended during the Level II review, the individual cannot be admitted to the nursing facility or continue to reside in the facility.

514.6.9 Fair Hearing Process

A Pre-admission Screening (PAS) form will be completed to determine Medicaid medical eligibility for nursing facility placement. If the PAS is determined not to meet Medicaid medical eligibility after being reviewed by BMS' UMC, the member or their responsible party has the right to request a Fair Hearing. During the appeal, the resident may chose to remain at the facility. If the resident is a Medicaid member at the time of appeal, the facility will receive continued payment during the appeal process. . After the hearing, the Hearing Officer will issue the decision, in writing, to BMS, the nursing facility and member/responsible party. This letter, from the Hearing Officer, will have the effective date of the decision. If the decision is to uphold the denial for Medicaid Medical Eligibility, the facility will have 35 days of continued Medicaid payment, in order to account for mailing time.

At the beginning of the 35-day discharge period, the facility will issue a 30-day discharge letter to the resident so that the facility will be able to conduct a safe and orderly discharge while receiving continued payment, in accordance with Code of Federal Regulation 42 CFR Ch. IV, 483.12 (7).

514.6.10 Contribution to the Cost of Care

As a part of the financial eligibility determination for the Medicaid nursing facilities benefit, the DHHR calculates the dollar amount the individual must contribute to the cost of care every month. The monthly Medicaid payment to the nursing facility will be reduced by the dollar amount of the contribution to the cost of care (resource).

The administrator or designee is responsible for collecting the monthly contribution to the cost of care. If the administrator or designee is unable to collect the money for any reason, that dollar amount may not be charged to the Medicaid program in any manner.

It is the responsibility of the nursing facility to notify the local WV DHHR office when a Medicaid member is admitted to the facility and when a member discharges from the facility in order for the facility and member to receive the appropriate benefit.

514.6.11 Admission Policies

A nursing facility must not require a resident, a potential resident or his/her representative to waive rights to Medicaid benefits. A governing body or designee of a nursing facility must not charge, solicit, accept or receive any gifts, money, donations or other consideration as a precondition of admission, expedited admission or continued stay in the facility for any person eligible for Medicaid.

The WVDHHR has established a process of evaluation to determine eligibility for long term care services under the Medicaid Program. The evaluation is made on each member from information supplied by a physician, member or family/representative, health care facility and/or eligibility worker in the local Department of Health and Human Resources office. This determination for the Medicaid benefit for nursing facility is based on both medical and financial criteria. BMS or its designee is responsible for the medical necessity determination and the WV Bureau for Children and Families is responsible for the financial determination. The administrator or designee is responsible for verifying continued eligibility for residents.

Medical eligibility must be established prior to payment for services. Medicaid will not pay for any services prior to the resident qualifying for services both medically and financially.

The local WVDHHR office is responsible for notifying the individual/representative, the Bureau and the nursing facility of the date Medicaid eligibility begins.

514.6.12 Physician Recertification of Continued Stay

Recertification of the continuing need for nursing facility care must be documented in the resident's medical record by the physician at 60days, 180days, then annually after the initial certification. The administrator/designee must obtain recertification documentation from the physician for each nursing facility resident for whom payment is requested under the Medicaid program.

514.7 MANDATORY SERVICES

The following are mandatory services and are included in the per diem rate

514.7.1 In-Services Education Program

A written orientation program must be received by all new employees. The orientation program must be maintained at the facility. This program must include:

- A review of all policies for the nursing facility that pertain to the employee's position;
- An ongoing, in-service education plan for the development and improvement of skills

of all personnel at the nursing facility;

- All State and Federal regulations, including WV Legislative Rule 64CSR13 (the Nursing Home Licensure Rule) which are relevant to the employees position.

The personnel files for each individual employed by the nursing facility must include written documentation indicating the dates the employee participated and completed the orientation program and any staff development in-service training conducted thereafter.

514.7.2 Pharmacy Services

An administrator or designee must assure that pharmaceutical services are provided as outlined in 42 CFR 483.60 to accurately and safely provide or obtain pharmaceutical services, which include the provision of routine and emergency medications and biologicals and consultation of a licensed pharmacist, in order to meet the needs of its residents.

The administrator or designee shall assure the development and implementation of written procedures based on policies approved by the governing body, including procedures that assure the accurate acquisition, receipt, dispensing and administration of all medications and biologicals.

The administrator or designee shall assure that pharmaceutical services are provided in accordance with this policy and all other applicable Federal, State and local laws and the rules of the West Virginia Board of Pharmacy. The administrator or designee must employ or obtain the services of a pharmacist who is licensed to practice in West Virginia and is currently registered as a consultant pharmacist with the West Virginia Board of Pharmacy.

The consultant pharmacist shall review the medication regimen of each resident once a month or more frequently based on the resident's needs. The consultant pharmacist shall document the results of each resident's medication regimen review in the resident's medical record. The medication regimen review shall include substances that are regarded as herbal products or dietary supplements. The consultant pharmacist shall report any irregularities in the medication regimen to the attending physician and the director of nursing. The nursing facilities pharmacist consultant must be available to advise the nursing facility regarding Medicaid drug coverage and limitations.

Drugs and biologicals used in the nursing facility must be labeled in accordance with the requirements of Federal, State and local laws, rules and regulations. The labels must include the appropriate accessory and cautionary instructions with the expiration date when necessary and must conform to the physician order and must adhere to all applicable State Board of Pharmacy rules for labeling.

In accordance with State and Federal laws, the administrator or designee must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The governing body or designee must provide separately locked, permanently affixed compartments for the storage of drugs subject to

abuse and controlled drugs as identified by Federal regulations. The nursing facility may also use single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

The administrator or designee must establish a policy to assure residents' requests for obtaining prescription medications from sources other than the contracted pharmacy will be honored.

Prescription drugs are covered for residents of nursing facilities when prescribed by a qualified practitioner and furnished by a Medicaid participating pharmacy. The coverage rules and regulations may be found in *Chapter 518 Pharmacy Services.*

Residents are exempt from all co-pay requirements. Non-covered drugs are not reimbursed by Medicaid for residents of nursing facilities.

514.7.3 Rehabilitation Services

If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, respiratory therapy and psychological or psychiatric rehabilitative services, are required in the resident's comprehensive plan of care, the administrator or designee must provide the required services directly or in accordance with 42 CFR 483.45 and §514. 8.2 of this manual. These services are covered services included in the reimbursement from Medicaid.

514.7.4 Minimum Data Set (MDS)

The Minimum Data Set (MDS), Version 3.0 with the RUGs III and the West Virginia-specific Section S are to be used by NFs to fulfill the federally mandated requirements for payment.

These forms may be found in the Resident Assessment Instrument (RAI) Manual as published and periodically updated by CMS; please refer to OHFLAC website for Section S instructions www.wvdhhr.org/ohflac specifications.

CMS requires that a comprehensive MDS assessment be completed on every resident admitted into a NF by day 14 of the admission and reassessed on at least a quarterly basis and annually thereafter. Reference should be made to the RAI manual for the complete Omnibus Budget Reconciliation Act (OBRA) assessment schedule.

514.7.5 MDS Submission Criteria for Reimbursement

BMS utilizes the MDS assessments to determine (through the West Virginia specific 29 – case mix grouper), the acuity level of each individual residing in the nursing facility. West Virginia has case mix classes 01-29, (when billed on the UB claim form or 837I format, the scores are depicted as AAA01-AAA29). The case mix workbook may be found online at www.dhhr.wv.gov/bms. The billing schedule is published annually, which may also be found on the BMS website at www.dhhr.wv.gov/bms, with the nursing facility billing deadline dates, as well as the MDS extraction date.

The nursing facilities must transmit all assessments that correspond with claims scheduled for payment in that month at least 36 hours in advance of this extraction. If MDS transmissions occur on or after the MDS extraction date, the MDS assessment will not be included until the following month's extraction. Therefore, authorizations in the claims payment system will not be loaded manually if the transmissions occur on or after the extraction date.

When the MDS extraction is completed, this is given to the fiscal agent for BMS in order to create authorizations for nursing facility placement. Nursing facility providers may review their MDS authorization reports on the web portal to identify which MDS assessments were loaded from the extract received.

Authorizations are created for a three-month period of time and are based upon the ARD (i.e., if the MDS assessment has an ARD of 06/30/11, the authorization in the claims processing system will be created for 06/01/11 - 08/31/11). If a resident has two MDS assessments with ARD dates in the same month, the second assessment is to be used for billing, (i.e. assessment with ARD on 08/05/11 and a second assessment was completed with ARD 08/19/11, the second MDS submitted will be the assessment used by the facility for claim submission).

Please take note that, if a member's MDS assessment is missed or submitted late, the default rate must be billed.

514.7.6 Care Area Assessments (CAAs)

Per Federal regulations, each triggered Care Area Assessments (CAAs) must be addressed further to facilitate design of the care plan, but it may or may not represent a condition that should be addressed in the care plan. The CAAs and the process for their completion are published and periodically updated by CMS and may be found in the RAI Version 3.0 User Manual.

514.7.7 Care Plan (CP)

A comprehensive care plan must be developed by the interdisciplinary care plan team at the nursing facility for each resident that includes measurable objectives and time-tables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment as promulgated in 42 CFR 483.20(k).

514.8 SERVICES UNDER ALL-INCLUSIVE RATE

BMS will pay an all-inclusive per diem rate for nursing facility services. This rate represents payment for all medically necessary and medically appropriate services and items that are required to be provided by the nursing facility to achieve optimum quality care and quality of life for each resident.

514.8.1 Nursing Services

Covered services include general nursing and restorative nursing care such as, but not limited to, medication administration, treatments, assessment, care planning, and restorative programs. General nursing care consists of, but is not limited to, personal care services rendered by the nursing staff and assistance with activities of daily living rendered by any staff including hair and nail hygiene, bathing and routine foot care.

514.8.2 Therapy Services

Covered services include physical therapy, speech-language pathology, occupational therapy, respiratory therapy, psychological and psychiatric rehabilitative services. Services must be documented in the resident's physician orders and be included in the plan of care.

Rehabilitative services, whether provided either directly or through qualified outside resources must be designed to preserve and improve abilities for independent function, to prevent progressive disabilities, and restore maximum function.

514.8.3 Non-Prescription Items

The nursing facility's all-inclusive rate includes over-the-counter drugs. Additionally, all diabetic supplies including diabetic testing supplies and syringes/needles are covered in the facility's all-inclusive rate.

514.8.4 Medical Supplies, Accessories and Equipment

Facilities may not charge a resident or the Medicaid program for routine personal hygiene items and services required to meet the needs of resident, as this cost is included in the all-inclusive rate. These include but are not limited to; hair hygiene supplies; comb; brush; bath soap; disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; razor; shaving cream; toothbrush; toothpaste; denture adhesive; denture cleaner; dental floss; moisturizing lotion; tissues; cotton balls; cotton swabs; deodorant; incontinence care and supplies; sanitary napkins and related supplies; towels; washcloths; hospital gowns; nail services including routine trimming, cleaning, filing, and care for ingrown or damaged nails; bathing and basic personal laundry.

Also included are nursing supplies including over the counter wound care items; sterile saline; pressure ulcer treatment supplies; dressings: bandages; tape and any other wound care supplies prescribed by the physician, syringes and needles; dietary supplements; salt and sugar substitutes; tube feedings and equipment needed to deliver the feeding; disposable incontinence supplies; supplies such as catheters; colostomy and ileostomy bags and any other incontinence supply items prescribed by a physician.

Medical supplies, accessories and equipment that the nursing facility is required to have available include, but are not limited to, hospital beds, standard wheelchairs, walkers,

gerichairs, crutches, canes, bedside commodes, traction equipment, blood pressure equipment, protective restraints, lifts, nebulizers, air mattresses, weight scales and gait belts.

514.8.5 Room and Board

Covered services include the resident's room and basic room furnishings, including a bed of proper size, length, and height for each resident; a clean, well–maintained, comfortable mattress of the proper length for each resident; pillows; clean linens and bedding appropriate to the weather and climate; functional furniture appropriate to the resident's needs; and individual closet space with clothes racks, hangers and shelves.

514.8.6 Laundry

Covered services include laundry services such as basic personal laundry.

514.8.7 Food and Dietary Services

Covered services include all nutritional meals, snacks, food supplements, tube feedings, supplies and equipment required for tube feedings, and food substitutes needed for special diets.

514.8.8 Activities Program

Covered services include the cost for the provision of an activities program for residents.

514.8.9 Social Services

Covered services include the provision of medically-related social services and coordination with other social service agencies in the resident's community and the resident's family.

514.8.10 Non-Emergency Transportation Services

Nursing facilities must provide non-emergency medical transportation (NEMT) which includes non-emergency ambulance transportation for all residents. If the nursing facility does not provide these services with a facility owned vehicle, the facility must contract with a transportation vendor that provides non-emergency van and non-emergency ambulance transportation. These contracted services for transportation are not billable to West Virginia Medicaid by the facility or transportation provider. Additionally any nursing facility that may be enrolled as a non-emergency transportation provider with WV Medicaid shall not bill for NEMT reimbursement for transportation provided to their residents. The nursing facility must cover the cost of these transportation services and may be counted as an allowable expense on the cost report, under nursing- purchased services.

However, the cost of all non-emergency medical transportation, provided by a vehicle owned by the nursing facility, is included in the all-inclusive Medicaid rate. Refer to section 514.13.19.

Upon transfer to another nursing facility, it is the responsibility of the receiving nursing facility to provide the transportation to their facility. This is because the sending facility is not reimbursed for the day of discharge and the receiving facility is reimbursed for the day of admission.

514.9 RESIDENT RIGHTS

As promulgated in 42 CFR 483.10, the resident has a right to a dignified existence, self-determination, and communication and access to persons and services inside and outside the facility.

514.9.1 Notice of Rights

A facility must protect and promote the rights of each resident, including each of the rights defined below. Written policies and procedures must be implemented to ensure that each resident or his/her representative is fully informed of his/her rights and responsibilities. Notification of resident rights must be provided periodically during the stay to the resident/representative.

The administrator or designee must encourage and assist the resident throughout the period of stay to exercise rights as a resident and a citizen including the right to vote, formulate advanced directives and meet and organize in resident/representative groups to voice grievances and recommend changes in policies and services to facility staff and/or other representatives of choice free from restraint, interference, coercion, discrimination or reprisal. The administrator or designee must assure each resident civil and religious liberties, privacy of telephone and written communications, provide services and care consistent with special needs and individual preference, and respond promptly to requests.

In the case of a resident adjudicated to be incompetent, the rights described in this provision shall be exercised by the individual's guardian or committee, in accordance with the West Virginia Guardianship Act. If the resident has not been adjudged incompetent by the State, any legal surrogate designated in accordance with State Law may exercise the resident's rights to the extent provided by State Law.

The administrator or designee must inform each resident and/or his/her representative both orally and in writing, in a language or method of communication that the resident understands of his/her rights and of all rules and regulations governing patient conduct and responsibilities. Such information must be provided prior to or at the time of admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of resident right's policies. Written acknowledgment of the receipt of resident rights information must be maintained within the facility.

The administrator or designee will keep all personal and medical records private and refuse to allow access to these records without written authorization by the resident/representative unless State and/or Federal regulations regarding release of information supersedes. The resident or is/her representative will have access to all records pertaining to the resident including clinical

record. Upon receipt of a written request by the resident or his/her representative, the administrator or designee will provide within two working days copies of all records requested at a cost not to exceed the community standard for photocopies.

The resident has the right to receive adequate, appropriate health care and appropriate protection and support services with reasonable accommodation of individual need and preference including, but not limited to selection of personal physician. The resident or his/her representative has the right to be fully informed in a language that he/she can understand of his/her total health status. The resident or his/her representative has the right to refuse treatment, and to refuse to participate in experimental research.

The resident or his/her representative has the right to be present and participate in the formulation of a care plan as well as be consulted in advance about any changes in treatment or care. Self-medication by a resident must be allowed if individual capabilities are assessed and documented by professional staff.

Outside of the formal plan of care, the resident has the right to plan personal daily activities and participate in activities both inside and outside the facility.

Residents who are entitled to Medicaid benefits or become eligible for Medicaid benefits must be informed in writing of the items and services under the State Plan for which the resident may not be charged as well as the items for which the resident may be charged and the amount of the charges including an explanation of the resource amount. This information must also be provided to the resident annually during the resident's stay in the nursing facility.

A resident of a nursing facility must be provided a room as homelike as possible according to individual tastes, desires and medical necessities. Personal furnishings including furniture must be allowed depending on space. A private storage space within the personal room for clothing and possessions must be provided. The administrator or designee must take reasonable precautions to protect and treat personal possessions with respect, as well as investigate incidents of loss, damage or misappropriation of property.

The facility must provide a written description of legal rights including:

- The manner of protection of personal funds;
- The names, addresses, and telephone numbers of all pertinent State advocacy groups;
- A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and/or misappropriation of funds or property in the facility;
- The name, specialty and way of contacting the physician responsible for the care of the resident; and
- The procedures for applying for and using Medicare and Medicaid benefits as a resident of a nursing facility.

514.9.2 Transfer and Discharge Policies

According to 42 CFR 483.12, transfer and discharge of an individual includes movement of a resident to a bed outside of the Medicaid-certified portion of the facility, whether that bed is in the same physical plant. Transfer and discharge does not refer to movement of a resident to a bed within the Medicaid-certified portion of the facility.

The administrator or designee must permit each resident to remain in the facility, and not be transferred or discharged from the facility unless one of the following conditions is met:

- The transfer or discharge is necessary for the resident's welfare when the needs of the resident cannot be met in the facility; or
- The transfer or discharge is appropriate because the health of the resident has improved sufficiently that the individual no longer meets the medical criteria for nursing facility services; or
- The safety of individuals in the facility is endangered; or
- The health of individuals in the nursing facility would otherwise be endangered; or
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicaid) a stay at the nursing facility, including but not limited to, the amount of money determined by the financial eligibility evaluation as co-payment for the provision of nursing facility services; or
- The facility ceases to operate; or
- The resident is identified by the State and/or Federal certification agency to be in immediate and serious danger.

Documentation must be recorded in the resident's medical record by a physician of the specific reason requiring the transfer or discharge. Discharge documentation is required regardless of the reason for discharge.

Before the nursing facility transfers or discharges a resident, the administrator or designee must notify the resident and/or the responsible party verbally and in writing, in a language that is understandable to the parties, of the intent and reason for transfer or discharge. The same information must be recorded in the resident's medical record and a copy of this written notice must be sent to the State Long-Term Care Ombudsman or his/her designee. Except in the case of immediate danger to the resident and/or others as documented, the notice of transfer or discharge must be provided at least 30 days prior to the anticipated move to ensure a safe and orderly discharge to a setting appropriate to the individual's needs.

Waiver of this 30-day requirement may be appropriate if the safety of individuals in the facility would be endangered, the immediate transfer is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days.

The written notice must include the following:

- The effective date of the transfer or discharge;
- Reason for the discharge;
- The location or person(s) to whom the resident is transferred or discharged;
- A statement that the resident has the right to appeal the action to the State Board of Review, during this time of appeal, the resident/member may choose to stay in the facility;
- The name, address and telephone number of the State long term care ombudsman;
- The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled and mentally ill individuals.

It is the responsibility of the nursing facility to notify the local WVDHHR office when a Medicaid member is admitted to the facility and when a member discharges from the facility in order for the facility and member to receive the appropriate Medicaid benefit.

514.9.3 Bed Reservation

A nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility. This is paid at the facility's established Medicaid base rate.

The facility's occupancy must be 95% or greater as of midnight on the day immediately before the time that the resident leaves and there must be a current waiting list for admission to the nursing facility. The midnight census must be obtained daily and kept either in hard copy or electronic format and must contain, at a minimum, the names and ID numbers for each resident. A waiting list for admission must be maintained either in hard copy or electronic format by day and must contain, at a minimum, the names, addresses and contact numbers of the individuals on the waiting list and must be available immediately upon request by the Department.

A day of leave is defined as a continuous 24-hour period. At the time the resident leaves the facility, the primary payer for services must be Medicaid. Bed reservation days may be for acute care hospitalization or a therapeutic leave.

The resident whose bed is reserved is to be accepted by the facility immediately upon discharge from the hospital or return from therapeutic leave. Placement is to be in the same bed and living space occupied by the resident prior to the hospital or therapeutic leave of absence unless

the resident's physical condition upon returning to the facility prohibits access to the bed previously occupied. If the nursing facility discharges a resident and return is not anticipated, as indicated on the MDS, the facility cannot charge BMS for a Medicaid bed hold.

When all hospital or therapeutic days have been used by a Medicaid resident, a facility may charge a resident to reserve a bed only when there are no vacancies and there is a current waiting list. Families that are willing and able are free to pay these charges, and the amount paid is not considered as a resource or income for Medicaid purposes.

Personal needs allowance may be used to reserve a bed only with the resident/member or responsible party's written consent. The resident's contribution to the cost of care (resource) may not be used to pay to reserve a bed. After a hospitalization or a leave of absence for which there was no bed-hold, a former resident has the right to be re-admitted to the first available bed in a semi-private room in the nursing home from which he or she came if the resident requires the services provided by the nursing home and has not been out of the facility for more than 30 days.

514.9.4 Medical Leave of Absence

The medical leave of absence is payable for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, who is expected to return to the facility, and whose stay in the acute care facility is 24 hours or greater. The maximum number of medical leave of absence days which may be reimbursed for an individual for a medical leave of absence is 12 days in a calendar year (i.e. January 1 through December 31).

The resident's medical record must contain the physician's order, the date and time the resident is transferred to the hospital and the date and time the resident returns to the reserved bed in the nursing facility. The day of transfer from the nursing facility to the hospital is counted as Day one of the leave. If the Medicaid member returns to the nursing facility in less than 24 hours, this is not considered a leave day. If the resident expires in the hospital, is transferred to another facility or goes home, that day must be considered the day of discharge from the nursing facility.

514.9.5 Therapeutic Leave of Absence

For a therapeutic leave of absence, such as a home visit, to be eligible for payment, the medical record must contain a physician's order for therapeutic leave and must be a part of the resident's plan of care. The maximum number of therapeutic leave of absence days which may be reimbursed for an individual resident is 6 days in a calendar year (i.e. January 1 through December 31).

The medical record of the individual requesting therapeutic leave must contain a physician's order, the date and time of the beginning of the therapeutic leave, and the date and time the resident returns to the reserved bed in the nursing facility. For therapeutic leave, the date the member leaves the nursing facility is counted as a leave day and the day the resident returns to the facility is not counted as a therapeutic leave day.

514.9.6 Resident Personal Funds

The resident has the right to manage his or her own financial affairs and the administrator or designee shall not require residents to deposit their personal funds with the nursing facility, in compliance with the Code of Federal Regulations. Upon written authorization of a resident, the administrator or designee shall hold, safeguard, manage and account for the personal funds of the resident deposited with the nursing facility as specified in the following sections.

514.9.7 Deposit of Funds

According to 42 CFR 483.10 (12)(3), an administrator or designee must deposit any resident's personal funds in excess of $50.00 in an interest-bearing account (or accounts) that is separate from any of the nursing facility's operating accounts and that credits all interest earned on a resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

An administrator or designee must maintain a resident's personal funds that do not exceed $50.00 in a non-interest bearing account, interest bearing account, or petty cash fund.

514.9.8 Accounting and Records

The administrator or designee must establish and maintain a system that assures a complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing facility. The system shall preclude any co-mingling of a resident's personal funds with nursing facility funds or with the funds of any person other than another resident.

Each resident's financial record shall be provided through quarterly statements and on request of the resident or his/her legal representative. For any transaction from a resident's account, the administrator or designee shall provide the resident with a signed receipt and retain a copy of the receipt.

The administrator or designee shall administer the funds on behalf of the resident in the manner directed by the resident or in the case of the resident's inability to make financial decisions, the legal representative.

514.9.9 Notice of Certain Balances

An administrator or designee shall notify each resident who receives Medicaid benefits or his/her legal representative when the amount in the resident's personal funds account reaches within $200.00 of the Supplemental Security Income (SSI) limit for one person. Should the amount in the account, in addition to the value of the resident's other non-exempt resources, reach the SSI resource limit for one person, it may result in the individual losing eligibility for Medicaid and SSI.

514.9.10 Conveyance Upon Discharge

Upon the death or discharge of a resident with personal funds deposited with the nursing facility, the administrator or designee shall comply with all applicable State and if appropriate, Federal statutory and regulatory provisions.

514.9.11 Allowable Resident Charges

Allowable resident charges, according to 42 CFR 483.10(C)(8), are charges by the facility to the resident/financial representative that are amenities/items/services above the "all inclusive rate" that are requested by the resident or responsible party. Additional charges must be explained to the resident/responsible party during the admission process. The following may be used as examples of allowable resident charges: telephone, television/radio, personal comfort items, smoking materials, cosmetic items personal clothing, personal reading materials, flowers and plants, social events and entertainment offered outside the scope of an activities program, and special care services such as privately hired individuals. Commercial laundry/dry cleaning expenses for personal items of clothing will be the responsibility of the resident.

For a Medicaid resident desiring a private room, the administrator or designee may charge the difference between the facility's actual charge for room and board of a semi-private room and the charge for room and board of a private room. For a Medicaid resident's whose medical condition warrants an isolation/private room, the administrator or designee may not charge an additional fee.

Individuals may reserve a bed in a nursing facility as a contractual agreement to pay the nursing facility for a bed hold as long as the amount paid is not considered as a resource or income for Medicaid. However, the resident's contribution of cost of care (resource) cannot be used for this purpose.

514.10 ANCILLARY SERVICES

The nursing facility must have formal arrangements for the provision of ancillary services which are necessary to support the primary activities of the nursing facility; however, they are not included in the per-diem rate.

514.10.1 Orthotics and Prosthetics

O & P devices/appliances that are prescribed by an enrolled practitioner to residents in a nursing facility are subject to service limitations and prior authorization requirements noted in *Chapter 516 Orthotics and Prosthetics*.

514.10.2 Dental Services

Generally, dental care is not a covered service and is not reimbursable as a fee for service. However, in accordance with *Chapter 505 Dental and Oral Health*, emergent dental care for adults is covered and defined as treatment for pain, infection, fractures, and trauma. Coverage is limited to the Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT). Please refer to the local Department of Health and Human Resources (DHHR) office for further information.

514.10.3 Vision Care Services

Covered vision services may be found in *Chapter 525 Vision Services*. All covered services MUST be medically necessary and prescribed by an enrolled physician.

514.10.4 Podiatry Services

The Medicaid Program covers podiatry services, with certain limitations, furnished to a resident when referred by the attending physician.

Routine foot care is not a covered service, except for residents referred by the physician for the treatment of a metabolic disease (such as diabetes). Routine foot care includes, but is not limited to, the cutting or removal of corns or calluses, the trimming of nails, observation and cleaning of the feet, nail care not involving surgery, and other hygienic and maintenance care. Routine foot care is considered a part of the nursing services provided by facility staff.

The regulations detailed in *Chapter 520 Podiatry Services* for the Medicaid program apply to nursing facility residents.

514.10.5 Laboratory, X-Ray, and Other Diagnostic Services

Laboratory and x-ray services are covered as ancillary services when provided by a certified and participating hospital or laboratory upon the order of the attending physician as needed to diagnose or treat an illness, accident, or injury.

The resident's initial medical evaluation which is required within 48 hours after admission may include a chest x-ray and/or routine laboratory work in order to safeguard against the spread of disease and to ensure adequate medical care.

42 CFR 483.75 (j) (1) states: the facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

A nursing facility that provides laboratory services must follow Clinical Laboratory Improvements Amendment (CLIA) regulations as applicable. Please refer to *Chapter 529 Laboratory Services*.

514.10.6 Emergency Ambulance Transportation Services

West Virginia Medicaid reimburses emergency transportation services rendered to members residing in nursing facilities when the services are medically necessary. Services must be rendered in the nearest hospital or facility that has the appropriate equipment and personnel and is documented in the nursing facility transfer agreement. Please refer to *Chapter 524 Transportation Services* for further emergency guidelines.

Use of an ambulance merely for the member or the nursing facility's convenience is not covered nor is residence in a NF adequate justification for the utilization of transportation via ambulance. The following are not emergency transportation services and will not be reimbursed;

- Transport for services routinely available at the nursing facility;
- Transport for personal services;
- Transport for services that do not meet medical necessity guidelines;
- Transportation for services where the level of transportation does not meet the medical necessity requirements of the member;
- Transportation to any location that does not render covered medical, diagnostic or therapeutic services.

This list is not intended to be all inclusive.

514.10.7 Hospice/Nursing Facility Resident

West Virginia Medicaid maintains a separate program of Hospice Services for individuals who are residents of a nursing facility. If a member electing hospice care is a resident of a West Virginia Medicaid certified nursing facility, the administrator or designee may contract with a Medicare/Medicaid certified hospice agency to provide hospice services for eligible individuals who qualify medically for both the hospice benefit and Medicaid nursing facility benefits. Medicare certification of a nursing facility is not a requirement of this program. The hospice agency must enroll with the Medicaid agency to be a provider of this benefit in nursing facilities. The hospice agency staff must follow the nursing facilities policies and procedures.

The room and board component provided by the nursing facility shall include the provision of a living space, nutrition, and ancillary services normally provided for residents. Ancillary services may include, but are not limited to, the basic activities of daily living, social and activity programs, and laundry and housekeeping.

The hospice provider is responsible for specialized services covered by Medicare or Medicaid, including but not limited to, medications associated with the terminal illness and assistance with care planning. The hospice provider becomes an active participant in the interdisciplinary care plan team and the care plan must be immediately updated to reflect these changes. Emotional support for the member and the member's family is also provided. The hospice must bill Medicare and Medicaid for all covered services, including nursing facility room and board. The

nursing facility cannot charge Medicaid a bed hold if the resident is under the Hospice benefit. The bed hold is to be contracted between nursing facility and the approved Hospice provider.

A significant change in status assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains a resident at the nursing home. The assessment reference date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same as or later than the date of the hospice election statement, but not earlier). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.

A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease the resident is experiencing.

A SCSA is required to be performed when a resident who is receiving hospice services decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following:

- The effective date of the hospice election revocation (which can be the same as or later than the date of the hospice election revocation statement, but not earlier);
- The expiration date of the certification of terminal illness; or
- The date of the physician's or medical director's order stating the resident is no longer terminally ill.

If a resident elects the hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident. In addition to coordinating plans of care between the nursing facility and the hospice provider, the two entities must also coordinate billing procedures for these members, which should include but is not limited to, the proration of patient resource amounts. When nursing facility residents are receiving hospice care, the nursing facility cannot bill Medicaid for the days that the member is receiving hospice services. The hospice provider is responsible for billing Medicaid. When a nursing facility resident is receiving hospice services for a partial month, the patient resource amount may need to be prorated. For example, a member is admitted to the nursing facility on January 1st and remains in the facility for the entire month and then on January 11th, the member elects hospice services in the nursing facility and continues to receive the hospice services through January 31st. The nursing facility would prorate the resource amount for the January claim for 10 days. The hospice claim would reflect a prorated resource amount for 21 days. If the nursing facility resident is receiving hospice services for the entire month, the full resource amount will be deducted from the payment made to the hospice provider for room and board.

514.10.8 Documentation Requirements for Hospice/Nursing Facility Authorization

For each individual who applies for hospice coverage in a nursing facility, election of services and physician certification documentation is required. *Please refer to Chapter 509 Hospice Services.* The hospice provider must submit to BMS or its designee for review of the following information:

- An agreement between the specific nursing facility and the hospice provider that each will provide its appropriate services to residents who qualify, and
- Documentation to support the medical necessity for each covered hospice service and the financial eligibility documentation for the specific individual regarding Medicare and Medicaid.

As with hospice services provided in other settings, those hospice services provided in nursing facilities apply only to the terminal condition or disease. For health needs not related to the terminal diagnosis, established West Virginia Medicaid policies and procedures are to be followed.

The authorization information must be submitted with the first claim for payment.

514.11 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

The administrator or designee must comply with the documentation and maintenance of records requirements described in *Common Chapter 100, General Information; Common Chapter 300, Provider Participation Requirements*, and *Common Chapter 800, General Administration*. In addition to the documentation requirements described in those chapters, the following requirements also apply to payment for nursing facility services.

514.11.1 Resident Record System

A resident record system must be maintained which assures that the record is available to professional and other staff directly involved with the resident as well as authorized representatives.

Resident records must be safeguarded against destruction, loss, or unauthorized use and must comply with all Health Information Portability and Accountability Act (HIPAA) regulations. Records must be retained for a minimum of five years following a resident's discharge. Representatives of the WVDHHR and USDHHS may have access to the resident records at any time without the consent of the resident or responsible party. A separate clinical record must be maintained for each resident at a location that is accessible to appropriate nursing facility staff with all entries recorded in accordance with current professional standards and practices.

514.11.2 Demographic Information

The clinical record must include at a minimum the following information:

- Name of resident (first, middle, last, and generation if applicable)
- Date and time of admission
- Social Security identification number
- Medicare identification number (where applicable)
- Medicaid identification number (where applicable) or any other payer identification number
- Marital status
- Date of birth
- Gender
- Home address
- Religion
- Name, address, and telephone number of referral agency (including institution from which admitted, where applicable)
- Attending physician
- Next of kin or other responsible person
- Admitting diagnosis
- Final diagnoses (or cause of death)
- Condition on discharge and disposition (where applicable)
- Inventory of personal effects.

514.11.3 Medical Information

For each resident, the clinical record must include at a minimum the following information all of which must be signed and dated:

- Physician's certification reflecting the need for nursing facility services upon admission to the nursing facility.
- An overall plan of care based on a comprehensive assessment setting forth goals to be accomplished, prescribing an integrated program of individually designed activities, therapies and treatments necessary to achieve such goals, and indicating which professional service or individual is responsible for each element of care or service prescribed in the plan.
- Initial medical evaluation including medical history, physical examination, diagnoses, and estimation of restoration potential done on admission.
- Physician's orders including all medications, treatments, diets, therapies and special restorative /medical procedures.
- Medication and treatment administration records including all medications, treatments, and special procedures performed.
- Physician's progress reports noted for each visit or consultation describing the residents' health status and/or significant changes in resident's condition.
- Nursing note documentation must reflect the current conditions as well as changes in conditions of the resident. Monthly documentation which indicates observations, medication changes, progress, regress, any changes in conditions. Physician re-

- certification must include documentation by the physician substantiating the resident's need for continued services in the nursing facility.
- Hospital transfer information (where applicable).
- Discharge summary completed by the physician prior to the resident's discharge for transmittal to the receiving institution at the time the resident is discharged, if applicable.
- A record of the resident's major grievances, if any, and the disposition.
- Laboratory, x-ray and other diagnostic reports.
- A list of medications transferred to the resident or responsible party upon discharge, to include a medication disposition form signed and dated by the receiving individual and the discharging nurse.
- Pre-Admission Screening (PAS) form.

514.12 PAYMENT AND BILLING PROCEDURES

Nursing facility providers must comply with the payment and billing procedures and requirements as noted below and found in *Common Chapter 600*, *Reimbursement Methodologies*.

514.12.1 Payment and Billing Procedures Non-Hospice

Nursing facilities must bill for services using either the UB04 paper form or the 837i electronic institutional format. The services may not be billed until the following month after which the services were provided.

Nursing facilities will use bill type 21X. The following are the revenue codes and the **Health Insurance Prospective Payment System** (HIPPS) codes that must be billed in order to receive appropriate payment for services provided:

- Revenue Code 0190 is the room and board (fixed portion of the rate);
- Revenue Code 0550 in skilled nursing (nursing portion of the rate) and must have HIPPS/RUGs Code attached;
    - HIPPS/RUGs Codes are AAA01-AAA29 to identify the West Virginia specific case mix class
    - HIPPS/RUGs Code AAA00 is to identify there is no MDS available;
- Revenue Code 0183 is the therapeutic bed hold leave of absence;
- Revenue Code 0185 is the hospital bed hold leave of absence and
- Revenue Code 0189 is the non-covered leave of absence.

514.12.2 Nursing Facility Billing Procedures for Hospice Patients

To be billed under Revenue Code 0658:

The West Virginia Medicaid Program will remit to the hospice provider, who is contracted to provide services in the nursing facility, 95% of the daily rate which would have been paid to the nursing facility for care of this member had they not elected hospice coverage. The hospice will reimburse the nursing facility for the cost of room and board, as identified in their contract. The amount of reimbursement will be based on the nursing facility base per diem rate with the Medicaid adjustment for the acuity of the beneficiary. The claim form for billing is the UB04 and cannot be billed electronically. Documentation identifying the specific case mix class of the individual must be attached.

514.12.3 Reimbursement Requirements

The West Virginia nursing facility reimbursement system is prospective with semi-annual rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. To meet these goals, complete and accurate cost data must be maintained by each facility with cost reports accurately prepared and submitted on a timely basis.

The basic principles and methodology for the system are described in this chapter. Detailed instructions and guidelines are published in the revised West Virginia Medicaid Long Term Care Users Guide to Reimbursement, which is hereby incorporated by reference into these regulations.

Federal and State law, the West Virginia State Plan and Medicaid regulations cover reimbursement principles in the following order. When Medicaid regulations are silent and Medicare cost principles and regulations are silent, then generally accepted accounting principles (GAAP) will be applied. None of these secondary applications will serve to reduce the Department's ability to apply "reasonable cost" limits under Medicaid.

514.13 COST REPORTING

All participating facilities are required to maintain cost data and submit cost reports according to the methods and procedures specified in this chapter and the Medicaid Reimbursement Guide for Long Term Care Nursing Facilities (see www.dhhr.wv.gov/bms), whichever is more restrictive.

514.13.1 Chart of Accounts

The Medicaid Chart of Accounts (MCOA) is mandated by the West Virginia Department of Health and Human Resources (WVDHHR) for nursing facility service providers who are required to complete the Financial and Statistical Report for Nursing Homes (Medicaid Cost Report) as part of their participation in the Medicaid program. The MCOA details the account number, account name, file/field specification (FIELD), page and line reference (MAP) and description of items applicable for each account. The FIELD column contains the file and field layout for submission of the Medicaid Cost Report.

It is not mandatory for providers to use the MCOA for internal reporting purposes; however the provider's internal chart of accounts MUST contain a sufficient number of accounts to capture data in the level of detail necessary to correlate to the MCOA. Individual accounts must be used to report separate types of costs, even if the accounts aggregate to one cost report cost center.

The provider must submit a trial balance using the MCOA as part of the automated cost reporting process. This is accomplished in the cost reporting software by assigning the appropriate MCOA number to the provider's internal account number. It is the provider's responsibility to secure and maintain acceptable cost report software. The MCOA is maintained by Rate Setting Unit of the Office of Accountability and Management Reporting (OMAR) and is periodically updated. Cost reports must be submitted in accordance with the MCOA.

The Grouping Report (Trial Balance submitted with the cost report through which each provider internal account has been assigned to the appropriate MCOA number) must reflect the actual balance in each provider internal account for the semi-annual period reported, and the "Per Books" column must agree directly to the balance for each account in the provider's general ledger for that six-months of activity. All adjustments are to be posted through the "Net Adjustments" column of the Grouping Report.

514.13.2 Financial and Statistical Report

Facility costs must be reported on the Financial and Statistical Report for Nursing Homes, which must be completed in accordance with generally accepted accounting principles (GAAP) and the accrual method of accounting. The reports must be submitted to WVDHHR Office of Accountability and Management Reporting; Attention: Division of Audit and Rate Setting, in the form of a hard copy and on a 3.5" 1.44 high density diskette or compact disc (CD).

The report must also be accompanied by the Medicaid grouping report trial balance that matches the costs on the report. These reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be rejected and returned to the facility for correction.

514.13.3 Cost Reporting and Filing Periods

Facility costs are reported semi-annually with the two reporting periods being January 1 through June 30 with a deadline of August 29, and July 1 through December 31 with a deadline of March 1 (February 29 on leap years). Cost reports must be filed with the Department within 60 days following the end of the reporting period.

514.13.4 Extension Requests

An extension of time for filing cost reports may be granted by DHHR for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. Extension requests will be limited to a maximum of 15 calendar days. Requests

must be addressed to the WVDHHR Office of Accountability and Management Reporting; Attention: Director of Rate Setting, #1 Davis Square, Suite 304, Charleston, WV 25301.

514.13.5 Penalty – Delinquent Reporting

Failure to submit cost reports by the due date, where no extension has been granted to the facility or within the time constraints of an extension may result in penalties to that facility. If incomplete cost reports are not corrected and resubmitted within 10 calendar days, the facility may be subject to these penalty provisions at the discretion of the DHHR. See also *Common Chapter 300, Provider Participation Requirements*.

514.13.6 Correction of Errors

Errors in cost report data identified by the facility must be corrected and resubmitted to the Department. If submitted within 30 days after the original rate notification, those corrections will be considered for rate revision. The DHHR will make rate revisions resulting from computational errors in the rate determination process.

An instance where a rate is revised for correction of an error, whether identified by the facility or the DHHR for computational or other errors, shall not prohibit the DHHR from making additional rate revisions as needed upon subsequent discovery of additional errors.

514.13.7 Changes in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if the change affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the bed size change has been certified. If the annual appraisal has been completed, the facility will be responsible for the cost of the additional appraisal.

514.13.8 Projected Rates

A projected rate will be established for new facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. A projected rate will last no longer than 18 months from the opening date of the facility. The facility may choose to go off the projected rate at any time after a full 6 months of operating experience in a cost reporting period. Each facility on a projected rate must submit the calendar semi-annual cost reports during the projected rate period even if the first report is a partial report (less than six months).

514.13.9 Projected Rates – Change of Ownership

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility. When a stock purchase occurs a projected rate is not established. If a change of

ownership and control has occurred because there has been a complete purchase of assets, a projected rate is established.

At the end of the projected rate period, the audited cost report of the facility will be reconciled with the projected cost reimbursement using actual occupancy and tested for reasonableness against the cost standard established for the bed groups (0-90 beds and 91+ beds). Overpayment identified in the reconciliation process will be recovered by the Department in accordance with the provision of *Common Chapter 800, General Administration*.

A projected rate for a new facility or a facility with a recognized change of ownership and control will be established as follows:

a. Standard Services - The cost standard CAP (Cost Average Point) established for the bed group
b. Mandated Services - The cost standard CAP established for the bed group
c. Nursing Services - The average of the cost established for the bed group
d. Cost of Capital - The Standard Appraised Value (SAV) methodology is applied to a new facility or the SAV established for the facility if a change of ownership occurs

Full disclosure of ownership is required on the cost report. Refer to page WV2 and WV 3 on the cost report for information requested.

514.13.10 Maintenance of Records

A desk review of the cost report will be done prior to rate setting and an on-site audit of facility records will be conducted periodically. Financial and statistical records must be maintained by the facility to support and verify the information submitted on the cost reports. Such records must be maintained for a minimum of five years from the ending date of the report. Upon request by the DHHR, all records will be made available within 10 working days. If not produced within that time frame, the records will be considered non-existent. The DHHR reserves the right to determine the site where the records are to be made available. Costs or census data reported that are found to be unsubstantiated or related to records requested but not produced will be disallowed.

514.13.11 Census Data

Providers shall include with the cost report a detail of census data and bed reservations billed to Medicaid for the cost reporting period.

Upon request for desk review or audit, source documentation for census as reported on the cost report must include at a minimum a midnight census (by payer class with bed reservations specifically identified) that agrees in aggregate to a monthly census (by payer class with bed reservations specifically identified), which agrees (or has an accompanying reconciliation) to each month as reported on the cost report, with bed reservations specifically identified.

514.13.12 Allowable Costs for Cost Centers

Reimbursement for nursing facility services is limited to those costs required to deliver care to residents. These are costs related to inpatient care, i.e., facility operating costs and the cost of direct services to residents, which are considered for reimbursement. Allowed costs are subject to the regulations prescribing the treatment of specific items in this manual.

The cost centers are standard services, mandated services, nursing services and capital. A cost standard is developed for each cost center which becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following four methodologies: Standard Services, Mandated Services, Nursing Services, and Cost of Capital.

514.13.13 Standard Services

The cost standard for standard services is comprised of 4 departmental cost centers: Dietary, Laundry & Housekeeping, Medical Records and Administration. A separate cost standard is calculated for each of these cost centers by bed group based on bed size (0-90 beds and 91+ beds). Within each cost center, the per patient day (PPD) allowable costs are arrayed assuming 100% occupancy on a facility specific basis. Extremes are eliminated by including only those values falling within plus or minus one standard deviation; this is 90% occupancy level. The cost standard for standard services is the sum of the cost center CAP for Dietary, Laundry & Housekeeping, Medical Records and Administration. The cost standard then establishes the maximum allowable cost by bed group for Standard Services.

514.13.14 Mandated Services

The Mandated Services component is comprised of (4) four departmental cost centers: Activities, Maintenance, Utilities and Taxes & Insurance. A separate cost standard is calculated for each of these costs centers by bed group. Within each cost center the PPD allowable costs are arrayed from highest to lowest. The 90th percentile value of each cost center is then selected as the CAP. The Mandated Services cost standard is the sum of the cost center CAP for Activities, Maintenance, Utilities and Taxes & Insurance. The cost standard then establishes the maximum allowable cost by bed group for Mandated Services.

514.13.15 Nursing Services

The cost standard for Nursing Services is shown as the Resident Assessment calculation on the rate sheet. This calculation provides for professional staffing levels and supply costs that are recognized as representative of those necessary for delivery of the core level of resident needs. It incorporates all minimum Federal and State mandates for licensure and certification of nursing facilities.

The professional staffing hours on the Resident Assessment calculation serve as a benchmark and are held constant over time. A factor of 0.35 hours PPD is included in the LPN hours for 0-90 beds and 0.30 hours PPD for 91+ beds to account for restorative services. Additionally, 0.05 hours PPD is included in the standard Aides hours for restorative services.

The standard hours PPD, by bed group, for each of the professional levels of nursing staff are as follows:

Staff	1-90 Beds	91+ Beds
RN	0.20	0.20
LPN	0.85	0.80
Aides	1.85	1.85
Total Hours PPD	2.90	2.85

The cost standard for nursing wage rates uses total compensation and is calculated by bed group. Hourly wage rates, by professional level, are derived from the cost reports of each facility and arrayed from highest to lowest in each bed group. The 70th percentile value is then selected as the bed group CAP. The CAP is multiplied by the hour benchmark to yield the salary component of the Nursing Services cost standard. Nursing and restorative supply costs are summed for each facility and converted to a PPD cost. These PPD costs are then arrayed, by bed group, from highest to lowest, and the 70th percentile is selected as the Nursing Supplies CAP.

The Director of Nursing (DON) salary is selected at the 70th percentile, by bed group, as derived from the submitted cost reports. An additional factor is added for the DON by dividing the DON salary by each facility's beds at 100% occupancy.

The cost standard for Nursing Services is derived as the sum of the above factors (RN, LPN, Aide, Supplies and DON). The CAP is then adjusted to a facility specific CAP based on the facility's average Medicaid MDS score from the six month reporting period. The average Medicaid MDS score (including the Medicaid Hospice resident) is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted Nursing Services CAP for each facility. The adjusted Nursing Services CAP cannot exceed 112% (MDS average of 2.8) or be less than 80% (MDS average of 2.0) of the base constant. The facility actual allowable PPD nursing costs are reimbursed up to the level of the nursing services CAP.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the rate period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a specific resident. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing Rate to derive a PPD Nursing Services add-on.

514.13.16 Cost of Capital

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). This value includes the necessary real property and equipment associated with the actual use of the property as a nursing facility. The Standard

Appraised Value (SAV) uses the cost approach to value modified by the Model Nursing Facility Standard. This valuation is the basis for capitalization to determine a PPD cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest and return on equity in the traditional approach to capital cost allowance.

A. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting from them the estimated accrued depreciation and adding the market value of the land (actually used if required for use as if vacant and available for development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are Marshall Valuation Services and Boeckle Building Valuation Manual.

B. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the “breakdown” method which involves an analysis of loss in value from the following sources:

1. Physical deterioration; curable and incurable
2. Functional obsolescence; curable and incurable
3. Economic obsolescence

The nursing facility appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

C. Model Nursing Facility Standard

The Model Nursing Facility Standard is a composite of current regulations and criteria derived from several sources which include “Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities” - HHS Publication No. (HRS) 81-14500 and 64CSR13 (Nursing Home Licensure Rule).

These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved resident care or cost effective measures which do not compromise resident care.

The Model Nursing Facility Standard also sets an upper reasonable cost limit for constructing a nursing facility. This effectively discourages the creation of unnecessarily costly facilities. Currently, land is being appraised at its "highest and best" use. This occasionally results in land values in excess of the building and equipment appraisal.

D. Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually and used in the October 1st rate setting period, in addition to the following April 1st rate setting period. Updates may be performed at any time during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate setting purposes. Initial and annual appraisals must include onsite inspections. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index. All appraisals will include an on-site evaluation.

A copy of the facility appraisal report is furnished to the facility for its records.

514.13.17 Capitalized Assets

Assets that have a value equal to or greater than $3,000 with an estimated useful life of two years or more should be capitalized. The cost of the asset includes, but is not limited to, installation, delivery and acquisition costs. A repair of an asset that exceeds $3,000 per project and extends the useful life of the asset more than two years should be capitalized. The cost of the repair includes, but is not limited to labor and materials. Renovation type projects where small amounts of material at a time are purchased, over an extended period of time, should be capitalized to reflect the true nature of the project.

514.13.18 Working Capital Interest

Working Capital Interest (WCI) is limited to short term loans (term of one year or less) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and these notes are merely renewed throughout the year, the Program will not consider these to be bona fide working capital notes and the interest incurred on them will not be allowed if no justification can be made for nonpayment of the note.

514.13.19 Vehicle Expenses

The cost of operating all licensed vehicles will be limited to the per mile rate approved by the West Virginia Travel Management Office. This limitation applies to vehicles owned by the facility, any costs related to reimbursement to employees for use of personal vehicles, rental vehicles, or any other vehicles. The per-mile rate is computed to include the following costs: rental or lease payments, fuel, interest, repairs, routine maintenance, inspections and licenses,

insurance and depreciation, therefore these costs are not separately allowed. Detailed mileage logs must be maintained to support the miles reported on the cost report. This will include beginning and ending odometer reading and purpose of travel. All travel must be authorized by administrator or designee. All travel must be included in the mileage log and be indicated for those miles directly related to resident services.

514.13.20 Allocated Costs

Hospital based nursing facilities and nursing facilities associated with assisted living facilities or other related parties that use allocated costs must maintain detailed documentation to support any costs allocated on the cost report (either allocated to the facility or allocated among individual cost centers) and the allocation calculation(s) must be made available upon request for desk review or audit.

All costs must show reasonableness and be comparable to other facilities in the industry.

514.13.21 Home Office Costs

Certain home office costs may be includable in the provider's cost report and considered for reimbursement as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain. The administrator or designee must prove the home office costs are related to patient care. The administrator or designee must maintain documentation to establish the benefit to patient care realized as a result of any home office costs included in the cost report, please reference section 514.13.12 for additional guidance. Management fees charged between related organizations are not allowable costs and such fees must be reported as non-allowable on the provider's cost report. Any cost report received with related party management fees and home office costs will be rejected and returned to the facility for correction. Home office costs must be appropriately reported by individual line item on the home office schedules of the cost report, and should not be aggregated as management fees. Thus, allowable cost is limited to the lesser of (1) allowable costs properly allocated to the provider and (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking into account the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chain wide basis. Home office costs must be reported at cost and net of any inter-company profit, and the home office must be disclosed as a related party on the cost report.

Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. Costs related to nonmedical enterprises are not considered allowable home office costs. All allocated central office costs are considered administrative in nature and, therefore, must comply with regulations governing allowability at individual facility locations.

Starting with its total costs, including those costs paid on behalf of providers (or components in the chain), the home office must delete all costs which are not specifically allowable in accordance with this manual and as listed on pages WV20 A&B of the cost report.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation basis used must provide for the appropriate allocation of costs such as rent, administrative salaries, organization costs, and other general overhead costs which are attributable to nonresident care activities, as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general administrative costs.

The basis for allocation of allowed costs among long-term care facilities should be patient days. However, another basis may be considered appropriate and more accurate. The home office must make written request, with its justification, to the Department for approval of the change.

The written request must be received no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The Department's approval of a home office request will be furnished to the home office in writing. Where the Medicare intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approved a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

514.13.22 Non-Reimbursed Prescription Costs

Prescription drugs are not allowable on the cost report and are not included in the per diem rate. See sections *514. 8.4 Pharmacy Services* and *514. 10.2 Prescription Drugs* and *Chapter 518 Pharmacy Services* for information regarding covered prescription drug services.

514.13.23 Transportation Services

The cost of emergency and non-emergency ambulance services is not allowed on the cost report. However, the cost of the transportation contract between the nursing facility and the NEMT provider and the transportation provided by a vehicle owned by the facility is included in the all-inclusive Medicaid rate and is allowable on the cost report.

514.13.24 Compensation

Allowable compensation is compensation that is reasonable for services that are necessary, related to patient care and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked must be documented as well as the compensation received. This information must be reported to all appropriate State and Federal authorities for income tax, Social Security and unemployment compensation purposes.

"Reasonable" means that the compensation must be comparable for the same services provided by facilities in the bed group. The method used to calculate "reasonable" will be as follows: The (90th) ninetieth percentile of the hourly wage of the employee classification for each bed group. No owners, operators and relatives will be included in the calculation. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 1,040 hours per cost report period worked in resident related duties and includes documented vacation and sick time.

Compensation must include the total benefits paid for the services rendered, i.e., fees, salaries, wages, payroll taxes, fringe benefits and other increments paid to or for the benefit of those providing the services.

If bonuses are a part of an employee's compensation a clearly established non-discriminatory bonus plan (covering owners and related parties of owners) must be set in writing to employees before the cost reporting period begins. Otherwise the bonus or bonus plan will not be considered allowable. The amount of the bonus must be accrued to the period earned.

514.13.25 Administrators

No owners, operators or relatives will be included in the calculation. Full time is considered at least 1,040 documented hours which include vacation and sick time, per cost reporting period for resident related duties. If the services are provided less than full time, the compensation must reflect this fact. The administrator cannot act as director of nursing.

The facility must be able to document, upon request for desk review or audit, that the compensation for the non-administrator position does not exceed the market rate for those services.

514.13.26 Owners

Administrators-Owners will be compensated for administrative duties performed. Where the costs of administrative services are allowed, additional services performed by the administrator who is also an owner are considered rendered primarily to protect their investment and are not allowed.

Owners that do not serve as administrators will be compensated for duties performed, excluding services rendered primarily to protect their investment. To be included on the cost report, the facility must be able to document that the services provided by the owner are not duplicated by other positions.

Compensation is not allowed for owners, operators or their relatives who claim to provide some administrative or other function required to operate the facility, but who do not actually provide said service. Where functions claimed to be provided by owners, operators or their relatives are merely a duplication of services already provided by other employees or are functions which should reasonably be expected to be performed by other employees, such services are not

reimbursable. For example: if a facility has a full-time administrator or other full-time or part-time staff position filled and compensated, the facility's owner, operator or their relative claiming compensation for the same or similar functions are not allowed by the program.

Where owners, operators, or their relatives are on salary at a facility, the program will reimburse the facility to the extent that said individuals salaries are not excessive compared to other individuals who perform the same or similar functions and who are not owners, operators or their relatives. Owners include any individual or organization with any financial interest in the facility operation and any member of such individual's family including the spouse's family. Owners also include all partners and all stockholders of organizations which have a financial interest in the facility.

514.13.27 Non-Allowable Costs

Non-allowable costs are those costs which are not related to patient care or for which a separate charge is made. This includes, but is not limited to, bad debts, charity and courtesy allowances, Medicare Part B chargeable items, personal resident property that has been reported as lost or stolen, flowers and retirement gifts for employees. Refer to the West Virginia Medicaid Long Term Care Users Guide to Reimbursement and MCOA for other non-allowable costs. Other items not referred to in the Chart of Accounts may be specified in State or Federal regulations as non-allowable costs. All undocumented expenses shall be considered non-allowable.

514.13.28 Travel – Out of State

The cost of travel and associated expenses outside the State for conventions, meetings, trainings, assemblies, conferences or any related activities are non-allowable costs.

514.13.29 Automobiles – Central Office

Automobiles used by central/home office personnel are non-allowable.

514.13.30 Legal Fees

Legal fees on failed appeals against the DHHR are non-allowable.

514.13.31 Fines and Penalties

In an effort to contain costs, it is expected that providers will pay obligations on time as well as take advantage of any early payment discounts that are offered by vendors. Costs related to fines, penalties, late charges or any other cost increase imposed by vendors for not paying obligations in a timely manner are not allowed. Similarly, any financial penalties or cost increases resulting from violations of regulations or from non-fulfillment of stipulations are disallowed.

514.13.32 Damage Awards and Negotiated Settlements

Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, as well as the associated legal deductibles or legal costs is non-allowable.

514.13.33 Reorganization/Refinancing Costs

Organization and reorganization costs are the costs incurred in the creation or restructuring of an entity. These costs are considered to be non-allowable for cost reporting and reimbursement purposes.

514.13.34 Purchases From Related Companies or Organizations

All related companies or organizations involved in any business transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records which describe the kind and extent of such business transactions. Cost for purchase of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less. The facility must maintain and make available, upon request for desk review or audit, detailed documentation that the related party purchase has been included in the cost report at the related party's cost and any calculations to demonstrate that any inter-company profit that would have passed to the related party from the transaction has been eliminated in the cost report preparation.

514.13.35 Filing Reports – Requests for Assistance

Financial and statistical reports and questions regarding cost reporting are to be addressed to WVDHHR Office of Accountability and Management Reporting; Attention: Division of Audit and Rate Setting, #1 Davis Square, Suite 304, Charleston, WV 25301.

514.13.36 Rate Determination

Individual facility rates are established on a prospective basis, considering costs to be expected during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors of omissions of data or reconciliation of audit findings related to falsification or misreporting of costs or census. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report for Nursing Homes.

The reported costs are subject to desk review and then converted to cost per patient day. Rates will be issued for six month periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period.

514.13.37 Cost Adjustment

Reported facility costs are subject to review and analysis through document/desk review process. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies: Standard Services, Mandated Services, and Nursing Services (described below).

514.13.38 Standard Services

Total reported allowable costs in the standard services area are compared against the total cost standard for these cost centers using the appropriate bed group for the facility. If the total reported allowable exceeds the total cost standard, then the facility rate is limited to the standard services CAP.

514.13.39 Mandated Services

Total reported allowable costs in the mandated services area are fully recognized for these cost centers, providing they do not exceed the 90th percentile of total reported costs by bed group.

514.13.40 Nursing Services

Allowable costs and reimbursement for nursing services will be determined on a facility by facility basis by the kind and amount of services needed and being delivered to the resident. The staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by the case mix characteristics.

Monthly billing information for services rendered to nursing facility residents will include data derived directly from the computerized assessment instrument for each resident, which may be used to determine case mix scores for each resident and composite score for the facility. These case mix scores will measure the relative intensity and service needs of the facility's residents and will comprise the basis for determining allowable adjustments to per diem staffing and nursing costs required to deliver the kind and amount of services needed.

514.13.41 Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraisal Value (SAV) methodology.

A. Capitalization Rate
   A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, an allowance for return on the equity investment in the land, building and equipment, and an appraisal factor used to index all facilities to the cost reporting period ending June 30.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate which may be changed annually or semi-annually to reflect current money time values in the mortgage market. This band of investment sets a 75:25 debt service to equity ratio.

The yield of equity allowance (for proprietary facilities) is based on the average Medicare Trust Fund return on equity allowable during the cost reporting period.

The interest rate for the mortgage component will be based upon an average of the Prime Rate of interest as published by the Federal Reserve Board. A 10-year running average of the Prime Rates will be calculated by the Bureau, with an additional 3% added to the calculated interest rate average in order to establish, as needed, the allowable interest rate to be used for rate setting purposes. A floor and ceiling with a maximum of 12% and a minimum of 10%, respectively, will be used in the interest rate calculation.

B. Capital Allowance
All facilities per patient day capital allowance shall be determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology. As facility valuations under SAV methodology are updated annually over a period of several months, all derived facility valuations will be standardized to June 30 of each year using the Consumer Price Index (CPI).

514.13.42 Minimum Occupancy Standard

Cost adjustments will be made by applying a minimum occupancy standard of 90% to all cost centers. Actual facility occupancy is used to determine allowable costs per patient day if equal to or greater than 90%. However, if the actual occupancy level is less than 90%, the per patient day, allowable cost will be adjusted to assume a 90% occupancy level.

514.13.43 Efficiency Incentive

An efficiency incentive will be allowed where the standard services area allowable costs are less than the total of the cost standard. Fifty percent of the difference between the total allowable cost and the total cost standard will be applied to the prospective rate for the standard services area. The total of the calculated efficiency incentive may not exceed $2.00 per patient day.

A facility qualifying for efficiency incentive shall not have any deficiencies related to standard services or substandard care, quality of life, and/or quality of care, during the reporting period. Statements of Deficiencies generated by OHFLAC for non-compliance found during licensure inspections and/or certification surveys are reviewed to determine compliance with licensure, certification and agency standards.

If it has been determined that a facility has significant deficiencies (defined as one or more deficiencies cited at a severity level of actual harm or immediate jeopardy and/or constituting substandard quality of care on the survey and licensure agency reports), the facility may be denied efficiency incentive for that period. When an audit adjustment results in the allowable costs in the Standard Services component, no increase or decrease in the efficiency incentive will be made.

514.13.44 Inflation Factor

After combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. The amount of change in the Consumer Price Index (CPI) experienced during the six-month reporting period becomes the inflation factor applied to the next six month period. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases.

Regulatory costs, such as minimum wage increases, tax changes, FICA increase, Worker's Compensation changes, etc., will be considered an inclusive component of the inflation factor.

514.13.45 Audits

Department staff will perform a desk review of cost reports prior to rate setting and will conduct on-site audits of facility records periodically.

514.13.46 Document/Desk Review

Financial and statistical reports submitted by the participating facilities will be subjected to a document/desk review and analysis for rate setting within 60 days of receipt. Incomplete and inaccurate cost reports are not accepted.

514.13.47 Field Audit

Periodic on-site audits of the financial and statistical records of participating facilities will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff (or their representatives) for audit purposes upon notice. **Records found to be incomplete or missing at the time of the scheduled on-site visit must be delivered to the Department within 48 hours or an amount of time agreed upon with audit staff at the exit conference. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.**

514.13.48 Records Retention

Audit reports will be maintained by the Department for five years following date of completion.

514.13.49 Credits and Adjustments

The State will account for the return of the Federal portion of all overpayments to CMS in accordance with the applicable Federal laws and regulations.

514.14 NURSE AIDE TRAINING AND REIMBURSEMENT

In accordance with CFR 483.154 (3), reimbursement is available for nursing facilities that are eligible and approved by OHFLAC to conduct nurse aid training classes in their facility. The educational costs for Nurse Aide training may be reimbursed to the facility where the training and evaluation was held at a maximum of $400 for training and $100 for competency evaluation to equal $500. Reimbursement is only available to the nursing facility after the individual has successfully passed the complete competency evaluation and the training nursing facility verifies the nurse aid has been hired as a nurse aid either at the training facility or another nursing facility. The documentation of employment must be attached to the reimbursement form (see Appendix 3) and it must consist of a letter from the administrator at the hiring nursing facility stating the individual has been hired as a nurse aid, along with dates of hire. This reimbursement is only available to a nursing facility once in a lifetime per individual Nurse Aide.

514. 15 MOUNTAIN HEALTH CHOICES (MHC)

Nursing home services are covered for the Traditional, Basic and Enhanced adult benefit packages with appropriate prior authorization and approval requirements. Service coverage, prior authorization requirements, service limitations and all policy information that must be followed as outlined in this policy.

When a member is admitted to a nursing facility, the member is removed from MHC and placed in the traditional program because it is considered long term care. This occurs on the first of the month following the admission when the member is admitted before approximately the 20th of the month, but no later than the 1st of the second month. Services will be covered upon admission if the member meets all program and eligibility requirements. Inpatient rehabilitation services provided in nursing homes are not covered separately for any adult benefit plans.

CHAPTER 514
NURSING FACILITY SERVICES
XXXXX, 2011

APPENDIX 1
AGREEMENT FOR NURSING FACILITY PARTICIPATION IN THE TITLE XIX MEDICAID PROGRAM
PAGE 1 OF 4

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

AGREEMENT

FOR

NURSING FACILITY PARTICIPATION IN THE TITLE XIX MEDICAID PROGRAM

Nursing Home Name: _____

Address: _____

Type of State License: _____Nursing Facility _____ NPI#_____

Title XIX Medicaid Provider Number: _____

This Agreement, made and entered into on this____ day of _____(mo./yr.) by and between the West Virginia Department of Health and Human Resources Bureau for Medical Services, hereinafter designated as the Bureau, and the _____(name of Nursing Home), a Provider of Service hereinafter designated as the Nursing Home. This agreement is for the purpose of defining the responsibilities of the parties hereto in providing needed medical care in the form of medical services to eligible members under the Medical Assistance Program, Title XIX (Medicaid) of the Social Security Act and for payment of such services.

To participate in the West Virginia Medicaid Title XIX Program, the Nursing Home must:

- be licensed as a nursing home under the applicable State Laws of West Virginia and Local Law;
- meet and maintain the standards for licensure, on a continuing basis;
- be administered by a licensed nursing home administrator who is legally responsible for establishing and implementing policies regarding the management and operation of the home and who holds an approved, current license, as required by State law;
- meet all Federal and State standards for participation in the Title XIX Medicaid Program; and,
- remain in substantial compliance with all other applicable Federal, State, and Local laws, rules**,** and regulations affecting the health and safety of all residents.

I. THE NURSING HOME AGREES TO FOLLOW THE FEDERAL REGULATIONS 42 PART 483, AS UPDATED AND REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES OF THE FEDERAL REGULATIONS.

The Nursing Home agrees to complete and sign this Nursing Home Agreement to participate in the Title XIX Medicaid Program and to keep the information in the agreement current. Any/all succeeding change(s) in this agreement require(s) notification to the Bureau within five (5) working days and will constitute an amendment to this Agreement. Failure to keep the information current constitutes a breach of this Agreement. The Nursing Home will understand that any breach or violation of any of these provisions shall make this entire Agreement, at the Bureau's discretion, subject to immediate cancellation. This includes all

Changes in Ownership, either in part or whole, of the Nursing Home including administration/management changes and stock or asset transfers for Ownership. This also includes Ownership transfers, either through sale or otherwise; the Nursing Home's provider number may not be transferred or used by another entity, and payments under this scenario are not reimbursable.

The Nursing Home agrees to accept the Bureau's payment, in full, for services rendered according to 42 CFR Part 483. The payment will be accepted as payment in full for the care of the resident and no additional charge will be made to the resident, any member of the family, estate or any other payer source for any supplementation of payment for services.

The Nursing Home agrees to provide the Bureau with full and complete information on all persons having an ownership, managerial or controlling interest in the nursing home and to promptly report any changes which would affect the current accuracy of the information required to be supplied. This includes continuance with the provider enrollment application information submitted to the Bureau. The Nursing Home agrees to supply the Bureau or its designee with any / all changes in the current enrollment application within five (5) business working days of a change. The Nursing Home agrees to notify the Bureau of all structural changes proposed in the physical environment prior to implementation and inform the Bureau when the proposed structural changes to the facility are completed.

The nursing home will keep current with Federal Laws, State Laws, Medicaid State Plan Changes, and Medicaid Policy services.

II. THE BUREAU AGREES:

A. To pay for such nursing services in amounts and under conditions determined by the Bureau, for persons receiving nursing care, who have been determined by the Department to be eligible for such assistance under the Title XIX Medicaid Program;

B. To make such payments in accordance with the applicable laws and after a proper claim is submitted and approved;

C. To withhold payments, if necessary, due to irregularity from whatever cause, until such irregularity or difference can be adjusted with the view toward providing excellence in nursing care within the limitations of the law;

D. To provide the Nursing Home reasonable notice of any impending change in its status as a participating Nursing Home with the Bureau for Medical Services;

E. To provide an administrative review procedure for the Nursing Home, in the event the Bureau suspends or cancels the Nursing Home's participation in the Title XIX Medicaid Program or denies payment;

F. To provide methods and procedures for establishing medical review of care and services in accordance with the Title XIX Medicaid Program.

III. THE BUREAU AND THE NURSING HOME MUTUALLY AGREE:

A. That, in the event the Federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this Agreement on the part of either party

infeasible or impossible, or if the parties to this Agreement should be made unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX Medicaid Program as a result of amendments or judicial interpretations, then, and in that event, both the Nursing Home and the Bureau shall be discharged from further obligation created under the terms of this Agreement.

B. That the term of this Agreement shall be ongoing, or until the Federal and/or State government ceases to participate in the program. Either party to this Agreement may cancel by providing a 30-day written notice to the other party.

C. That the effective date of this agreement will be the date the Nursing Home attains participating status as determined by the Bureau under the Federal standards for participation, and that such determination shall be made a part of this Agreement.

D. That this Agreement shall not be transferable or assignable.

E. It is agreed and understood that, by signing this Agreement, the Nursing Home and the Bureau accept all of the stipulations in the Agreement and agree to each and every

Agreement Effective date shall be:_____.

(Date)

NURSING HOME ADMINISTRATING AUTHORITY

Name of Nursing Home:_____

BY (Authorized Signature)

(Title)_____ (Date)_____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES/BUREAU FOR MEDICAL SERVICES

BY (Authorized Signature)

(Title) BMS_____ (Date)_____

CHAPTER 514
NURSING FACILITY SERVICES
XXXXX, 2011

APPENDIX 2
PRE-ADMISSION SCREENING (PAS) 2000
PAGE 1 OF 7

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

PRE-ADMISSION SCREENING

Reason for Screening:
Check Only One

A. Nursing Home Only: Initial Transfer
B. Nursing Home waiting Waiver: yes
C. A/D Waiver Only: Initial Re-Evaluation
D. Personal Care: Initial Re-Evaluation

Facility/Agency/Person making referral:

NAME: _____
ADDRESS:_____
CONTACT PERSON: _____
PHONE: (_____)_____ -_____
FAX: (_____) _____ -_____

1. DEMOGRAPHIC INFORMATION

1. Individuals Full Name	2. Sex		3. Medicaid Number	4. Medicare Number
	F	M		
5. Address (Including Street/Box, City, State & Zip)				6. Private Insurance
7. County	8. Social Security Number	9. Birth date (M/D/Y)	10. Age	11. Phone Number
12. Spouses Name		13. Address (If different from above)		

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)
_____
_____

15. Name and Address of Provider, if applicable:
_____
_____

16. Medicaid Waiver Recipient a. Yes b. No c. Aged/Disabled d. MR/DD

17. Has the option of Medicaid Waiver been explained to the applicant? a. Yes b. No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative.

_____ / _____/_____
SIGNATURE - Applicant or Person acting for Applicant Relationship Date

19. Check if Applicant has any of the following:
a. Guardian d. Power of Attorney g. Other _____
b. Committee e. Durable Power of Attorney
c. Medical Power of Attorney f. Living Will

Name & Address of the Representative_____
_____
_____
Phone: (_____)_____-_____

II. MEDICAL ASSESSMENT

Date _____

Name _____

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

_____
_____
_____
_____

21. Normal Vital Signs for the individual:

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate

22. Check if Abnormal:

a. Eyes	g. Breasts	m. Extremities	s. Musculo-Skeletal
b. Ears	h. Lungs	n. Abdomen	t. Skin
c. Nose	i. Heart	o. Hernia(s)	u. Nervous System
d. Throat	j. Arteries	p. Genitalia-male	v. Allergies (Specify)_____
e. Mouth	k. Veins	q. Gynecological	
f. Neck	l. Lymph System	r. Ano-Rectal	

Describe abnormalities and treatment:

_____
_____

23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

a. Angina-rest	____	e. Paralysis	____	i. Diabetes	
b. Angina-exertion	____	f. Dysphagia	____	j. Contracture(s)	
c. Dyspnea	____	g. Aphasia	____	k. Mental Disorder(s)	
d. Significant Arthritis	____	h. Pain	____	l. Other (Specify)	_____

24. Decubitus a. Yes b. No If yes, check the following:

A. Stage _____ **B. Size** _____ **C. Treatment** _____

Location: a. Left Leg b. Left Arm c. Right Leg d. Right Arm e. Left Hip f. Left Buttock g. Right Hip h. Right Buttock

Other _____ **Developed at:** a. 9 Home b. 9 Hospital c. 9 Facility

25. In the event of an emergency, the individual can vacate the building: (check only one)

a. Independently b. With Supervision c. Mentally Unable d. Physically Unable

DATE: _____

NAME: _____

26. Indicate individual=s functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a.__ Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b.__ Bathing	Self/Prompting	Physical Assistance	Total Care	
c.__ Dressing	Self/Prompting	Physical Assistance	Total Care	
d.__ Grooming	Self/Prompting	Physical Assistance	Total Care	
e.__ Cont./Bladder	Continent	Occas. Incontinent*	Incontinent	Catheter
f. __ Cont./Bowel	Continent	Occas. Incontinent* *less than 3 per wk.	Incontinent	Colostomy
g.__ Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h.__ Transferring	Independent	Supervised/Assistive Devise	One Person Assistance One Person Assistance	Two Person Assist. Two Person Assist.
i.__ Walking	Independent	Supervised/Assistive Devise	Situational Assistance	Total Assistance
j.__ Wheeling	No Wheelchair	Wheels Independently	(Doors, etc.)	
k.__ Vision	Not Impaired	Impaired /Correctable	Impaired/Not Correctable	Blind
l.__ Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m.__ Communication	Not Impaired	Impaired/Understandable	Understandable with Aids	Inappropriate/None

27. Professional and technical care needs (check all that apply).

a. Physical Therapy	f. Ostomy	k. Parenteral Fluids
b. Speech Therapy	g. Suctioning	l. Sterile Dressings
c. Occupational Therapy	h. Tracheostomy	m. Irrigations
d. Inhalation Therapy	i. Ventilator	n. Special Skin Care
e. Continuous Oxygen	j. Dialysis	o. Other _____

28. Individual is capable of administering his/her own medications (check only one).

a. Yes b. With Prompting/Supervision c. No Comment:_____

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

III. MI/MR ASSESSMENT

DATE: _____

NAME: _____

30. Current Diagnoses (Check all that apply)

a. None
b. Mental Retardation
c. Autism
d. Seizure Disorder (Age at onset: _____)
e. Cerebral Palsy
f. Other Developmental Disabilities (Specify: _____)
g. Schizophrenic Disorder
h. Paranoid Disorder
i. Major Affective Disorder
j. Schizoaffective Disorder
k. Affective Bipolar Disorder
l. Tardive Dyskinesia
m. Major Depression
n. Other related conditions (Specify:_____)

Date of last PASARR Level II Evaluation_____

31. Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness? □ Yes □ No **If yes, specify agency**

Name_____ **Address**_____
Admission Date _____ **Discharge Date** _____

32. Has the individual received any of the following medications on a regular basis within the last two years? □Yes □ No
33. Was this medication used to treat a neurological disorder? □Yes □ No

□ Chlorpromazine	□ Thorazine	□ Perphenazine	□ Trilafon	□ Haloperidol	□ Haldol
□ Promazine	□ Sparine	□ Fluphenazine	□ Prolixin	□ Molindone	□ Moban
□ Trifupromazine	□ Vesprin	□ Fluphenazine HCl	□ Permitil	□ Loxapine	□ Loxitane
□ Thioidazine	□ Mellaril	□ Trifluphenazine	□ Stelazine	□ Clozapine	□ Clozaril
□ Mesoridazine	□ Serentil	□ Chlorprothixene	□ Taractan	□ Procholorperazine	
□ Actiphenazine	□ Tindal	□ Thiothixene	□ Navane	□ Compazine	

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

a. Substance Abuse (Identify_____)
b. Combative
c. Withdrawn/Depressed
d. Hallucinations
e. Delusional
f. Disoriented
g. Bizarre Behavior
h. Bangs Head
i. Sets Fires
j. Displays Inappropriate Social Behavior
k. Seriously Impaired Judgment
l. Suicidal Thoughts, Ideations/Gestures
m. Cannot Communicate Basic Needs
n. Talks About His/Her Worthlessness
o. Unable to Understand Simple Commands
p. Physically Dangerous to Self and Others, if Unsupervised
q. Verbally Abusive
r. Demonstrates Severe Challenging Behaviors
s. Specialized Training Needs
t. Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? □ Yes □ No
Other (Specify) _____

IV. PHYSICIAN RECOMMENDATION

DATE: _____

NAME: _____

35. Prognosis - Check one only: a__ Stable b__ Improving c___ Deteriorating d__ Terminal

Other _____

36. Rehabilitative Potential (Check one only) a___ Good b___ Limited c___ Poor

37. Diagnosis:

a. Primary _____

b. Secondary _____

c. Other medical conditions requiring services _____

38. Physician Recommendations

A. FOR NURSING FACILITY PLACEMENT ONLY

On the basis of present medical findings, the individual may eventually be able to return home or be discharged.

a ___ Yes b___ No

If yes, check one of the following:

a. Less than 3 months
b. 3-6 months
c. Over 6 months
d. Terminal illness

B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

a. Nursing Home
b. Nursing Home waiting A/D Waiver
c. A/D Waiver
d. Personal Care

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)

_____

Physicians Signature **MD/DO**

_____

Date This Assessment Completed:

TYPE OR PRINT Physicians name/address below:

_____

_____

_____

_____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.

V. ELIGIBILITY DETERMINATION

DATE: _____

NAME: _____

DEPARTMENT USE ONLY

LEVEL I (Medical Screen)

Medical and other professional personnel of the Medicaid Agency or its designees MUST evaluate each individuals need for admission by reviewing and assessing the evaluations required by regulation.

Exemptions from requirements for Level II Assessment

40. Does the individual have or require:

a. Diagnosis of dementia (Alzheimer's or related disorder)? **Yes** **No**

b. Thirty days of respite care? **Yes** **No**

c. Serious Medical Condition? **Yes** **No**

41. Medical Eligibility Determination:

a. Nursing Facility Services/Aged/Disabled Waiver **b. Personal Care Services**

c. No Services Needed **d. Optional Services**

42. PASARR Determination:

a. Level II required **b. Level II not required**

_____ _____

Nurse Reviewers Signature - Title **Date** **Control Number**

Printed Name_____

WAIVER ONLY: Level of Care:_____ **Number of Hours:**_____

DEPARTMENTAL USE ONLY

LEVEL II (MI/MR Screen)

(Completed by PASARR Provider)

43. DETERMINATION:

a. Nursing facility services needed - Specialized services not needed.
b. Nursing facility services needed - Specialized services needed.
c. Alzheimer's or related disorder identified.
d. Thirty day Respite care needed.
e. Terminal illness identified.
f. Serious illness identified.
g. Nursing facility services not needed.

44. RECOMMENDED PLACEMENT:

a. Nursing Facility Services/Aged/Disabled Wavier
b. Psychiatric Hospital (21 years or under)
c. ICF/MR or I/DD Waiver
d. Other-Identify:_____

_____ _____

PASARR Reviewers Signature **Title** **Printed Name**

_____ _____

Agency Name **Date**

A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS

CHAPTER 514
NURSING FACILITY SERVICES
XXXXX, 2011

APPENDIX 3
INVOICE FOR REIMBURSEMENT OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION
PAGE 1 OF 2

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Invoice for Reimbursement
Nurse Aide Training and Competency Evaluation

This form is to be submitted with all documentation as listed on page 2 of this invoice, to the Bureau for Medical Services.

Purpose

( ) 1. Nurse Aide Training Cost

( ) 2. Competency Evaluation Cost

Nurse Aide Information:

Social Security Number:
Name: _____

Address:_____

_____

Facility I.D.

Provider Number:

Facility Name:

Facility Phone Number:

Nurse Aide Training Information:
Trainer Name: _____

Address: _____

Location: _____

Training Date Start: _____
MM DD YY

Finish:_____
MM DD YY

Date Exam was passed: _____

Training Plan Code Number: _____

Cost of Training:

( ) Nurse Aide Training (Max $400)
$_____

( ) Competency Evaluation (Max $100)
$_____

Invoice Amount $_____

Submitted by: _____ Date: _____
(Signature) MM DD YY

_____
(Title)

Submit this form to: WV Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3707
Attention: Kelley Johnson

LTC – 2 (6-9-09)

Needed Documentation for Reimbursement:

- Documentation of employment in the form of a letter from the Administrator of the hiring nursing facility, stating the individual has been hired as a nurse aide, along with dates of hire
- Copy of the test results, showing a passing score for the individual
- Proof that the individual has been placed on the Nurse Aid Registry
- Proof the nursing facility paid for the training and/or testing

PLEASE NOTE: The above documentation must be attached to this invoice for each individual for reimbursement to be considered. Reimbursement in only available to a nursing facility once in a lifetime, per individual nurse aide.

CHAPTER 515 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 515.1	Definitions	02/08/05	05/01/05
Section 515.6	Non-Covered Services and Documentation Requirements	02/08/05	05/01/05
Section 515.8	School Services vs. Private Practitioners	02/08/05	05/01/05
Section 515.9	Billing and Reimbursement	02/08/05	05/01/05
Attachment 1	Occupational / Physical Therapy Services Covered by WV Medicaid	01/01/05	05/01/05
Attachment 2	Occupational/Physical Therapy Services Prior Authorization Form with Header page	10/01/04	11/01/04

CHAPTER 515 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

FEBRUARY 8, 2005

SECTION 515.1

Introduction: Clarification of definition.

Change: Removed the word “or” and replaced with “and” in the definition of Physical Therapist.

Directions: Replace old pages with new pages.

SECTION 515.6

Introduction: Rewritten to provide more clarity.

Change: Deleted text – "when rendered by a therapist in independent practice" from second sentence in first paragraph.

Deleted sixth bullet regarding *Occupational/Physical Therapy services rendered in the school system.*

Added wording to seventh bullet – Occupational / physical therapy services will not be authorized for members who have reached maximum rehab potential

Deleted text, "such as the evaluation or another modality," from the ninth bullet.

Directions: Replace old pages with new pages.

SECTION 515.8

Introduction: Added section to coincide with WV Department of Education regulations regarding services available in schools.

Change: Re-number section and create new heading "School Services vs. Services Provided by Private Practitioners."

Directions: Replace old pages with new pages.

SECTION 515.9

Introduction: Changes made for formatting and clarification

Change: Section re-numbered and change heading to Billing and Reimbursement

Directions: Replace old pages with new pages.

JANUARY 1, 2005

ATTACHMENT 1

Introduction: 1) Reformatted the entire section for better clarity.

2) Procedure code 97601 has been replaced with 97597 and 97598 and included in with the codes that have a 20 unit limit.

Directions: Attachment 1 in this section supercedes previous policy.

Change: Replace old pages with new pages.

OCTOBER 1, 2004

ATTACHMENT 2

Introduction: This section has been updated and reformatted.

Directions: Attachment 2 in this section supercedes previous policy.

Change: Replace old pages with new pages.

CHAPTER 515—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

CHAPTER 515–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

WV Medicaid covers certain occupational therapy and physical therapy services when provided in an outpatient setting, ordered by a licensed attending physician, and furnished by or under the direct supervision of a qualified occupational or physical therapist.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the WV Code. The BMS (BMS) in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program.

515.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200. In addition, the following definitions also apply to the requirements for payment of the services described in this chapter.

Modality – any physical agent supplied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical or electric charge.

Occupational Therapist - a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association (AMA) and the American Occupational Therapy Association and is licensed or registered in the State in which he or she practices.

Occupational Therapy Assistant - an Associate of Arts graduate employed by and under the direct supervision of an Occupational Therapist and is licensed by the Board of Occupational Therapy in the State in which he/she practices.

Physical Therapist - a graduate of a program of physical therapy approved by the American Physical Therapy Association and the Committee on Allied Health Education and Accreditation of the AMA, and is licensed or registered in the State in which he or she practices.

Physical Therapy Assistant – an Associates of Arts graduate under the direct supervision of a Physical Therapist and licensed by the Board of Physical Therapy in the State he/she practices.

515.2 PROVIDER ENROLLMENT REQUIREMENTS

Occupational and Physical Therapists in private practice that wish to participate in the WV Medicaid Program must meet the general enrollment requirements in Chapter 300.

515.3 COVERED THERAPY SERVICES

Attachment 1 is a list the occupational / physical therapy services that are covered by WV Medicaid. To be covered, occupational and physical therapy services must be ordered by a participating physician or nurse practitioner and provided by or under the direction of a registered licensed occupational /physical therapist on an outpatient basis.

"Under the direction of" means that the therapist is on the premises when the services are rendered and is available for any emergency or question that may arise. As circumstances permit, the therapist must be involved in patient education, including but not limited to, teaching the patient exercise, manipulation, and how to use devices for their own rehabilitation.

Continuous progress/improvement must be documented for coverage of therapy. The member must show compliance with therapy and the home regimen plan. Continuation of services may be considered, when an exacerbated episode of a chronic condition is clearly documented; otherwise chronic conditions are non-covered.

It is the responsibility of the service provider to verify Medicaid eligibility before individual receives services. Gaps in Medicaid eligibility may occur, with an individual ineligible for Medicaid coverage at the time of a specific treatment. Therefore, it is recommended that the therapist review the individual's medical care before provision of each service. PRIOR AUTHORIATION does NOT guarantee payment. The individual receiving services must be eligible when the service is provided regardless of prior authorization.

IMPORTANT: *The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.*

515.3.1 INITIAL SESSIONS

For Medicaid payment purposes, prior authorization is not required for members who need no more than 20 occupational / physical therapy visits during a calendar year, in addition to the evaluation and re-evaluation. This benefit is for each member, per calendar year.

Attachment 1 - list the valid procedure codes for occupational /physical therapy services**.** Certain service limitations and regulations do apply.

515.4 PRIOR AUTHORIZATION

Prior authorization (PA) is required when service limits exceed the Medicaid limit defined in 515.3.1. Service limits for occupational/physical therapy services are 20 visits in a calendar year. One visit may include any combination of occupational/physical therapy procedures performed on the same day, excluding the evaluation and re-evaluation codes.

For payment purposes, prior approval must be obtained before therapy is continued. However, prior authorization does not necessarily mean that WV Medicaid will pay for the services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) in order for a qualified therapist to provide a member with more than 20 occupational / physical therapy sessions during the calendar year. The WVMI can be called at (304) 346-9167, option 5 or faxed at 304-346-8185. Their mailing address is:

WV Medical Institute
Occupational / Physical Therapy Review
3001 Chesterfield Avenue, S.E.
Charleston, WV 25304

Attachment 2 is a copy of the prior authorization request form. At a minimum, the therapist must submit the following information to the WVMI for its determination of whether to approval occupational or physical therapy services beyond the service limits:

- Signed written physician's prescription, including diagnosis
- A patient summary that includes:

1. A description of the treatment already provided including the number of session and the modalities utilized.

2. A description of the progress the patient has made toward short and long term treatment goals.

3. A summary of the continuing treatment plan, including the number and frequency and duration of session, proposed modalities, and special equipment needed.

4. A statement indicating whether the patient is able to reach the functional goals by consistent application of the home program, using equipment available at home or with assistance of a trained or non-professional friend or relative.

515.5 MANAGED CARE

If a Medicaid member is a member of an HMO, occupational and physical services must be prior authorized in accordance with the particular HMO's prior authorization requirements. If the member is a member of the PAAS Program, the service must be authorized by the member's PCP. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met.

515.6 NON-COVERED SERVICES

WV Medicaid does not cover the following occupational / physical therapy services.

- Occupational / physical therapy services that are rendered to an inpatient in a hospital, skilled nursing facility, or other facility.

- Occupational / physical therapy services in excess of 20 visits provided for chronic conditions, such as arthritis, cerebral palsy, and developmental delay.
- More than 20 outpatient occupational / physical therapy visits during a calendar year, unless approved in advance by the BMS or Utilization Management Agency (UMA)
- Occupational / physical therapy services furnished to persons who are not eligible for such services on the date the services are rendered
- Occupational / physical therapy services furnished by persons who are not licensed or certified and enrolled in the WV Medicaid Program.
- Occupational / physical therapy services paid to therapists in private practice when rendered in the school system.
- Occupational / physical therapy services will not be authorized for members who have reached maximum rehabilitation potential
- Unsupervised care rendered by an occupational / physical therapist aide or assistant
- Separate payment for hot or cold packs (CPT 97010). Payment for this code has been bundled into the payment for other services.
- Experimental services or drugs.

515.7 DOCUMENTATION REQUIREMENTS

Documentation in the therapist's records must contain at least the following information about the occupational / physical therapy that a member received:

- Diagnosis–the diagnosis must substantiate the patient's need for occupational or physical therapy. A brief description of the patient's medical condition may be necessary
- Date of injury or onset of illness, if applicable
- Name and Medicaid provider number of the physician prescribing the occupational or physical therapy
- Dates of each therapy session–beginning date and ending date
- Name of the registered therapist and facility providing the therapy
- Copy of the Individualized Education Plan if a school-age member needs occupational therapy or physical therapy, if applicable.

Documentation of the services provided on the date billed must substantiate fully the amounts charged to the Medicaid Program. The records must be clear and concise and include the physician's prescription. Documentation must be made available upon request to the BMS or its representative.

515.8 SCHOOL SERVICES VS. SERVICES PROVIDED BY PRIVATE PRACTITIONERS

Parents have the freedom to choose services from Medicaid providers outside the school system. However, West Virginia cannot cover this duplication of services, that is, pay claims for the same services provided in the school system and also outside the school system by private

practitioners for the same Medicaid member. Therefore, the parent/guardian must notify the school district to not seek Medicaid reimbursement for the relevant services.

If parents do not want the county boards of education to seek reimbursement through Medicaid, they must notify the Regional Educational Services Agency or the local education Agency in writing. A copy of the letter must be attached to the request for prior approval submitted to the West Virginia Medical Institute by the private practitioner chosen to provide the services.

When school is not in session, continuation of therapy services, if necessary, should be coordinated with a qualified therapist in private practice. The treatment plan established by the school system should be written in a way that the private practitioner can pick up where the school therapist ended.

515.9 BILLING AND REIMBURSEMENT

General billing requirements and procedures are discussed in Chapter 600. Direct billing by therapists is required using the professional claim format, ASC X12N 837 (004010X098A1) for electronic or CMS -1500 paper claims.

Occupational and physical therapy services provided in an outpatient hospital setting are billed using the Institutional format, ASCX12N 837 (004010X096A1) or the UB92 paper claim. The following revenue codes are required for billing occupational and physical therapy services:

Occupational therapy:	Evaluation	0434
	Reevaluation	0439
	Therapy Procedures	0430,0431
Physical therapy:	Evaluation	0424
	Reevaluation	0429
	Therapy procedures	0420, 0421

The Medicaid payment amount equals the lower of the provider's usual and customary charges or the RBRVS fee. The claim can not be submitted until the service has been rendered.

CHAPTER 515
OCCUPATIONAL/PHYSICAL THERAPY SERVICES
JULY 1, 2004

ATTACHMENT 1
OCCUPATIONAL/PHYSICAL THERAPY SERVICES
COVERED BY WEST VIRGINIA MEDICAID

REVISED MAY 1, 2005

Procedure Code Listing

Billable services for Occupational and Physical Therapists.

Neurology and Neuromuscular Procedures

CPT Code	Description	Service limits
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	1 daily
95832	Muscle testing, manual separate procedure with report, hand, with or without comparison with normal side.	1 daily
95833	Muscle testing, manual separate procedure with report, total evaluation of body, excluding hand.	1 daily
95834	Muscle testing, manual separate procedure with report, total evaluation of body, including hands.	1 daily
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).	1 daily
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side.	1 daily

Evaluation Services

CPT Code	Description	Services limits
97001	Physical therapy evaluation.	1 per calendar year
97002	Physical therapy re-evaluation.	2 per calendar year
97003	OT evaluation	1 per calendar year
97004	OT re-evaluation	2 per calendar year

Other Services

For the occupational/physical therapy services listed below the service limits are 20 visits/dates of services in a calendar year. One visit may include any combination of the following occupational/physical therapy services listed below. Services exceeding the limit will require PA from the UMA, who will issue the prior authorization based on the code and service units.

CPT Code	Description
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices

97018	Application of a modality to one or more areas; paraffin bath
97020	Application of a modality to one or more areas; microwave
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039*	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139*	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (eg. Mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive response to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with / without suction, sharp selective debridement with scissors, scalpel and forceps), with or with out topical applications(s), wound assessment, and instructions(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 sq. centimeters.

97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with / without suction, sharp selective debridement with scissors, scalpel and forceps), with or with out topical applications(s), wound assessment, and instructions(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 sq centimeters.
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97799*	Unlisted physical medicine/rehabilitation service or procedure.

* Prior authorization required

CHAPTER 515

OCCUPATIONAL/PHYSICAL THERAPY SERVICES

JULY 1, 2004

ATTACHMENT 2
PRIOR AUTHORIZATION REQUEST FORM FOR
OCCUPATIONAL / PHYSICAL THERAPY SERVICES
PAGE 1 OF 3

OCCUPATIONAL/ PHYSICAL THERAPY SERVICES
PRIOR AUTHORIZATION REQUEST FORM

WEST VIRGINIA MEDICAL INSTITUTE (WVMI), 3001 Chesterfield Place, Charleston, WV 25304
PHONE: 1-800-982-6334: Opt. 5 FAX: 1-877-762-4338 or 1-304-346-8185

Date: ____/____/_____ Patient's name: _____DOB: ____/_____/_____

Patient Address: _____

Street City State Zip

Medicaid Identification Number: _____

A. Date & history of onset of illness, injury or surgical procedure: _____

_____

_____

B. Diagnosis with ICD-9 codes:

1. Primary _____

2. Secondary _____

C. Subjective Complaints:

1. _____ 2. _____

3. _____ 4. _____

D. Objective Findings: _____

_____

_____

E. Treatment Plan: _____

_____

_____

Page 2 of 2 (Continue) Patient's name: _____

F. Short-Term Goals: (With expected dates that goals are to be met) _____

_____

G. Long-Term Goals: (With expected dates that goals are to be met) _____

_____

H. Prognosis: _____

_____

I. Progress notes of past treatments and dates of service for the past calendar year _____

_____

_____

J. Frequency of requested visits:

1. Original start of care date: _____

2. This request is for _____ Treatments: For period _____ to_____

3. Treatments are to be rendered _____ Time per week for _____weeks

4. Requested CPT procedure code: _____ _____ _____

_____ _____ _____ _____ _____

5. How many units of OT/PT has the patient had this calendar year? _____

K. Ordering Physician's Name: _____ Phone #: _____

L. Treating Therapist's Name: _____ Fax #: _____

Phone #: _____

M. Therapist's Medicaid provider number _____

NOTE: The therapist must obtain prior authorization before rendering treatment beyond Medicaid's service limits.

Physician's order and copy of *initial* evaluation must be attached to this form

PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT

It is the provider's responsibility to verify eligibility by the Medicaid card or calling Unisys 1-888-483-0793 or 304-348-3360.

CHAPTER 516–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR ORTHOTIC/PROSTHETIC SERVICES CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment I	Covered/Non-Covered Orthotic/Prosthetic Services with Assigned HCPCS Codes	01/16/08	01/01/08
Entire Manual	Entire Manual	02/07/07	03/01/07

CHAPTER 516– COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR ORTHOTIC/PROSTHETIC SERVICES

JANUARY 1, 2008

Attachment I

Introduction: Covered/Non-Covered Orthotic/Prosthetic Services with Assigned HCPCS Codes
New Policy: Updated HCPCS Codes
Directions: Replace Attachment I

CHAPTER 516-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR ORTHOTICS AND PROSTHETICS REPLACEMENT MANUAL

TABLE OF CONTENTS

CHAPTER 516–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR ORTHOTICS AND PROSTHETICS

REPLACEMENT MANUAL

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be provided by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. The WV Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS), pursuant to Title XIX of the Social Security Act and Chapter 9 of the WV Code, is the single State agency responsible for administering the Medicaid Program within Federal and State defined parameters.

One aspect of the comprehensive scope of services offered by WV Medicaid is orthotic and prosthetic (O&P) devices/appliances. These items are available to Medicaid members when (1) medical necessity has been established; (2) item/services are ordered by a Medicaid approved practitioner; and (3) devices/appliances are provided by individuals trained and certified by the National Commission for Certifying Agencies (NCCA), American Board for Certification in Orthotics and Prosthetics (ABC), or the Board of Orthotics and Prosthetics (BOC).

This chapter describes WV Medicaid major coverage policies for O&P. Any service, device, appliance or situation not discussed in this manual must be presumed non-covered unless informed otherwise in writing by BMS.

516.1 DEFINITIONS

In addition to Chapter 200 Definitions, the following definitions also apply to the provision of services related to devices/appliances.

Custom Device: A device fabricated to comprehensive measurements and/or a mold or patient model in accordance with a prescription that requires substantial clinical and technical judgment in its design, fabrication, and fitting.

Mastectomy Fitter: An individual trained and certified by the American Board of Certification in Orthotics and Prosthetics (ABC) or the Board for Orthotics and Prosthetics (BOC) in the fitting and delivery of breast prosthesis and mastectomy products and services.

Orthotic: A device to support or correct a weak or deformed body part, and/or to restrict or eliminate motion in a diseased or injured body part.

Orthotic Fitter: An individual trained and certified by the American Board for Certification in Orthotics and Prosthetics (ABC) or the Board for Orthotics and Prosthetics (BOC) in the fitting and delivery of prefabricated orthotic devices and/or off-the-shelf orthoses.

Orthotist: An individual certified by the American Board for Certifications in Orthotics and Prosthetics (ABC) or the Board for Orthotics and Prosthetics (BOC) to manage the provision of the comprehensive orthotic care based on clinical assessment**.**

Pedorthist: An individual trained and certified by the Board for Certification in Pedorthtics, Inc. (BCP) in the design, manufacture, modification and/or fit of footwear, including shoes, orthoses and foot devices, to prevent or alleviate foot problems caused by disease, congenital defect, overuse or injury.

Prescribing Practitioner: Identified as an M.D., D.O., DPM, Nurse Practitioner (NP), or Physician Assistant (PA) under the supervision of a participating physician. WV Medicaid does not recognize services ordered by hospital residents. All resident orders must be signed by a Medicaid-enrolled attending physician.

Prosthetic: An artificial appliance or device to replace all or part of permanently inoperative or missing body part.

Prosthetist: An individual trained and certified by the American Board for Certifications in Orthotics and Prosthetics (ABC) or the Board for Orthotics and Prosthetics (BOC) to manage the provision of the comprehensive prosthetic care based on clinical assessment**.**

Refer to Chapter 525 Vision Manual for information related to ocularist.

516.2 PRESCRIBING PRACTITIONER AND CERTIFIED PROVIDER PARTICIPATION REQUIREMENTS

516.2.1 Prescribing Practitioner

In addition to Chapter 300 Provider Participation Requirements, M.D, D.O., DPM, and NP prescribing orthotic/prosthetic devices and related items must:

(1) be actively enrolled in Medicaid;
(2) verify member's eligibility before providing services;
(3) inquire if the member has a orthotic/prosthetic provider of choice;
(4) provide a written prescription to the member;
(5) provide clinical documentation for medical necessity to include diagnosis code, frequency of use, duration, quantity, functional level and any relevant information to WVMI. Documentation may be submitted to WVMI in writing (with legal signature of prescribing practitioner) or via fax to 1-304-346-8183;
(6) maintain all appropriate medical documentation in the Medicaid member's individual file; and,
(7) participate in on-site reviews and/or submission of medical documentation to BMS upon request.

The Internet is the most efficient means of keeping current on updates and information regarding the Bureau for Medical Services. If you do not have Internet access, you may request a CD or paper copy of manuals or manual updates by calling Unisys Provider Enrollment at 1-888-483-0793.

516.2.2 Orthotist, Prosthetist, Pedorthist, and Fitters

In addition to provider enrollment requirements identified in Chapter 300, the orthotic or prosthetic provider must:

(1) be actively enrolled in WV Medicaid and adhere to WV Code §30-3-13;

(2) provide current certification of ABC and/or BOC for the independent provider and employed fitters (refer to Attachment I for fitter requirement);

(3) maintain a physical location within thirty (30) miles of the WV border;

(4) maintain inventory of at least one of every device/appliance, excluding custom-made items;

(5) obtain individual WV Medicaid provider number for each physical location under the same ownership;

(6) verify member's eligibility before providing services;

(7) provide orthotic/prosthetic devices/appliances per prescribing practitioner's prescription;

(8) assure device/services can be used by the member;

(9) provide the most economical devices/appliances that meet the member's basic health care needs. Expensive items are not covered when less costly devices/ appliances are available;

(10) provide appropriate replacement at no extra cost if the member is unable to use the device provided;

(11) accept Medicaid's reimbursement as payment in full for all covered devices/ appliances;

(12) maintain all medical documentation and proof of delivery of devices/appliances in the member's individual file;

(13) notify Unisys Provider Enrollment, PO Box 2002, Charleston, WV 25327-2002 of any change(s) in the initial enrollment application (i.e., name of physical location, personnel, credentials, demographics), no less than annually; and,

(14) participate in on-site reviews and submit medical records upon request by BMS.

516.3 COVERED ORTHOTIC/PROSTHETIC DEVICES/APPLIANCES

Orthotic/prosthetic devices/appliances provided are considered for reimbursement by WV Medicaid when requested by a prescribing practitioner and determined medically necessary to meet the basic health care needs of the member.

A complete list of covered and non-covered devices/appliances assigned to specific HCPCS codes is available in **Attachment I. Attachment I** describes the assigned HCPCS code, description of each code, replacement code for closed codes (as appropriate), service limit, prior authorization (PA) requirement and special coverage instructions.

516.3.1 WARRANTY, REPAIR, AND REPLACEMENT

Orthotic/prosthetic repairs and replacements are limited to medically necessary devices/appliances purchased by BMS or the Children with Special Healthcare Needs (CSHCN) Program. All repairs and replacement require PA through WVMI.

Medicaid's initial payment for devices/appliances includes all adjustments and/modifications needed to make the item functional for delivery to the member. The provider must document training and

instruction to the member and/or caregiver on the safe, effective and appropriate use of the device/appliance.

516.3.1. a Warranty

Manufacturer's warranty for devices/appliances is required for not less than one (1) year and begins on the date of delivery (date of service). The O&P provider is responsible for repairs and replacement of devices/appliances for the first year under warranty. The original warranty must be given to the member with a copy maintained in the member's individual file and a copy available to WVMI and/or BMS upon request.

516.3.1. b Repair

WV Medicaid's coverage for repair of devices/appliances is limited to: (1) items fully purchased by WV Medicaid or purchased by the Children With Special Healthcare Needs (CSCHN) program even if the member is no longer eligible for CSCHN; (2) the medical need is expected to continue; and (3) the repair is more economical than replacement. Providers may be reimbursed for materials necessary to complete the repair; however, they are not eligible for reimbursement of setup or delivery following repair or service calls. Labor services are to be billed separately with the units equal to the number of labor hours.

516.3.1. c Replacement

Replacement of orthotic/prosthetic devices/appliances may be covered by WV Medicaid on an as-needed basis due to: (1) acute rapid change in the member's physical condition; (2) wear, theft, irreparable damage; or (3) loss by disaster. Prior authorization for medical necessity must be obtained from WVMI for replacement prior to providing the device/appliance. Except when related to growth, changes in physical condition or loss by disaster, total replacement of an appliance will not be considered if less than three years after the original purchase. In addition to medical documentation to justify replacement, a police or insurance report is required for devices/appliances stolen; and, an insurance liability report is required for lost or destroyed devices/appliances. Note: In cases of neglect and/or wrongful misuse of the device/appliance, the request for replacement will be denied if such circumstances are confirmed.

516.4 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements 320.5, DOCUMENT AND RETAIN RECORDS, providers submitting claims for Medicaid reimbursement must maintain complete, individual, accurate and legible records. Records must include documentation of medical necessity for devices/appliances provided to meet the basic health care needs of the member as follows:

(1) Effective March 1, 2007, formal certificate of medical necessity forms (i.e., the WVMI Medicaid DME Authorization Request Form and the Orthotic/Prosthetic Certificate of Medical Necessity) are not required to document medical necessity of items requiring prior authorization. However, as an enrolled participant of WV Medicaid, practitioners and O&P providers are required to maintain individual Medicaid member files with documentation to assure that all services provided to Medicaid members are medically necessary and that billing of such services are accurate. Practitioners and O&P providers may develop individual documentation methods or use the above referenced forms available in **Attachment II** of this manual. Documentation may be submitted via fax to: 1-304-346-

8185 or in writing to WVMI Medical Review Department, 3001 Chesterfield Place, Charleston, WV 25304.

(2) Effective March 1, 2007, a written prescription which includes the member's name, date of prescription, ICD-9 code, device/appliance required, estimated length of need in months, quantity of item(s), frequency of use, member's functional level of care (FLC) 0-4 and prescribing practitioner's signature, is to be given to the member by the prescribing practitioner. FLC is defined as:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlisted household ambulatory.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulatory.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

It is the responsibility of the member to submit the prescription to the O&P provider of choice.

A copy of the hospital discharge plan and/or progress notes do not constitute a written prescription for O&P.

(3) A delivery document signed by the member or caregiver and documentation of education for the O&P item provided must be maintained in the individual member's record;

(4) O&P providers must track serial, lot, and product numbers of O&P devices/appliances for purposes of recall and;

(5) Medical documentation submitted for review must not be more than six (6) months old at the time the prescription is written.

516.5 PRIOR AUTHORIZATION

For O&P services requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the written prescription (see Section 516.4, 3rd paragraph for clarification) and all relevant information. Additionally, a PA must be obtained when the request for services exceeds the established service limits.

It is strongly recommended that O&P providers, in partnership with prescribing practitioners, assist in obtaining prior authorizations. Prescribing practitioners must provide clinical information and a written prescription while O&P providers provide the appropriate HCPCS code and billing information. If devices/appliances are provided before the PA is confirmed, the device/appliance will not be reimbursed. Prior authorization does not guarantee payment. Refer to **Attachment I** for specific O&P items requiring PA and service limits for covered services.

Effective, January 1, 2006, Medicaid covered services requiring a PA no longer require a PA if the members primary insurance approves the service. An explanation of benefits (EOB), documenting the reasons(s) for denial of services requested, must be submitted to WVMI when requesting prior authorization. If the service is not covered by the primary insurance, but is a covered service for Medicaid and the service requires a PA from WVMI, Medicaid policy will be enforced. If administrative denials are given by the primary payer, Medicaid will not reimburse for services. Please refer to Chapter 600 – Payment Methodologies for additional information.

Effective March 1, 2007, InterQual Criteria for specific O&P items will be utilized by WVMI to determine medical necessity as follows:

- Above Knee Prosthetics HCPCS code L5150, L5160, L5200, L5311, L5321, L5420, L5430, L5560, L5570, L5580, L5585, L5590, L5610, L5613, L5616, L5631, L5652, L5671, L5695, L5701, L5705, L5790, L5920, L5950, L5964, L5984, L5985, L5986, L5987, L8410, L8430, L8460, L8480

- Above Knee Prosthetics, Microprocessor – Controlled Knee HCPCS code L5311, L5321, L5631, L5652, L5671, L5695, L5701, L5705, L5828, L5845, L5920, L5950, L5964, L8410, L8430, L8460, L8480

- Below Knee Prosthetics HCPCS code L5100, L5105, L5301, L5400, L5410, L5510, L5520, L5530, L5535, L5540, L5629, L5647, L5666, L5670, L5671, L5700, L5704, L5785, L5910, L5940, L5962, L8400, L8420, L8470

- Cranial Remodeling Orthosis HCPCS code S1040
- Lower Extremity Orthotic Devices, Knee Braces HCPCS code L1800, L1810, L1815, L1830, L1834, L1840, L1844, L1845, L1855, L1858

Items requiring PA not listed above will follow Palmetto, Region C, medical necessity criteria for covered services. When documentation fails to meet criteria, WVMI may either deny for lack of documentation or request additional information to be submitted within seven (7) days. If additional information is requested and is not received by WVMI within seven (7) days, the request will be denied for lack of documentation to support medical necessity.

Retrospective authorization is available: (1) for items denied by primary insurance; (2) retrospective Medicaid eligibility; and, (3) on a case-by-case basis. A request for consideration of retrospective authorization does not guarantee approval or payment.

516.6 NURSING FACILITIES

O & P devices/appliances covered to members residing in a Long Term or Intermediate Care Facilities are subject to service limitation and prior authorization requirements noted in this manual. Refer to Chapter 514 – Nursing Home Manual on BMS website at www.wvdhhr.org for additional information.

516.7 OUT OF STATE SERVICES

For WV Medicaid members receiving covered services from an out-of–state facility and requiring O&P devices/appliances at discharge, a written prescription by the respective out-of-state attending physician must be presented to a WV provider for provision of services requested. WV O&P policies apply. This process is required for warranty validity and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WV Medicaid members.

516.8 NON-COVERED ORTHOTICS/PROSTHETIC SERVICES

In addition to non-covered services listed in **Attachment I**, the following items are not covered by WV Medicaid:

(1) Use of an unlisted code when a national HCPCS code is available;

(2) Unbundled HCPCS codes;

(3) Services rendered prior to obtaining prior authorization;

(4) Routine or periodic maintenance;

(5) Travel, set up or delivery of O&P following repairs;

(6) Service calls that do not involve actual labor time for repairs;

(7) Orthotics or Prosthetics for participants enrolled in the Division of Rehabilitative Services, Workers Compensation and/or Hospice;

(8) Orthotics or Prosthetics for members enrolled in a Medicaid MCO; or

(9) Orthotics or Prosthetics for members enrolled in the PAAS Program without a referral from the PCP.

516.9 BILLING AND REIMBURSEMENT

WV Medicaid requires practitioners, O&P providers and other appropriate individuals/groups to enroll as a Medicaid provider to be eligible for reimbursement of services rendered with exception of an emergent/medically necessary circumstance. Billing prior to rendering services/items is prohibited.

Medicaid is payer of last resort. Third-party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The third-party may be an individual, institution, corporation or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS, Medicare, Hospice, etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers' Compensation Plan. In those instances where liability cannot be currently established, i.e., accident or injury, Medicaid benefits will not be withheld. Subsequent establishment of liability which provides compensation and payment for the costs of such medical care requires that an adjustment be made by the provider to the Medicaid agency for benefits paid. Prior authorization is not required for services reimbursed by third-party payers. All claims must be submitted to Unisys at PO Box 3767, Charleston, WV 25337 for reimbursement consideration.

Medicaid payment is based, where possible, on a percentage of the Medicare fee schedule and is equal to the lesser of the billed charge or the fee schedule amount less any third party payment. This same rule applies to payments for repairs and maintenance.

When billing for unlisted and/or unpriced O & P codes (L0999, L1499, L2999, L3031, L3251, L3649, L3956, L3999, L4210, L5999, L6965, L6970, L6975, L7180, L7499, L8039 and L8499) the description of the item provided must be entered on the claim form. An unaltered cost invoice is to be submitted to WVMI for pricing of unlisted/unpriced codes. Refer to **Attachment I** for specific codes and special instructions.

The professional claim form, CMS 1500 or ASCX12N837P (004010X098A1) must be used to bill O&P Items. Repair and replacement of O&P requires an RP modifier. Options or accessories bundled in the base appliance/device are not reimbursable.

516.10 MANAGED CARE

Unless otherwise noted in this manual or appendices, services detailed in this manual are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a WV MCO, MCO requirements must be met for reimbursement. If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for the O&P requested prior to rendering the services. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met.

CHAPTER 516
ORTHOTIC/PROSTHETIC SERVICES
MARCH 1, 2007

ATTACHMENT I
COVERED/NON-COVERED ORTHOTIC/PROSTHETIC SERVICES
WITH ASSIGNED HCPCS CODES
PAGE 1 OF 70

REVISED JANUARY 1, 2008

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
A4565	Slings	L1750	4 per year	X	X				
A5500	For diabetics only, fitting (including follow up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5501	For diabetics only, fitting (including follow up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth inlay shoe with wedge(s), per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe		2 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5508	For diabetics only, deluxe feature of off-the shelf depth-inlay shoe or custom-molded shoe, per shoe								Not Covered
A5509	For diabetics only, direct formed, molded to foot with external heat source (i.e., heat gun) multiple density insert(s), prefabricated, per shoe								Discontinued by CMS 12/31/2005
A5510	For diabetics only, direct form, compression molded to patient’s foot without external heat source, multiple-density insert(s) prefabricated, per shoe								Not Covered
A5511	For diabetics only, custom molded from model of patient’s foot, multiple density insert(s), custom-fabricated, per shoe								Discontinued by CMS 12/31/2005
A5512	For diabetics only, multiple density insert, direct form, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient’s foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each	A5509	6 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93
A5513	For diabetics only, multiple density insert, custom molded from model of patient’s foot, total contact with patient’s foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer of 3/16 inch material (or higher), includes arch filler and other shaping material custom fabricated, each	A5511	6 per year	X	X			X	Diagnosis Requirements: 250.00 - 250.93

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
A6501	Compression burn garment, body suite (head to foot), custom fabricated	L8210		X	X				Cost Invoice Required
A6502	Compression burn garment, chin strap, custom fabricated	L8210		X	X				Cost Invoice Required
A6503	Compression burn garment, facial hood, custom fabricated	L8210		X	X				Cost Invoice Required
A6504	Compression burn garment, glove to wrist, custom fabricated	L8210		X	X				Cost Invoice Required
A6505	Compression burn garment, glove to elbow, custom fabricated	L8210		X	X				Cost Invoice Required
A6506	Compression burn garment, glove to axilla, custom fabricated	L8210		X	X				Cost Invoice Required
A6507	Compression burn garment, foot to knee length, custom fabricated	L8210		X	X				Cost Invoice Required
A6508	Compression burn garment, foot to thigh length, custom fabricated	L8210		X	X				Cost Invoice Required
A6509	Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated	L8210		X	X				Cost Invoice Required
A6510	Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated	L8210		X	X				Cost Invoice Required
A6511	Compression burn garment, lower trunk including leg openings (panty), custom fabricated	L8210		X	X				Cost Invoice Required
A6512	Compression burn garment, not otherwise classified	L8210		X	X				Cost Invoice Required
A6513	Compression burn mask, face and/or neck, plastic or equal, custom fabricated	L8210		X	X				Cost Invoice Required
A6530	Gradient compression stocking, below knee, 18-30 mm Hg, each	L8100	4 per 6 months	X	X				
A6531	Gradient compression stocking, below knee, 30-40 mm Hg, each	L8110	4 per 6 months	X	X				
A6532	Gradient compression stocking, below knee, 40-50 mm Hg, each	L8120	4 per 6 months	X	X				
A6533	Gradient compression stocking, thigh length, 18-30 mmHg, each	L8130	4 per 6 months	X	X				
A6534	Gradient compression stocking, thigh length, 30-40 mm Hg, each	L8140	4 per 6 months	X	X				
A6535	Gradient compression stocking, thigh length, 40-50 mm Hg, each	L8150	4 per 6 months	X	X				
A6536	Gradient compression stocking, full length/chap style, 18-30 mm Hg, each	L8160	4 per 6 months	X	X				
A6537	Gradient compression stocking full length/chap style, 30-40 mm Hg, each	L8170	4 per 6 months	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
A6538	Gradient compression stocking, full length/chap style, 40-50 mm Hg, each	L8180	4 per 6 months	X	X				Cost Invoice Required
A6539	Gradient compression stocking, waist length,18-30 mm Hg, each	L8190	2 per 6 months	X	X				
A6540	Gradient compression stocking, waist length, 30-40 mm Hg, each	L8195	2 per 6 months	X	X				Cost Invoice Required
A6541	Gradient compression stocking, waist length, 40-50 mm Hg, each	L8200	2 per 6 months	X	X				Cost Invoice Required
A6542	Gradient compression stocking, custom made	L8210	1 per 6 months	X	X				Cost Invoice Required
A6543	Gradient compression stocking, lymphedema	L8220	1 per 6 months	X	X				Cost Invoice Required
A6544	Gradient compression stocking, garter belt	L8230	2 per year	X	X				
A6549	Gradient compression stocking, not otherwise specified	L8239		X	X				Cost Invoice Required
A8000	Helmet, protective, soft prefabricated, includes all components and accessories	L0110	1 per year	X	X				New code 01/01/2007
A8001	Helmet, protective, hard, prefabricated, includes all components and accessories	L0100	1 per year	X	X				New code 01/01/2007
A8002	Helmet, protective, soft, custom fabricated, includes all components and accessories	L0110	1 per year	X					New code 01/01/2007
A8003	Helmet, protective, hard, custom fabricated, includes all components and accessories	L0100	1 per year	X					New code 01/01/2007
A8004	Soft interface for helmet, replacement only								Not Covered
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material								Not Covered
E1801	Bi-directional static progressive stretch elbow device with range of motion adjustment, includes cuffs								Not Covered
E1802	Dynamic adjustable forearm pronation/supination device, includes soft interface material								Not Covered
E1805	Dynamic adjustable wrist extension/flexion device, includes								Not Covered
E1806	Bi-directional static progressive stretch wrist device with range of motion adjustment, includes cuffs								Not Covered
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material								Not Covered
E1811	Bi-directional static progressive stretch knee device with range of motion adjustment, includes cuffs								Not Covered
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material								Not Covered
E1816	Bi-directional static progressive stretch ankle device with range of motion adjustment , includes cuffs								Not Covered
E1818	Bi-directional static progressive stretch forearm pronation/supination device with range of motion adjustment, includes cuffs								Not Covered

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
E1820	Replacement soft interface material, dynamic adjustable extension/flexion device								Not Covered
E1821	Replacement soft interface material/cuffs for bi-directional static progressive stretch device								Not Covered
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material								Not Covered
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material								Not Covered
E1840	Dynamic adjustable shoulder flexion/abduction/rotation device includes soft interface material								Not Covered
K0628	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, includes arch, base layer minimum of ¼ inc material of Shore A 35 durometer or 3/16 inch material of Shore A 40 (or higher), prefabricated								Discontinued by CMS 12/31/2005
K0629	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each								Discontinued by CMS 12/31/2005
K0630	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0631	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005
K0632	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting adjustment								Discontinued by CMS 12/31/2005
K0633	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may included pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005
K0634	Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
K0635	Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0636	Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L05 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0637	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0638	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005
K0639	Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0640	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0641	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
K0642	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closure, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0643	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005
K0644	Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panels, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0645	Lumbar sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005
K0646	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0647	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
K0648	Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s) /Panel(s) posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment								Discontinued by CMS 12/31/2005
K0649	Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated								Discontinued by CMS 12/31/2005
L0100	Cranial orthosis (helmet), with or without soft-interface, molded to patient model		1 per year	X					Prior Authorization Discontinued by CMS 12/31/2006
L0110	Cranial orthosis (helmet), with out without soft-interface, non- molded		1 per year	X					Prior Authorization Discontinued by CMS 12/31/2006
L0112	Cranial cervical orthosis, congenital torticollis type with or without soft interface material, adjustable range of motion joint, custom fabricated		2 per year	X					Prior Authorization
L0120	Cervical, flexible; non-adjustable (foam collar)		1 per year	X	X				
L0130	Cervical, flexible, thermoplastic collar, molded to patient		2 per year	X	X				
L0140	Cervical, semi-rigid; adjustable (plastic collar)		2 per year	X	X				
L0150	Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece		4 per year	X	X				
L0160	Cervical, semi-rigid, wire frame occipital/mandibular support		2 per year	X	X				
L0170	Cervical collar; molded to patient model		2 per year	X					
L0172	Cervical, collar, semi-rigid, thermoplastic foam, two piece		4 per year	X	X				
L0174	Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension		4 per year	X	X				
L0180	Cervical, multiple post collar, occipital/mandibular supports; adjustable		2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L0190	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (SOMI, Guilford, Taylor types)		2 per year	X	X				
L0200	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension		2 per year	X	X				
L0210	Thoracic, rib belt		2 per year	X	X				
L0220	Thoracic, rib belt, custom fabricated		2 per year	X	X				
L0430	Spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted (dewall posture protector only)		2 per year	X	X				Prior Authorization
L0450	TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment	L0300	2 per year	X	X				
L0452	TLFO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays on panel(s), includes shoulder straps and closures, custom fabricated	L0310	2 per year	X					
L0454	TLS0 flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment	L0315 L0317 L0321	2 per year	X	X				
L0456	TLSO, flexible provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, includes fitting and adjustment	L0315 L0317 L0321	2 per year	X	X				
L0458	TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment								Not Covered

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L0460	TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment								Not Covered
L0462	TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment								Not Covered
L0464	TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment								Not Covered
L0466	TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plan, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	L0320	2 per year	X	X				
L0468	TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	L0330	2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L0470	TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	L0340	2 per year	X	X				
L0472	TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	L0370	2 per year	X	X				
L0480	TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal and transverse planes, includes a carved plaster or cad-cam model, custom fabricated	L0390	2 per year	X					Prior Authorization
L0482	TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal and transverse planes, includes a carved plaster or cad-cam model, custom fabricated	L0400	2 per year	X					Prior Authorization
L0484	TSLO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal and transverse planes, includes a car-cam plaster or cad-cam model, custom fabricated	L0410	2 per year	X					Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L0486	TLFO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal and transverse planes, includes a carved plaster or cad-cam model, custom fabricated	L0420	2 per year	X					Prior Authorization
L0488	TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal and transverse planes, prefabricated, includes fitting and adjustment	L0430	2 per year	X	X				
L0490	TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment	L0440	2 per year	X	X				
L0491	TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment		2 per year	X	X				
L0492	TLSO, sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment		2 per year	X	X				
L0621	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment	K0630	2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L0622	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may includes pendulous abdomen design, custom fabricated	K0631	2 per year	X	X				
L0623	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac join, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment	K0632	2 per year	X	X				
L0624	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac join, includes straps, closures, may include pendulous abdomen design, custom fabricated	K0633	2 per year	X					Cost Invoice Required
L0625	Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, include straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment	K0634	2 per year	X	X				
L0626	Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes, straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0635	2 per year	X	X				
L0627	Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may includes padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0636	2 per year	X	X				
L0628	LSO, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may includes stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0637	2 per year	X	X				
L0629	LSO, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral disc, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated	K0638	2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L0630	LSO, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding , stays, should straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0639	2 per year	X	X				
L0631	LSO, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0640	2 per year	X	X				Prior Authorization
L0632	LSO, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated	K0641	2 per year	X					Prior Authorization Cost Invoice Required
L0633	LSO, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0642	2 per year	X	X				
L0634	LSO, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated	K0643	2 per year	X	X				Prior Authorization Cost Invoice Required
L0635	LSO, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/Panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0644	2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L0636	LSO, sagittal-coronal control, lumbar flexion rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated	K0645	2 per year	X					Prior Authorization
L0637	LSO, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0646	2 per year	X	X				Prior Authorization
L0638	LSO, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated	K0647	2 per year	X					Prior Authorization
L0639	LSO, sagittal-coronal control, rigid shell (s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may includes soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment	K0648	2 per year	X	X				Prior Authorization
L0640	LSO, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid , produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated	K0649	2 per year	X					Prior Authorization
L0700	CTLSO, anterior-posterior-lateral control, molded to patient model; (Minerva type)		3 per year	X	X				Prior Authorization
L0710	CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material, (Minerva type)		3 per year	X					Prior Authorization
L0810	Halo procedure, cervical halo incorporated into jacket vest		1 per lifetime	X					Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L0820	Halo procedure, cervical halo incorporated into plaster body jacket		1 per lifetime	X					Prior Authorization
L0830	Halo procedure, cervical halo incorporated into Milwaukee type orthosis		1 per lifetime	X					Prior Authorization
L0859	Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material	L0860	1 per lifetime	X					Prior Authorization
L0860	Addition to halo procedures, magnetic resonance image compatible system								Closed by CMS 12/31/2005
L0861	Additional to halo procedure, replacement liner/interface material		2 per year	X					
L0960	Torso support, post surgical support, pads for post surgical support		2 per year	X	X				Discontinued by CMS 12/31/2007
L0970	TLSO, corset front		4 per year	X					
L0972	LSO, corset front		4 per year	X					
L0974	TLSO, full corset		4 per year	X					
L0976	LSO, full corset		4 per year	X					
L0978	Axillary crutch extension		2 per year	X					
L0980	Peroneal straps, pair		1 per year	X	X				
L0982	Stocking supporter grips, set of four (4)		6 per year	X	X				
L0984	Protective body sock, each		6 per year	X					
L0999	Additional to spinal orthosis, not otherwise specified			X					Prior Authorization Cost Invoice
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosis, including model		3 per year	X					Prior Authorization
L1001	Cervical thoracic lumbar sacral orthosis immobilizer, infant size, prefabricated, includes fitting and adjustment		2 per year	X	X				New Code 01/01/2007 Cost Invoice Required
L1005	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment								Not Covered
L1010	Additions to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis; axilla sling		3 per year	X					
L1020	Addition to CTLSO or scoliosis, kyphosis pad		3 per year	X					
L1025	Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating		3 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L1030	Addition to CTLSO or scoliosis orthosis, lumbar bolster pad		3 per year	X					
L1040	Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad		3 per year	X					
L1050	Addition to CTLSO or scoliosis orthosis, sternal pad		3 per year	X					
L1060	Addition to CTLSO or scoliosis orthosis, thoracic pad		3 per year	X					
L1070	Addition to CTLSO or scoliosis orthosis, trapezius sling		3 per year	X					
L1080	Addition to CTLSO or scoliosis orthosis, outrigger		3 per year	X					
L1085	Addition to CTLSO or scoliosis orthosis. outrigger, bilateral with vertical extension		3 per year	X					
L1090	Addition to CTLSO or scoliosis orthosis, lumbar sling		3 per year	X					
L1100	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather		3 per year	X					
L1110	Addition to CTLSO or scoliosis orthosis. ring flange, plastic or leather, molded to patient model		3 per year	X					
L1120	Addition to CTLSO or scoliosis orthosis covers for upright, each		3 per year	X					
L1200	Thoracic-lumbar-sacral-orthosis (TLSO), inclusive of furnishing initial orthosis only,		1 per year	X					Prior Authorization
L1210	Addition to TLSO, (low profile); lateral thoracic extension		3 per year	X					
L1220	Addition to TLSO, (low profile), anterior thoracic extension		3 per year	X					
L1230	Addition to TLSO, (low profile), Milwaukee type superstructure		3 per year	X					
L1240	Addition to TLSO, (low profile), lumbar derotation pad		3 per year	X					
L1250	Addition to TLSO, (low profile), anterior axis pad		3 per year	X					
L1260	Addition to TLSO, (low profile), anterior thoracic derotation pad		3 per year	X					
L1270	Addition to TLSO, (low profile), abdominal pad		3 per year	X					
L1280	Addition to TLSO, (low profile), rib gusset (elastic), each		3 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L1290	Addition to TLSO, (low profile), lateral trochanteric pad		3 per year	X					
L1300	Other scoliosis procedure, body jacket molded to patient model		1 per lifetime	X					Prior Authorization
L1310	Other scoliosis procedure, post operative body jacket		1 per lifetime	X					Prior Authorization
L1499	Spinal orthosis, not otherwise specified			X					Prior Authorization Cost Invoice
L1500	Thoracic-hip-knee-ankle, orthosis (THKAO), mobility frame (Newington, Parapodium types)		2 per year	X					Prior Authorization
L1510	THKAO, standing frame, with or without tray and accessories		2 per year	X					Prior Authorization
L1520	THKAO, swivel walker		2 per year	X					Prior Authorization
L1600	Hip orthosis, HO), abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment		3 per year	X	X				
L1610	HO, abduction control of hip joints; flexible, (Frejka cover only), prefabricated, includes fitting and adjustment		3 per year	X	X				
L1620	HO, abduction control of hip joints; flexible, (Pavlik harness), prefabricated, includes fitting and adjustment		3 per year	X	X				
L1630	HO, abduction control of hip joints; semi-flexible (Von Rosen type), custom fabricated		3 per year	X					
L1640	HO, abduction control of hip joints; static, pelvic band or spreader bar, thigh cuffs, custom fabricated		3 per year	X					
L1650	HO, abduction control of hip joints; static, adjustable, (Ilfled type), prefabricated, includes fitting and adjustment		3 per year	X	X				
L1652	HO, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type								Not Covered
L1660	HO, abduction control of hip joints; static, plastic, prefabricated, includes fitting and adjustment		3 per year	X	X				
L1680	HO, abduction control of hip joints; dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated		3 per year	X					Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L1685	HO, abduction control of hip joints; postoperative hip abduction type, custom fabricated		3 per year	X					Prior Authorization
L1686	HO, abduction control of hip joints; postoperative hip abduction type, prefabricated, includes fitting and adjustment		3 per year	X	X				Prior Authorization
L1690	Combination, bilateral, lumbo-sacral, hip, femur orthosis providing abduction and internal rotation control, prefabricated, includes fitting and adjustment		1 per year	X	X				Prior Authorization
L1700	Legg Perthes orthosis, (Toronto type), custom fabricated		4 per year	X					Prior Authorization
L1710	Legg Perthes orthosis, (Newington type), custom fabricated		4 per year	X					Prior Authorization
L1720	Legg Perthes orthosis, trilateral, (Tachdijan type), custom fabricated		4 per year	X					Prior Authorization
L1730	Legg Perthes orthosis, (Scottish Rite type), custom fabricated		1 per year	X					Prior Authorization
L1750	Legg Perthes orthosis, Legg Perthes sling (Sam Brown type), prefabricated, includes fitting and adjustment								Closed by CMS 12/31/2005
L1755	Legg Perthes orthosis, (Pattern bottom type), custom fabricated		3 per year	X					Prior Authorization
L1800	KO, elastic with stays, prefabricated, includes fitting and adjustment		3 per year	X	X				Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1810	KO, elastic with joints, prefabricated, includes fitting and adjustment		3 per year	X	X				Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1815	KO, elastic or other elastic type material with condylar pad(s), prefabricated, includes fitting and adjustment		3 per year	X	X				Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1820	KO, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment		3 per year	X	X				
L1825	KO, elastic knee cap, prefabricated, includes fitting and adjustment		3 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L1830	KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment		2 per year	X	X				Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1831	KO, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment		2 per year	X	X				
L1832	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes fitting and adjustment		2 per year	X	X				
L1834	KO, without knee joint, rigid, custom fabricated		2 per year	X					Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1836	KO, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment		2 per year	X					
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated		2 per year	X					Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1843	Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated		2 per year	X	X				Prior Authorization
L1844	Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated		2 per year	X					Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1845	Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment		2 per year	X	X				Prior Authorization Effective 10/01/2006 Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L1846	Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated	L1855, L1858, L1870, L1880	2 per year	X					Prior Authorization
L1847	KO, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment		2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L1850	KO, Swedish type, prefabricated, includes fitting and adjustment		2 per year	X	X				
L1855	KO, molded plastic, thigh and calf sections, with double upright knee joints, custom fabricated		2 per year	X					Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07 Discontinued by CMS 12/31/2007
L1858	KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI), custom fabricated		2 per year	X					Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07 Discontinued by CMS 12/31/2007
L1860	KO, modification of supracondylar prosthetic socket, custom fabricated (SK)		2 per year	X					Prior Authorization
L1870	KO, double upright, thigh and calf lacers with knee joint, custom fabricated		2 per year	X					Prior Authorization Discontinued by CMS 12/31/2007
L1880	KO, double upright, non-molded thigh and calf cuffs/lacers, with knee joints, custom fabricated		2 per year	X					Discontinued by CMS 12/31/2007
L1900	Ankle-foot orthosis (AFO), spring wire, dorsiflexion assist calf band, custom fabricated		3 per year	x					
L1901	Ankle orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., Neoprene, lycra)		2 per year	X	X				
L1902	AFO, ankle gauntlet, prefabricated, includes fitting and adjustment		4 per year	X	X				
L1904	AFO, molded ankle gauntlet, custom fabricated		4 per year	X					
L1906	AFO, multiligamentous ankle support, prefabricated, includes fitting and adjustment		4 per year	X	X				
L1907	AFO, supramalleolar with straps, with or without interface/pads, custom fabricated		4 per year	X					
L1910	AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment		4 per year	X					
L1920	AFO, single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated		4 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L1930	AFO, plastic or other material, prefabricated, includes fitting and adjustment		2 per year	X	X				
L1932	AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment		2 per year	X					Prior Authorization
L1940	AFO, plastic or other material, custom fabricated		4 per year	X					
L1945	AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated		2 per year	X					Prior Authorization
L1950	AFO, spiral (Institute of Rehabilitative Medicine type), plastic, custom fabricated		2 per year	X					
L1951	AFO, spiral, (institute of rehabilitative medicine type) plastic or other material, prefabricated, includes fitting and adjustment		2 per year	X					Prior Authorization
L1960	AFO, posterior solid ankle, plastic, custom fabricated		4 per year	X					
L1970	AFO, plastic with ankle joint, custom fabricated		2 per year	X					
L1971	AFO, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment		2 per year	X					
L1980	AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar "BK" orthosis), custom fabricated		2 per year	X					
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar "BK" orthosis), custom fabricated		2 per year	X					
L2000	Knee-ankle-foot-orthosis (KAFO); single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), custom fabricated		2 per year	X					Prior Authorization
L2005	KAFO, any material, single or double upright, stance control, automatic lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated		1 per year	X					Prior Authorization
L2010	KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), without knee joint, custom fabricated		2 per year	X					Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L2020	KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis), custom fabricated		2 per year	X					Prior Authorization
L2030	KAFO double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar "AK" orthosis), without knee joint, custom fabricated		2 per year	X					Prior Authorization
L2034	KAFO, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated		2 per year	X					Prior Authorization
L2035	KAFO, full plastic, static (pediatric size), prefabricated, includes fitting and adjustment		4 per year	X					
L2036	KAFO, full plastic, double upright, with or without free motion knee with or without free motion ankle, custom fabricated		2 per year	X					Prior Authorization
L2037	Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated		2 per year	X					Prior Authorization
L2038	Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabKnee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated		2 per year	X					Prior Authorization
L2039	KAFO full plastic, single upright, poly-axial hinge, medial lateral rotation control, custom fabricated								Closed by CMS 12/31/2005
L2040	Hip-knee-ankle-foot orthosis (HKAFO), torsion control, bilateral rotation straps, pelvic bands/belt, custom fabricated		4 per year	X					
L2050	HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated		4 per year	X					
L2060	HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt, custom fabricated		4 per year	X					
L2070	HKAFO, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated		4 per year	X					
L2080	HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated		4 per year	X					
L2090	HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt, custom fabricated		4 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L2106	Ankle-foot-orthosis (AFO), fracture orthosis, tibial fracture cast orthosis; thermoplastic type casting material, custom fabricated		4 per year	X					
L2108	AFO, fracture orthosis, tibial fracture cast orthosis, custom fabricated		4 per year	X					Prior Authorization
L2112	AFO, fracture orthosis, tibial fracture soft, prefabricated, includes fitting and adjustment		4 per year	X					
L2114	AFO, fracture orthosis, tibial fracture semi-rigid, prefabricated, includes fitting and adjustment		4 per year	X					
L2116	AFO, fracture orthosis, tibial fracture rigid, prefabricated, includes fitting and adjustment		4 per year	X					
L2126	Knee-ankle-foot-orthosis (KAFO), fracture orthosis, femoral fracture cast orthosis; thermoplastic type casting material, custom fabricated		4 per year						Prior Authorization
L2128	KAFO, fracture orthosis, femoral fracture cast orthosis, custom fabricated		4 per year	X					Prior Authorization
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment		4 per year	X					Prior Authorization
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment		4 per year	X					Prior Authorization
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment		4 per year	X					Prior Authorization
L2180	Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints		4 per year	X					
L2182	Addition to lower extremity fracture orthosis, drop lock knee joint		4 per year	X					
L2184	Addition to lower extremity fracture orthosis, limited motion knee joint		4 per year	X					
L2186	Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman type		4 per year	X					
L2188	Addition to lower extremity fracture orthosis, quadrilateral brim		4 per year	X					
L2190	Addition to lower extremity fracture orthosis, waist belt		4 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L2192	Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt		4 per year	X					
L2200	Addition to lower extremity, limited ankle motion, each joint		8 per year	X					
L2210	Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint		4 per year	X					
L2220	Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint		8 per year	X					
L2230	Addition to lower extremity, split flat caliper stirrups and plate attachment		2 per year	X					
L2232	Addition to lower extremity, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only		2 per year	X					Prior Authorization
L2240	Addition to lower extremity, round caliper and plate attachment		2 per year	X					
L2250	Addition to lower extremity, foot plate, molded to patient model, stirrup attachment		2 per year	X					
L2260	Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)		2 per year	X					
L2265	Addition to lower extremity, long tongue stirrup		2 per year	X					
L2270	Addition to lower extremity, varus/valgus correction, ("T") strap, padded/lined or malleolus pad		8 per year	X					
L2275	Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined		8 per year	X					
L2280	Addition to lower extremity, molded inner boot		2 per year	X					
L2300	Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable		2 per year	X					
L2310	Addition to lower extremity, abduction bar-straight		2 per year	X					
L2320	Addition to lower extremity, non-molded lacer , for custom fabricated orthosis only		2 per year	X					
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only		2 per year	X					
L2335	Addition to lower extremity, anterior swing band		2 per year	X					
L2340	Addition to lower extremity, pretibial shell, molded to patient model		2 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L2350	Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for "PTB" "AFO" orthoses)		2 per year	X					Prior Authorization
L2360	Addition to lower extremity, extended steel shank		4 per year	X					
L2370	Addition to lower extremity, Patten bottom		2 per year	X					
L2375	Addition to lower extremity, torsion control, ankle joint and half solid stirrup		2 per year	X					
L2380	Addition to lower extremity, torsion control, straight knee joint, each joint		2 per year	X					
L2385	Addition to lower extremity, straight knee joint, heavy duty, each joint		8 per year	X					
L2387	Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint		2 per year	X					
L2390	Addition to lower extremity, offset knee joint, each joint		2 per year	X					
L2395	Addition to lower extremity, offset knee joint, heavy duty, each joint		4 per year	X					
L2397	Addition to lower extremity orthosis, suspension sleeve		4 per year	X					
L2405	Addition to knee joint, drop lock, each		8 per year	X					
L2415	Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint		2 per year	X					
L2425	Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint		8 per year	X					
L2430	Addition to knee joint, ratchet lock for active and progressive knee extension, each joint		4 per year	X					
L2435	Addition to knee joint, polycentric joint, each joint								Discontinued by CMS 12/31/2004
L2492	Addition to knee joint, life look for drop lock ring		8 per year	X					
L2500	Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring		2 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L2510	Addition to lower extremity, thigh/weight bearing, quadrilateral brim, molded to patient model		2 per year	X					
L2520	Addition to lower extremity, thigh/weight bearing, quadrilateral brim, custom fitting		2 per year	X					
L2525	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model		2 per year	X					Prior Authorization
L2526	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted		2 per year	X					
L2530	Addition to lower extremity, thigh/weight bearing lacer, non-molded		2 per year	X					
L2540	Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model		2 per year	X					
L2550	Addition to lower extremity, thigh/weight bearing, high roll cuff		2 per year	X					
L2570	Addition to lower extremity, pelvic control, hip joint, Clevis type two position joint; each		2 per year	X					
L2580	Addition to lower extremity, pelvic control, pelvic sling		2 per year	X					
L2600	Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each		2 per year	X					
L2610	Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock each		2 per year	X					
L2620	Addition to lower extremity, pelvic control, hip joint; heavy duty, each		2 per year	X					
L2622	Addition to lower extremity, pelvic control, adjustable flexion, each		2 per year	X					
L2624	Addition to lower extremity, pelvic control, adjustable flexion, extension, abduction control, each		2 per year	X					
L2627	Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables		2 per year	X					Prior Authorization
L2628	Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables		2 per year	X					Prior Authorization
L2630	Addition to lower extremity, pelvic control, band and belt, unilateral		2 per year	X					
L2640	Addition to lower extremity, pelvic control, band and belt, bilateral		2 per year	X					
L2650	Addition to lower extremity, pelvic and thoracic control, gluteal pad, each		2 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L2660	Addition to lower extremity, thoracic control, band		2 per year	X					
L2670	Addition to lower extremity, thoracic control, paraspinal uprights		2 per year	X					
L2680	Addition to lower extremity, thoracic control, lateral support uprights		2 per year	X					
L2750	Addition to lower extremity orthosis, plating chrome or nickel, per bar		2 per year	X					
L2755	Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment (description is totally wrong)		2 per year	X					
L2760	Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)		16 per year	X					
L2768	Orthotic side bar disconnect device, per bar								Not Covered
L2770	Addition to lower extremity orthosis, any material, per bar or joint		8 per year	X					
L2780	Addition to lower extremity orthosis, non-corrosive finish, per bar		8 per year	X					
L2785	Addition to lower extremity orthosis, drop lock retainer, each		8 per year	X					
L2795	Addition to lower extremity orthosis, knee control, full kneecap		2 per year	X					
L2800	Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull		2 per year	X					
L2810	Addition to lower extremity orthosis, knee control, condylar pad		2 per year	X					
L2820	Addition to lower extremity orthosis, soft interface for molded plastic, below knee section		8 per year	X					
L2830	Addition to lower extremity orthosis, soft interface for molded plastic, above knee section		8 per year	X					
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each		2 per year	X					
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each		2 per year	X					
L2860	Additional to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism, each		4 per year						

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L2999	Lower extremity orthosis, not otherwise specified			X					Prior Authorization Cost Invoice
L3000	Foot, insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each		4 per year	X	X			X	
L3001	Foot, insert, removable, molded to patient model, Spenco, each		2 per year	X	X			X	
L3002	Foot, insert, removable, molded to patient model, Plastazote or equal, each		4 per year	X	X			X	
L3003	Foot, insert, removable, molded to patient model, silicone gel, each		2 per year	X	X			X	
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each		2 per year	X	X			X	
L3020	Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each		4 per year	X	X			X	
L3030	Foot, insert, removable, formed to patient foot each		2 per year	X	X			X	
L3031	Foot, insert/plate, removable, addition to lower extremity orthosis, high, strength, lightweight material, all hybrid lamination/prepreg composite, each		4 per year	X				X	Prior Authorization Cost Invoice
L3040	Foot, arch support, removable, premolded, longitudinal, each		4 per year	X	X			X	
L3050	Foot, arch support, removable, premolded, metatarsal, each		2 per year	X	X			X	
L3060	Foot, arch support, removable, premolded, longitudinal/metatarsal, each		2 per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3070	Foot, arch support, non-removable attached to shoe, longitudinal, each		2 per year	X				X	
L3080	Foot, arch support, non-removable attached to shoe, metatarsal, each		2 per year	X	X			X	
L3090	Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each		2 per year	X	X			X	
L3100	Hallus-valgus night dynamic splint		2 per year	X	X			X	
L3140	Foot, abduction rotation bar, including shoes		2 per year	X	X			X	
L3150	Foot, abduction rotation bars, without shoes		2 per year	X	X			X	
L3160	Foot, adjustable shoe-styled positioning device								Not Covered

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS	
L3170	Foot, plastic, silicone or equal, heel stabilizer		2 per year	X	X			X		
L3201	Orthopedic shoe, oxford with supinator or pronator, infant		6 units per year	X	X			X		
L3202	Orthopedic shoe, oxford with supinator or pronator child		6 units per year	X	X			X		
L3203	Orthopedic shoe, oxford with supinator or pronator junior		6 units per year	X	X			X		
L3204	Orthopedic shoe, hightop with supinator or pronator, infant		6 units per year	X	X			X		
L3206	Orthopedic shoe, hightop with supinator or pronator, child		6 units per year	X	X			X		
L3207	Orthopedic shoe, hightop with supinator or pronator, junior		6 units per year	X	X			X		
L3208	Surgical boot, each, infant		6 units per year	X	X			X		
L3209	Surgical boot, each, child		6 units per year	X	X			X		X
L3211	Surgical boot, each, junior		6 units per year	X	X			X		
L3212	Benesch boot, pair; infant		3 pair per year	X	X			X		
L3213	Benesch boot, pair, child		3 pair per year	X	X			X		
L3214	Benesch boot, pair, junior		3 pair per year	X	X			X		
L3215	Orthopedic footwear, ladies shoes, oxford, each		4 per year	X	X			X	Not covered for Diagnosis 250.00-250.93	
L3216	Orthopedic footwear, ladies shoes, depth inlay, each		4 per year	X	X			X	Not covered for Diagnosis 250.00-250.93	
L3217	Orthopedic footwear, ladies shoes, hightop, depth inlay, each		4 per year	X	X			X	Not covered for Diagnosis 250.00-250.93	
L3219	Orthopedic footwear, men's shoes, oxford, each		4 per year	X	X			X	Not covered for Diagnosis 250.00-250.93	
L3221	Orthopedic footwear, men's shoes, depth inlay, each		4 per year	X	X			X	Not covered for Diagnosis 250.00-250.93	
L3222	Orthopedic footwear, men's shoes, shoes, hightop, depth inlay, each		4 per year	X	X			X	Not covered for Diagnosis 250.00-250.93	

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3224	Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)		4 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3225	Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)		4 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3230	Orthopedic footwear, custom shoes, depth inlay, each		2 pair per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each		4 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3251	Foot, shoe molded to patient model, silicone shoe, each		2 per year	X	X			X	Prior Authorization Cost Invoice Not covered for Diagnosis 250.00-250.93
L3252	Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each		2 per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3253	Foot, molded shoe Plastazote (or similar) custom fitted, each		2 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3254	Non-standard size or width		2 units per year	X	X			X	
L3255	Non-standard size or length		2 units per year	X	X			X	
L3257	Orthopedic footwear, additional charge for split size		1 unit per year	X	X			X	
L3260	Surgical boot/shoe, each		2 units per year	X	X			X	
L3265	Plastazote sandal, each		2 units per year	X	X			X	
L3300	Lift, elevation, heel, tapered to metatarsal, per inch		6 units per year	X	X			X	
L3310	Lift, elevation, heel and sole, neoprene, per inch		8 units per year	X	X			X	
L3320	Lift, elevation, heel and sole, cork, per inch		4 units per year	X	X			X	
L3330	Lift, elevation, metal extension (skate)		2 per year	X	X				
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch		6 units per year	X	X			X	
L3334	Lift, elevation, heel, per inch		6 units per year	X	X			X	
L3340	Heel wedge, SACH		2 units per year	X	X			X	

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L3350	Heel wedge		4 units per year	X	X			X	
L3360	Sole wedge, outside sole		2 units per year	X	X			X	
L3370	Sole wedge, between sole		4 units per year	X	X			X	
L3380	Clubfoot wedge		2 units per year	X	X			X	
L3390	Outflare wedge		2 units per year	X	X			X	
L3400	Metatarsal bar wedge, rocker		2 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3410	Metatarsal bar wedge, between sole		2 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3420	Full sole and heel wedge; between sole		4 units per year	X	X			X	Not covered for Diagnosis 250.00-250.93
L3430	Heel, counter, plastic reinforced		2 units per year	X	X			X	
L3440	Heel, counter, leather reinforced		2 units per year	X	X			X	
L3450	Heel, SACH cushion type		2 units per year	X	X			X	
L3455	Heel, new leather, standard		2 units per year	X	X			X	
L3460	Heel, new rubber, standard		2 units per year	X	X			X	
L3465	Heel, Thomas with wedge		4 units per year	X	X			X	
L3470	Heel, Thomas extended to ball		2 units per year	X	X			X	
L3480	Heel, pad and depression for spur		2 units per year	X	X			X	
L3485	Heel, pad, removal for spur		2 units per year	X	X			X	
L3500	Orthopedic shoe addition, insole, leather		2 units per year	X	X			X	
L3510	Orthopedic shoe addition insole, rubber		2 units per year	X	X			X	

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3520	Orthopedic shoe addition insole, felt covered with leather		2 units per year	X	X			X	
L3530	Orthopedic shoe addition sole, half		4 per year	X	X			X	
L3540	Orthopedic shoe addition sole, full		4 per year	X	X			X	
L3550	Orthopedic shoe addition toe tap, standard)		8 per year	X	X			X	
L3560	Orthopedic shoe addition toe tap, horseshoe		8 per year	X	X			X	
L3570	Orthopedic shoe addition, special extension to instep (leather with eyelets)		2 units per year	X	X			X	
L3580	Orthopedic shoe addition, convert instep to velcro closure		8 units per year	X	X			X	
L3590	Orthopedic shoe addition, convert firm shoe counter to soft counter		2 units per year	X	X			X	
L3595	Orthopedic shoe addition, march bar		2 units per year	X	X			X	
L3600	Transfer of an orthosis from one shoe to another, caliper plate, existing		2 units per year	X				X	
L3610	Transfer of an orthosis from one shoe to another, caliper plate, new		2 units per year	X	X			X	
L3620	Transfer of an orthosis from one shoe to another, solid stirrup, existing		4 units per year	X	X			X	
L3630	Transfer of an orthosis from one shoe to another, solid stirrup, new		2 units per year	X	X			X	
L3640	Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes		2 units per year	X	X			X	
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified			X	X			X	Prior Authorization Cost Invoice Required
L3650	Shoulder orthosis, (SO); figure of eight design abduction restrainer, prefabricated, includes fitting and adjustment		4 units per year	X	X				
L3651	Shoulder orthosis, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., Neoprene, lycra)		2 units per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3652	Shoulder orthosis, double shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., Neoprene, lycra)		2 units per year	X					
L3660	Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment		4 units per year	X	X				
L3670	Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment		4 units per year	X	X				
L3671	Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment			X					Prior Authorization
L3672	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment			X					Prior Authorization
L3673	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment			X					Prior Authorization
L3675	Shoulder orthosis, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, includes fitting and adjustment								Not Covered
L3677	Shoulder orthosis, hard plastic, shoulder stabilizer, prefabricated, includes fitting and adjustment								Not Covered
L3700	Elbow orthosis (EO), elastic with stays, prefabricated, includes fitting and adjustment		4 units per year	X	X				
L3701	Elbow orthosis (EO), elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)								Not Covered
L3702	Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2 per year	X					Prior Authorization
L3710	Elbow orthosis (EO), elastic with metal joints, prefabricated ,includes fitting and adjustment		4 units per year	X	X				
L3720	Elbow orthosis (EO), double upright with forearm/arm cuffs, free motion, custom fabricated		2 units per year	X					
L3730	Elbow orthosis (EO), double upright with fore/arm cuffs, extension/flexion assist, custom fabricated		2 units per year	X	X				Prior Authorization
L3740	Elbow orthosis (EO), double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated		2 units per year	X					Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3760	Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type								Not Covered
L3762	Elbow orthosis (EO), rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment								Not Covered
L3763	EWHO, rigid, without joints, may includes soft interface, straps, custom fabricated, includes fitting and adjustment	L3986		X					Prior Authorization
L3764	EWHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	L3985		X					Prior Authorization
L3765	EWHFO, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment			X					Prior Authorization
L3766	EWHFO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment			X					Prior Authorization
L3800	Wrist-hand-finger-orthosis (WHFO), short opponens, no attachments, custom fabricated		2 units per year	X					Discontinued by CMS 12/31/2007
L3805	Wrist-hand-finger-orthosis (WHFO), long opponens, no attachment, custom fabricated		2 units per year	X					Discontinued by CMS 12/31/2007
L3806	Wrist-hand-finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may includes soft interface material, straps, custom fabricated, includes fitting and adjustment	L3914	4 units per year	X					New Code 01/01/2007
L3807	Wrist-hand-finger-orthosis (WHFO), without joint(s), prefabricated, includes fitting and adjustment		1 units per year	X	X				
L3808	Wrist-hand-finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment	L3800, L3805, L3907	4 units per year	X	X				New Code 01/01/2007
L3810	Wrist-hand-finger-orthosis, addition to short and long opponens, thumb abduction ("C") bar		2 units per year	X					Discontinued by CMS 12/31/2007
L3815	Wrist-hand-finger-orthosis, addition to short and long opponens, second M.P. abduction assist		2 units per year	X					Discontinued by CMS 12/31/2007
L3820	Wrist-hand-finger-orthosis, addition to short and long opponens, I.P. extension assist, with M/P. extension stop		2 units per year	X					Discontinued by CMS 12/31/2007

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3825	Wrist-hand-finger-orthosis, addition to short and long opponens, M.P. extension stop		2 units per year	X					Discontinued by CMS 12/31/2007
L3830	Wrist-hand-finger-orthosis, addition to short and long opponens, M.P. extension assist		2 units per year	X					Discontinued by CMS 12/31/2007
L3835	Wrist-hand-finger-orthosis, addition to short and long opponens, M.P. spring extension assist		2 units per year	X					Discontinued by CMS 12/31/2007
L3840	Wrist-hand-finger-orthosis, addition to short and long opponens, spring swivel thumb		2 units per year	X					Discontinued by CMS 12/31/2007
L3845	Wrist-hand-finger-orthosis, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop		2 units per year	X					Discontinued by CMS 12/31/2007
L3850	Wrist-hand-finger-orthosis, addition to short and long opponens, action wrist, with dorsiflexion assist		2 units per year	X					Discontinued by CMS 12/31/2007
L3855	Wrist-hand-finger-orthosis, addition to short and long opponens, adjustable M.P. flexion control		2 units per year	X					Discontinued by CMS 12/31/2007
L3860	Wrist-hand-finger-orthosis, addition to short and long opponens, adjustable M.P. flexion control and I.P.		2 units per year	X					Discontinued by CMS 12/31/2007
L3890	Additional to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each		2 units per year	X					
L3900	Wrist-hand-finger orthosis, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated		2 units per year	X					Prior Authorization
L3901	Wrist-hand-finger orthosis, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension cable driven, custom fabricated		2 units per year	X					Prior Authorization
L3902	Wrist-hand-finger orthosis, external powered, compressed gas, custom fabricated		2 units per year	X					Prior Authorization Discontinued by CMS 12/31/2006
L3904	Wrist-hand-finger orthosis, external powered, electric, custom fabricated		2 units per year	X					Prior Authorization
L3905	Wrist-hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2 per year	X					Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3906	Wrist-hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		4 units per year	X					
L3907	Wrist-hand-finger orthosis, wrist gauntlet with thumb spica, molded to patient model, custom fabricated		4 units per year	X					Discontinued by CMS 12/31/2007
L3908	Wrist-hand orthosis (WHO), wrist extension control cock-up, prefabricated, includes fitting and adjustment		4 units per year	X	X				
L3909	Wrist orthosis, elastic prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)								Not Covered
L3910	Wrist-hand-finger orthosis (WHFO), Swanson design, prefabricated, includes fitting and adjustment		4 units per year	X					Discontinued by CMS 12/31/2007
L3911	Wrist-hand-finger orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)								Not Covered
L3912	Hand-finger orthosis, flexion glove with elastic finger control, prefabricated, includes fitting and adjustment		4 units per year	X					
L3913	Hand-finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2 units per year	X					
L3914	Wrist-hand orthosis (WHO), wrist extension cock-up, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2006
L3915	Wrist-hand-finger orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment		4 units per year	X	X				New Code 01/01/2007
L3916	Wrist-hand-finger orthosis, wrist extension cock-up with outrigger, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3917	Hand orthosis, metacarpal fracture orthosis, prefabricated, includes fitting and adjustment		2 units per year	X	X				
L3918	Hand-finger orthosis (HFO), knuckle bender, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3919	Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2 units per year	X					
L3920	Hand-finger orthosis knuckle bender with outrigger, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3921	Hand-finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2 units per year	X					
L3922	Hand-finger orthosis knuckle bender, two segment to flex joints, prefabricated, includes fitting and adjustment		4 units per year	X					Discontinued by CMS 12/31/2007
L3923	HFO, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment	L3954	4 units per year	X	X				
L3924	Wrist-hand-finger orthosis (WHFO),Oppenheimer, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3925	Finger orthosis proximal interphalangeal (PIP)/distal interphalangeal (DIP), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment	L3932 L3934 L3948	2 units per year	X	X				Prior Authorization New Code 01/01/2008
L3926	Wrist-hand-finger orthosis (WHFO), Thomas suspension, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3927	Finger orthosis, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment		2 units per year	X	X				Prior Authorization New Code 01/01/2008
L3928	Hand-finger orthosis (HFO), finger extension, with clock spring, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3929	Hand finger orthosis, includes one or more nontorsion joint(s) turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	L3918, L3920, L3922, L3928, L3942, L3944, L3946	2 units per year	X	X				Prior Authorization New Code 01/01/2008
L3930	Wrist-hand-finger orthosis, finger extension, with wrist support, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3931	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	L3910, L3916, L3924, L3926, L3930, L3936, L3938, L3940, L3950, L3952	2 units per year	X	X				Prior Authorization New Code 01/01/2008
L3932	Finger orthosis (FO); safety pin, spring wire, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3933	Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment		2 units per year	X					
L3934	Finger orthosis, safety pin, modified, prefabricated, includes fitting and adjustment		4 units per year	X					Discontinued by CMS 12/31/2007
L3935	Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment		2 units per year	X					
L3936	Wrist-hand-finger orthosis (WHFO), Palmer, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3938	Wrist-hand-finger orthosis, dorsal wrist, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3940	Wrist-hand-finger orthosis, dorsal wrist, with outrigger attachment, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3942	Hand-finger orthosis (HFO), reverse knuckle bender, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3944	Hand-finger orthosis, reverse knuckle bender, with outrigger, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3946	Hand-finger orthosis ,composite elastic, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3948	Finger-orthosis (FO), finger knuckle bender, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3950	Wrist-hand-finger orthosis (WHFO); combination Oppenheimer, with knuckle bender and two attachments, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3952	Wrist-hand-finger orthosis, combination Oppenheimer, with reverse knuckle and two attachments, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3954	Hand-finger orthosis (HFO), spreading hand, prefabricated, includes fitting and adjustment		4 units per year	X	X				Discontinued by CMS 12/31/2007
L3956	Addition of joint to upper extremity orthosis, any material; per joint			X					Prior Authorization Cost Invoice Required
L3960	Shoulder-elbow-wrist-hand orthosis (SEWHO); abduction positioning, airplane design, prefabricated, includes fitting and adjustment		2 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3961	Shoulder-elbow-wrist-hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2 per year	X					Prior Authorization
L3962	Shoulder-elbow-wrist-hand orthosis, abduction positioning, Erbs palsy design, prefabricated, includes fitting and adjustment		2 per year	X					
L3963	Shoulder-elbow orthosis, molded shoulder, arm, forearm and wrist, with articulating elbow joint, custom fabricated								Closed by CMS 12/31/2005
L3964	Shoulder-elbow orthosis (SEO), mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment		1 per year	X					
L3965	Shoulder-elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable rancho type, prefabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3966	Shoulder-elbow orthosis, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3967	SEWHO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3968	Shoulder-elbow orthosis (SEO), mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3969	Shoulder-elbow orthosis (SEO), mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support, prefabricated, includes fitting and adjustment		1 per year	X					
L3970	Shoulder-elbow orthosis , addition to mobile arm support, elevating proximal arm		1 per year	X					
L3971	SEWHO, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated , includes fitting and adjustment	L3963	1 per year	X					Prior Authorization
L3972	Shoulder-elbow orthosis, offset or lateral rocker arm with elastic balance control		1 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L3973	SEWHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	L3963	1 per year	X					Prior Authorization
L3974	Shoulder-elbow orthosis, addition to mobile arm support, supinator		1 per year	X					
L3975	SEWHFO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3976	SEWHFO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3977	SEWHFO, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3978	SEWHFO, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1 per year	X					Prior Authorization
L3980	Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment		2 per year	X					
L3982	Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment		2 per year	X					
L3984	Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment		2 per year	X					
L3985	Upper extremity fracture orthosis, forearm, hand with wrist hinge, custom fabricated		2 per year	X					Discontinued by CMS 12/31/2007
L3986	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist (example - Colles' fracture), custom fabricated		2 per year	X					Discontinued by CMS 12/31/2007
L3995	Addition to upper extremity orthosis, sock, fracture or equal, each		2 per year	X					
L3999	Upper limb orthosis, not otherwise specified			X					Prior Authorization Cost Invoice Required
L4000	Replace girdle for spinal orthosis (CTLSO or SO)		2 per year	X					Prior Authorization
L4002	Replacement strap, any orthosis, includes all components, any length, any type		12 per year	X	X				
L4020	Replace quadrilateral socket brim, molded to patient model		2 per year	X					Prior Authorization
L4030	Replace quadrilateral socket brim, custom fitted		2 per year	X					

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L4040	Replace molded thigh lacer, for custom fabricated orthosis only		2 per year	X					
L4045	Replace non-molded thigh lacer, for custom fabricated orthosis only		2 per year	X					
L4050	Replace molded calf lacer, for custom fabricated orthosis only		2 per year	X					
L4055	Replace non-molded calf lacer, for custom fabricated orthosis only		2 per year	X					
L4060	Replace high roll cuff		2 per year	X					
L4070	Replace proximal and distal upright for KAFO		2 per year	X					
L4080	Replace metal bands KAFO, proximal thigh		2 per year	X					
L4090	Replace metal bands KAFO-AFO, calf or distal thigh		2 per year	X					
L4100	Replace leather cuff KAFO, proximal thigh		2 per year	X					
L4110	Replace leather cuff KAFO-AFO, calf or distal thigh		4 per year	X					
L4130	Replace pretibial shell		2 per year	X					
L4205	Repair of orthotic device, labor component, per 15 minutes		8 units per month	X					
L4210	Repair of orthotic device, repair or replace minor parts			X					Prior Authorization Cost Invoice Required
L4350	Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic gel), prefabricated, includes fitting and adjustment		4 per year	X	X				
L4360	Walking boot, pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment		4 per year	X	X				
L4370	Pneumatic full leg splint, prefabricated, includes fitting and adjustment		4 per year	X	X				
L4380	Pneumatic knee splint, prefabricated, includes fitting and adjustment		4 per year	X	X				
L4386	Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment		2 per year	X	X				
L4392	Replacement, soft interface material; static AFO		4 per year	X	X				
L4394	Replace soft interface material, foot drop splint		4 per year	X	X				
L4396	Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment		2 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L4398	Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment		2 per year	X	X				
L5000	Partial foot, shoe insert with longitudinal arch, toe filter		2 per year				X	X	
L5010	Partial foot, molded socket, ankle height, with toe filler		2 per year				X		
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler		2 per year				X		
L5050	Ankle, symes, molded socket SACH foot		2 per year				X		
L5060	Ankle, symes, metal frame, molded leather socket, articulated ankle/foot		2 per year				X		
L5100	Below knee, molded, socket, shin, SACH foot		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot		2 per year						Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot,		2 per year						Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5160	Knee disarticulation (or through knee), molded socket bent knee configuration, external knee joints, shin, SACH foot		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5210	Above knee, short prosthesis, no knee joint ("stubbies"), with foot blocks, no ankle joints, each		2 per year				X		
L5220	Above knee, short prosthesis, no knee joint ("stubbies"), with articulated ankle/foot, dynamically aligned, each		2 per year				X		
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot		2 per year				X		
L5250	Hip disarticulation, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot		2 per year				X		
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot		2 per year				X		
L5301	Below knee, molded socket, shin, SACH foot, endoskeletal system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5311	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5321	Above knee, molded socket, open end, SACH foot, endoskeletal system, single, axis knee		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5331	Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot		2 per year				X		
L5341	Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot		2 per year				X		
L5400	Immediate post surgical or early fitting; application of initial rigid dressing, including fitting, alignment, suspension, and one case change, below knee		1 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5410	Immediate post surgical or early fitting; application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment		1 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5420	Immediate post surgical or early fitting; application of initial rigid dressing, including fitting, alignment and suspension and one cast change "AK" or knee disarticulation		1 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5430	Immediate post surgical or early fitting; application of initial rigid dressing, including fitting, alignment and suspension, "AK" or knee disarticulation, each additional cast change and realignment		1 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5450	Immediate post surgical or early fitting; application of non-weight bearing rigid dressing, below knee		1 per lifetime				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5460	Immediate post surgical or early fitting; application of non-weight bearing rigid dressing, above knee		1 per lifetime				X		
L5500	Initial, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed		2 per lifetime				X		
L5505	Initial, above knee - knee disarticulation, ischial level socket non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed		2 per lifetime				X		
L5510	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot; plaster socket, molded to model		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5520	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed		2 per lifetime				X		Prior Authorization Effective 10/01/2006 Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5530	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, molded to model		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5535	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5540	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5560	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot; plaster socket, molded to model		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5570	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot; thermoplastic or equal, direct formed		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5580	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot; thermoplastic or equal, molded to model		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5585	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot; prefabricated adjustable open end socket		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5590	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot; laminated socket, molded to model		2 per lifetime				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5595	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot; thermoplastic or equal, molded to patient model		2 per lifetime				X		
L5600	Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH laminated socket, molded to patient model		2 per lifetime				X		
L5610	Addition to lower extremity, endoskeletal system; above knee, hydracadence system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5611	Addition to lower extremity, endoskeletal system; above knee, above knee - knee disarticulation, 4-bar linkage, with friction swing phase control		2 per year				X		
L5613	Addition to lower extremity, endoskeletal system; above knee - knee disarticulation, 4-bar linkage, with hydraulic swing phase control		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5614	Addition to lower extremity, endoskeletal above knee - knee disarticulation, 4-bar linkage, with pneumatic swing phase control		2 per year				X		Prior Authorization
L5616	Addition to lower extremity, endoskeletal above knee - universal multiplex system, friction swing phase control		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5617	Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each						X		
L5618	Addition to lower extremity, test socket, Symes		2 per year				X		
L5620	Addition to lower extremity, test socket, below knee		2 per year				X		
L5622	Addition to lower extremity, test socket, knee disarticulation		2 per year				X		
L5624	Addition to lower extremity, test socket, above knee		2 per year				X		
L5626	Addition to lower extremity, test socket, hip disarticulation		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L5628	Addition to lower extremity, test socket, hemipelvectomy		2 per year				X		
L5629	Addition to lower extremity, below knee, acrylic socket		4 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5630	Addition to lower extremity, Symes type, expandable wall socket		2 per year				X		
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5632	Addition to lower extremity, Symes type; "PTB" brim design socket		2 per year				X		
L5634	Addition to lower extremity, Symes type; posterior opening (Canadian) socket		2 per year				X		
L5636	Addition to lower extremity, Symes type; medial opening socket		2 per year				X		
L5637	Addition to lower extremity, below knee; total contact		4 per year				X		
L5638	Addition to lower extremity, below knee leather socket		2 per year				X		
L5639	Addition to lower extremity, below knee wood socket		2 per year				X		
L5640	Addition to lower extremity, knee disarticulation, leather socket		2 per year				X		
L5642	Addition to lower extremity, above knee, leather socket		2 per year				X		
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame		2 per year				X		Prior Authorization
L5644	Addition to lower extremity, above knee, wood socket		2 per year				X		
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame		2 per year				X		Prior Authorization
L5646	Addition to lower extremity, below knee, air cushion socket		2 per year				X		
L5647	Addition to lower extremity, below knee, suction socket		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5648	Addition to lower extremity, above knee, air cushion socket		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L5649	Addition to lower extremity, ischial containment/narrow M-L socket		2 per year				X		Prior Authorization
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket		2 per year				X		
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame		2 per year				X		Prior Authorization
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket		2 per year				X		
L5654	Addition to lower extremity, socket insert; Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)		2 per year				X		
L5655	Addition to lower extremity, socket insert below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)		2 per year				X		
L5656	Addition to lower extremity, socket insert, knee disarticulation, (Kemblo, Pelite, Aliplast, Plastazote or equal)		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)		2 per year				X		
L5661	Addition to lower extremity, socket insert ,multi-durometer Symes		2 per year				X		
L5665	Addition to lower extremity, socket insert multi-durometer, below knee		2 per year				X		
L5666	Addition to lower extremity; below knee, cuff suspension		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5668	Addition to lower extremity; below knee, molded distal cushion		2 per year				X		
L5670	Addition to lower extremity; below knee, molded supracondylar suspension ("PTS" or similar)		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5671	Addition to lower extremity; below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5672	Additional to lower extremity below knee, removable medial brim suspension		2 per year				X		
L5673	Additional to lower extremity below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	K0556	2 per year				X		
L5676	Additional to lower extremity below knee, knee joints, single axis, pair		2 pair per year				X		
L5677	Additional to lower extremity below knee, knee joints, polycentric, pair		2 pair per year				X		
L5678	Additional to lower extremity below knee, joint covers, pair		2 pair per year				X		
L5679	Additional to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	K0557	2 per year				X		
L5680	Additional to lower extremity below knee, thigh lacer, non-molded		2 per year				X		
L5681	Additional to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)	K0558	2 per year				X		Prior Authorization
L5682	Additional to lower extremity below knee, thigh lacer, gluteal/ischial, molded		2 per year				X		
L5683	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)	K0559	2 per year				X		Prior Authorization
L5684	Addition to lower extremity, below knee, fork strap		2 per year				X		
L5685	Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each		2 per year				X		
L5686	Addition to lower extremity, below knee, back check (extension control)		2 per year				X		
L5688	Addition to lower extremity, below knee, waist belt, webbing		2 per year				X		
L5690	Addition to lower extremity, below knee, waist belt, padded and lined		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5692	Addition to lower extremity, above knee; pelvic control belt, light		2 per year				X		
L5694	Addition to lower extremity, pelvic control belt, padded and lined		2 per year				X		
L5695	Addition to lower extremity, pelvic control, sleeve suspension, neoprene or equal, each		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5696	Addition to lower extremity, above knee or knee disarticulation; pelvic joint		2 per year				X		
L5697	Addition to lower extremity, pelvic band		2 per year				X		
L5698	Addition to lower extremity, Silesian bandage		2 per year				X		
L5699	All lower extremity prostheses, shoulder harness		2 per year				X		
L5700	Replacement, socket; below knee, molded to patient model		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5701	Replacement, socket; above knee/knee disarticulation, including attachment plate, molded to patient model		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5702	Replacement, socket; hip disarticulation, including hip joint, molded to patient model		2 per year				X		
L5703	Ankle, symes, molded to patient model, socket without solid ankle cushion heel		2 per year						Prior Authorization
L5704	Custom shaped protective cover, below knee		4 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5705	Custom shaped protective cover, above knee		4 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5706	Custom shaped protective cover, knee disarticulation		4 per year				X		
L5707	Custom shaped protective cover, hip disarticulation		4 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5710	Addition, exoskeletal knee-shin system, single axis; manual lock		2 per year				X		
L5711	Addition, exoskeletal knee-shin system, single axis; manual lock, ultra-light material		2 per year				X		
L5712	Addition, exoskeletal knee-shin system, single axis; friction swing and stance phase control (safety knee)		2 per year				X		
L5714	Addition, exoskeletal knee-shin system, single axis; variable friction swing phase control		2 per year				X		
L5716	Addition, exoskeletal knee-shin system, polycentric; mechanical stance phase lock		2 per year				X		
L5718	Addition, exoskeletal knee-shin system, single axis; friction swing and stance phase control		2 per year				X		
L5722	Addition, exoskeletal knee-shin system, single axis; pneumatic swing, friction stance phase control		2 per year				X		Prior Authorization
L5724	Addition, exoskeletal knee-shin system, single axis; fluid swing phase control		2 per year				X		Prior Authorization
L5726	Addition, exoskeletal knee-shin system, single axis; external joints fluid swing phase control		2 per year				X		Prior Authorization
L5728	Addition, exoskeletal knee-shin system, single axis; fluid swing and stance phase control		2 per year				X		Prior Authorization
L5780	Addition, exoskeletal knee-shin system, single axis; pneumatic/hydra pneumatic swing phase control		2 per year				X		Prior Authorization
L5781	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system								Not Covered
L5782	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty								Not Covered
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)		2 per year				X		Prior Authorization
L5810	Addition, endoskeletal knee-shin system, single axis; manual lock		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L5811	Addition, endoskeletal knee-shin system, single axis; manual lock, ultra-light material		2 per year				X		Prior Authorization
L5812	Addition, endoskeletal knee-shin system, single axis; friction swing and stance phase control (safety knee)		2 per year				X		
L5814	Addition, endoskeletal knee-shin system, polycentric; hydraulic swing phase control, mechanical stance phase lock		2 per year				X		Prior Authorization
L5816	Addition, endoskeletal knee-shin system, polycentric; mechanical stance phase lock		2 per year				X		
L5818	Addition, endoskeletal knee-shin system, polycentric; friction swing and stance phase control		2 per year				X		
L5822	Addition, endoskeletal knee-shin system, single axis; pneumatic swing, friction stance phase control		2 per year				X		Prior Authorization
L5824	Addition, endoskeletal knee-shin system, single axis fluid swing phase control		2 per year				X		Prior Authorization
L5826	Addition, endoskeletal knee-shin system, single axis hydraulic swing phase control, with miniature high activity frame		2 per year				X		
L5828	Addition, endoskeletal knee-shin system, single axis fluid swing and stance phase control		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5830	Addition, endoskeletal knee-shin system, single axis pneumatic swing phase control		2 per year				X		Prior Authorization
L5840	Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic/swing phase control		2 per year				X		Prior Authorization
L5845	Addition, endoskeletal, knee-shin system; stance flexion feature, adjustable		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5848	Addition to endoskeletal, knee-shin system, hydraulic stance extension, dampening feature, with or without adjustability								Not Covered
L5850	Addition, endoskeletal system; above knee or hip disarticulation, knee extension assist		2 per year				X		
L5855	Addition, endoskeletal system; hip disarticulation, mechanical hip extension assist		2 per year				X		Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s) any type								Not Covered
L5857	Additional to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type								Not Covered
L5858	Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type								Not Covered
L5910	Addition, endoskeletal system, below knee, alignable system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock		2 per year				X		Prior Authorization
L5930	Addition, endoskeletal system; high activity knee control frame		2 per year				X		Prior Authorization
L5940	Addition, endoskeletal system; below knee, ultra-light material (titanium, carbon fiber or equal)		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5950	Addition, endoskeletal system; above knee, ultra-light material (titanium, carbon fiber or equal)		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5960	Addition, endoskeletal system; hip disarticulation, ultra-light material (titanium, carbon fiber or equal)		2 per year				X		Prior Authorization
L5962	Addition, endoskeletal system; below knee, flexible protective outer surface covering system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5964	Addition, endoskeletal system; above knee, flexible protective outer surface covering system		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L5966	Addition, endoskeletal system; hip disarticulation, flexible protective outer surface covering system		2 per year				X		Prior Authorization
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature								Not Covered
L5970	All lower extremity prostheses; foot, external keel, SACH foot		2 per year				X		
L5971	All lower extremity prosthesis, solid ankle cushion heel (SACH) foot, replacement only		2 per year				X		
L5972	All lower extremity prosthesis, flexible keel foot (Safe, Sten, Bock Dynamic or equal)		2 per year				X		
L5974	All lower extremity prosthesis, foot, single axis ankle/foot		2 per year				X		
L5975	All lower extremity prosthesis; combination single axis ankle and flexible keel foot		2 per year				X		
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)		2 per year				X		
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot		2 per year				X		Prior Authorization
L5979	All lower extremity prostheses, multiaxial ankle, dynamic response foot, one piece system		2 per year				X		Prior Authorization
L5980	All lower extremity prostheses, flex foot system		2 per year				X		Prior Authorization
L5981	All lower extremity prostheses, flex-walk system or equal		2 per year				X		Prior Authorization
L5982	All exoskeletal lower extremity prostheses, axial rotation unit		2 per year				X		Prior Authorization
L5984	All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon		2 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L5986	All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)		2 per year				X		Prior Authorization
L5987	All lower extremity prostheses, shank foot system with vertical loading pylon		2 per year				X		Prior Authorization
L5988	Addition to lower limb prosthesis, vertical shock reducing pylon feature		2 per year				X		Prior Authorization
L5989	Addition to lower extremity prosthesis, endoskeletal system, pylon with integrated electronic force sensors								Code Closed by CMS 12/31/2004
L5990	Addition to lower extremity prosthesis, user adjustable heel height		2 per year				X		
L5993	Addition to lower extremity prosthesis, heavy duty feature, foot only, (for patient weight greater than 300 lbs)		2 per year				X		Prior Authorization Cost Invoice Required New Code 01/01/2007
L5994	Addition to lower extremity prosthesis, heavy duty feature, knee only, (for patient weight greater than 300 lbs)		2 per year				X		Prior Authorization Cost Invoice Required New Code 01/01/2007
L5995	Addition to lower extremity prosthesis, heavy duty feature (for patient weight > 300 lbs.)								Not Covered
L5999	Lower extremity prosthesis, not otherwise specified						X		Prior Authorization Cost Invoice
L6000	Partial hand, Robin-Aids; thumb remaining (or equal)		2 per year				X		
L6010	Partial hand, Robin-Aids; little and/or ring finger remaining (or equal)		2 per year				X		
L6020	Partial hand, Robin-Aids; no finger remaining (or equal)		2 per year				X		
L6025	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device								Not Covered
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad		2 per year				X		
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad		2 per year				X		
L6100	Below elbow, molded socket; flexible elbow hinge, triceps pad		2 per year				X		
L6110	Below elbow, (Muenster or Northwestern Suspension types)		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L6120	Below elbow, molded double wall split socket; set-up hinges, half cuff		2 per year				X		
L6130	Below elbow, molded double wall split socket stump activated locking hinge, half cuff		2 per year				X		
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm		2 per year				X		
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm		2 per year				X		
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm		2 per year				X		
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm		2 per year				X		
L6310	Shoulder disarticulation, passive restoration; (complete prosthesis)		2 per year				X		
L6320	Shoulder disarticulation, passive restoration; (complete prosthesis)		2 per year				X		
L6350	Interscapular thoracic; molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm		2 per year				X		
L6360	Interscapular thoracic passive restoration (complete prosthesis)		2 per year				X		
L6370	Interscapular thoracic passive restoration (shoulder cap only)		2 per year				X		
L6380	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change; wrist disarticulation or below elbow		1 per year				X		
L6382	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change; elbow disarticulation or above elbow		1 per year				X		
L6384	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change; shoulder disarticulation or interscapular thoracic		1 per year				X		
L6386	Immediate post surgical or early fitting; each additional cast change and realignment		1 per year				X		
L6388	Immediate post surgical or early fitting; application of rigid dressing only		1 per year				X		
L6400	Below elbow, molded socket endoskeletal system, including soft prosthetic tissue shaping		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2 per year				X		
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2 per year				X		
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2 per year				X		
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2 per year				X		
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model		1 per year				X		
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed		1 per year				X		
L6584	Preparatory, elbow disarticulation or above elbow; single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model		1 per year				X		
L6586	Preparatory, elbow disarticulation or above elbow; single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed		1 per year				X		
L6588	Preparatory, shoulder disarticulation or interscapular thoracic; single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model		1 per year				X		
L6590	Preparatory, shoulder disarticulation or interscapular thoracic; single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed		1 per year				X		
L6600	Upper extremity additions, polycentric hinge, pair		2 per year				X		
L6605	Upper extremity additions, single pivot hinge, pair		2 per year				X		
L6610	Upper extremity additions, flexible metal hinge, pair		2 per year				X		
L6611	Addition to upper extremity prosthesis, external powered, additional switch, any type		2 per year				X		Prior Authorization New Code 01/01/2007
L6615	Upper extremity additions, disconnect locking wrist unit		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L6616	Upper extremity additions, additional disconnect insert for locking wrist unit, each		2 per year				X		
L6620	Upper extremity additions, flexion/extension wrist unit, with or without friction		2 per year				X		
L6621	Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device		2 per year				X		Prior Authorization
L6623	Upper extremity additions, spring assisted rotational wrist unit with latch release		2 per year				X		
L6624	Upper extremity addition, flexion/extension and rotation wrist unit		2 per year				X		Prior Authorization New Code 01/01/2007
L6625	Upper extremity additions, rotation wrist unit with cable lock		2 per year				X		
L6628	Upper extremity additions, quick disconnect hook adapter, Otto Bock or equal		2 per year				X		
L6629	Upper extremity additions, quick disconnect lamination collar with coupling piece, Otto Bock or equal		2 per year				X		
L6630	Upper extremity additions, stainless steel, any wrist		2 per year				X		
L6632	Upper extremity additions, latex suspension sleeve, each		2 per year				X		
L6635	Upper extremity additions, lift assist for elbow		2 per year				X		
L6637	Upper extremity additions, nudge control elbow lock		2 per year				X		
L6638	Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow		2 per year				X		Prior Authorization
L6639	Upper extremity addition, heavy duty feature, any elbow		2 per year				X		Prior Authorization New Code 01/01/2007
L6640	Upper extremity addition to prosthesis, shoulder abduction joint, pair		2 per year				X		
L6641	Upper extremity addition to prosthesis, excursion amplifier, pulley type		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L6642	Upper extremity addition to prosthesis, excursion amplifier, lever type		2 per year				X		
L6645	Upper extremity addition to prosthesis, shoulder flexion - abduction joint, each		2 per year				X		
L6646	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external power system								Not Covered
L6647	Upper extremity addition, shoulder lock mechanism, body powered actuator								Not Covered
L6648	Upper extremity addition, shoulder lock mechanism, external powered actuator								Not Covered
L6650	Upper extremity addition, shoulder universal joint, each		2 per year				X		
L6655	Upper extremity addition, standard control cable, extra		2 per year				X		
L6660	Upper extremity addition, heavy duty control cable		2 per year				X		
L6665	Upper extremity addition, Teflon, or equal, cable lining		2 per year				X		
L6670	Upper extremity addition, hook to hand, cable adapter		2 per year				X		
L6672	Upper extremity addition, harness, chest or shoulder, saddle type		2 per year				X		
L6675	Upper extremity addition, harness, (e.g., figure of eight type), single cable design		2 per year				X		
L6676	Upper extremity addition, harness, (e.g., figure of eight type), for dual cable design		2 per year				X		
L6677	Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow		2 per year				X		
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow		2 per year				X		
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L6684	Upper extremity addition, test socket, should disarticulation or interscapular thoracic		2 per year				X		
L6686	Upper extremity addition, suction socket		2 per year				X		
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation		2 per year				X		
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation		2 per year				X		
L6689	Upper extremity addition, frame type socket, should disarticulation		2 per year				X		
L6690	Upper extremity addition, frame type socket, interscapular thoracic		2 per year				X		
L6691	Upper extremity addition, removable insert, each		2 per year				X		
L6692	Upper extremity addition, silicone gel insert or equal, each		2 per year				X		
L6693	Upper extremity addition, locking elbow, forearm counterbalance		2 per year				X		
L6694	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism		2 per year				X		Prior Authorization
L6695	Additional to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism		2 per year				X		Prior Authorization
L6696	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)		2 per year				X		Prior Authorization
L6697	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)		2 per year				X		Prior Authorization
L6698	Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes, socket insert						X		Prior Authorization
L6700	Terminal device, hook, Dorrance, or equal, model #3		2 per year				X		Discontinued by CMS 12/31/2006
L6703	Terminal device, passive hand/mitt, any material, any size		2 per year				X		Prior Authorization New Code 01/01/2007

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L6704	Terminal device, sport/recreational/work attachment, any material, any size	L6700 L6720 L6725 L6730							Not Covered
L6705	Terminal device, hook, Dorrance, or equal, model #5		2 per year				X		Discontinued by CMS 12/31/2006
L6706	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined	L6705 L6710 L6735 L6740 L6745 L6750 L6755 L6765 L6770 L6775 L6780 L6790	2 per year						Prior Authorization New Code 01/01/2007
L6707	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined	L6800 L6806 L6807 L6808	2 per year				X		Prior Authorization New Code 01/01/2007
L6708	Terminal device, hand, mechanical, voluntary opening, any material, any size	L6825 L6835 L6840 L6845 L6850 L6855 L6860 L6867 L6872 L6873 L6880	2 per year				X		Prior Authorization New Code 01/01/2007
L6709	Terminal device, hand, mechanical, voluntary closing, any material, any size	L6830 L6875	2 per year				X		Prior Authorization New Code 01/01/2007
L6710	Terminal device, hook, Dorrance, or equal, model #5X		2 per year				X		Discontinued by CMS 12/31/2006
L6715	Terminal device, hook, Dorrance, or equal, model #5XA		2 per year				X		Discontinued by CMS 12/31/2006
L6720	Terminal device, hook, Dorrance, or equal, model #6		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6725	Terminal device, hook, Dorrance, or equal, model #7		2 per year				X		Discontinued by CMS 12/31/2006
L6730	Terminal device, hook, Dorrance, or equal, model #7LO		2 per year				X		Discontinued by CMS 12/31/2006
L6735	Terminal device, hook, Dorrance, or equal, model #8		2 per year				X		Discontinued by CMS 12/31/2006
L6740	Terminal device, hook, Dorrance, or equal, model #8X		2 per year				X		Discontinued by CMS 12/31/2006
L6745	Terminal device, hook, Dorrance, or equal, model #88X		2 per year				X		Discontinued by CMS 12/31/2006
L6750	Terminal device, hook, Dorrance, or equal, model #10P		2 per year				X		Discontinued by CMS 12/31/2006
L6755	Terminal device, hook, Dorrance, or equal, model #10X		2 per year				X		Discontinued by CMS 12/31/2006
L6765	Terminal device, hook, Dorrance, or equal, model #12P		2 per year				X		Discontinued by CMS 12/31/2006

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L6770	Terminal device, hook, Dorrance, or equal, model #99X		2 per year				X		Discontinued by CMS 12/31/2006
L6775	Terminal device, hook, Dorrance, or equal, model #555		2 per year				X		Discontinued by CMS 12/31/2006
L6780	Terminal device, hook, Dorrance, or equal, model #55555		2 per year				X		Discontinued by CMS 12/31/2006
L6790	Terminal device, hook, Accu hook, or equal		2 per year				X		Discontinued by CMS 12/31/2006
L6795	Terminal device, hook-2 load, or equal		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6800	Terminal device, hook-APRL, VC or equal		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6805	Terminal device, modifier wrist flexion unit		2 per year				X		
L6806	Terminal device; hook, TRS grip, grip III, VC or equal		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6807	Terminal device; hook grip I, grip II, VC or equal		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6808	Terminal device; hook TRS adept, infant or child, VC or equal		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6809	Terminal device; hook TRS Super sport, passive		2 per year				X		Discontinued by CMS 12/31/2006
L6810	Terminal device; pincher tool, Otto Bock or equal		2 per year				X		
L6825	Terminal device, hand, Dorrance, VO		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6830	Terminal device, hand, APRL, VC		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6835	Terminal device, hand, Sierra, VO		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6840	Terminal device, hand, Becker imperial		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6845	Terminal device, hand, Becker lock grip		2 per year				X		Discontinued by CMS 12/31/2006
L6850	Terminal device, hand, Becker Plylite		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L6855	Terminal device, hand, Robin-Aids, VO		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6860	Terminal device, hand, Robin-Aids, VO soft		2 per year				X		Discontinued by CMS 12/31/2006
L6865	Terminal device, hand, passive hand		2 per year				X		Discontinued by CMS 12/31/2006
L6867	Terminal device, hand, Detroit infant hand (mechanical)		2 per year				X		Discontinued by CMS 12/31/2006
L6868	Terminal device, hand, passive infant hand (Steeper, Hosmer or equal)		2 per year				X		Discontinued by CMS 12/31/2006
L6870	Terminal device, hand, child mitt		2 per year				X		Discontinued by CMS 12/31/2006
L6872	Terminal device, hand, NYU child hand		2 per year				X		Discontinued by CMS 12/31/2006
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal		2 per year				X		Discontinued by CMS 12/31/2006
L6875	Terminal device, hand, Bock, VC		2 per year				X		Prior Authorization Discontinued by CMS 12/31/2006
L6880	Terminal device, hand, Bock, VO		2 per year				X		Discontinued by CMS 12/31/2006
L6881	Automatic grasp feature, addition to upper limb prosthetic terminal device								Not covered
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device								Not Covered
L6883	Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power						X		Prior Authorization
L6884	Replacement socket, above elbow, disarticulation, molded to patient model for use with or without external power						X		Prior Authorization
L6885	Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power						X		Prior Authorization
L6890	Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment		4 per year				X		
L6895	Addition to upper extremity prosthesis, glove for terminal device, any material, custom glove		2 per year				X		
L6900	Hand restoration (casts, shading and measurements included), partial hand; with glove, thumb or one finger remaining		2 per year				X		Prior Authorization
L6905	Hand restoration (casts, shading and measurements included), partial hand; with glove, multiple fingers remaining		2 per year				X		Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L6910	Hand restoration (casts, shading and measurements included), partial hand; with glove, no fingers remaining		2 per year				X		Prior Authorization
L6915	Hand restoration (shading and measurements included), replacement glove for above		2 per year				X		
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal; switch, cables, two batteries and one charger, switch control of terminal device		1 per 3 years				X		Prior Authorization
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal; electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		1 per 3 years				X		Prior Authorization
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell; Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device		1 per 3 years				X		Prior Authorization
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell; Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		1 per 3 years				X		Prior Authorization
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm; Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device		1 per 3 years				X		Prior Authorization
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm; Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		1 per 3 years				X		Prior Authorization
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm; Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device		1 per 3 years				X		Prior Authorization
L6955	Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		1 per 3 years				X		Prior Authorization
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm; Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device		1 per 3 years				X		Prior Authorization
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm; Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		1 per 3 years				X		Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L6970	Interscapular thoracic, external power, molded inner socket removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm; Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device		1 per 3 years				X		Prior Authorization
L6975	Interscapular thoracic, external power, molded inner socket removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm; Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		1 per 3 years				X		Prior Authorization
L7007	Electric hand, switch or myoelectric controlled, adult	L7010 L7015 L7025	2 per year				X		Prior Authorization New Code 01/01/2007
L7008	Electric hand, switch or myoelectric, controlled, pediatric	L7030					X		Prior Authorization New Code 01/01/2007
L7009	Electric hook, switch or myoelectric controlled, adult	L7020 L7035					X		Prior Authorization New Code 01/01/2007
L7010	Electronic hand; Otto Bock, Steeper or equal, switch controlled		1 per 3 years				X		Prior Authorization Discontinued by CMS 12/31/2006
L7015	Electronic hand; System Teknik, Variety Village or equal, switch controlled						X		Prior Authorization Discontinued by CMS 12/31/2006
L7020	Electronic Greifer, Otto Bock or equal, switch controlled		1 per 3 years				X		Prior Authorization Discontinued by CMS 12/31/2006
L7025	Electronic hand; Otto Bock or equal, myoelectronically controlled		1 per 3 years				X		Prior Authorization Discontinued by CMS 12/31/2006
L7030	Electronic hand; System Teknik, Variety Village or equal, myoelectronically controlled		1 per 3 years				X		Prior Authorization Discontinued by CMS 12/31/2006
L7035	Electronic Greifer, Otto Bock or equal, myoelectronically controlled		1 per 3 years				X		Prior Authorization Discontinued by CMS 12/31/2006
L7040	Prehensile actuator; Hosmer or equal, switch controlled		1 per 3 years				X		Prior Authorization
L7045	Electronic hook, child, Michigan or equal, switch controlled		1 per 3 years				X		Prior Authorization
L7170	Electronic elbow; Hosmer or equal, switch controlled		1 per 3 years				X		Prior Authorization
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device		1 per 5 years				X		Prior Authorization
L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device								Not Covered
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled		1 per 3 years				X		Prior Authorization

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	GO	G5	G7	G9	PE	SPECIAL INSTRUCTIONS
L7186	Electronic elbow, child, Variety Village or equal, switch controlled		1 per 3 years				X		Prior Authorization
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled		1 per 3 years				X		Prior Authorization
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled		1 per 3 years				X		Prior Authorization
L7260	Electronic wrist rotator; Otto Bock or equal		1 per 3 years				X		Prior Authorization
L7261	Electronic wrist rotator; for Utah arm		1 per 3 years				X		Prior Authorization
L7266	Servo control, Steeper or equal		1 per 3 years				X		Prior Authorization
L7272	Analogue control, UNB or equal		1 per 3 years				X		Prior Authorization
L7274	Proportional control, 6-12 volt, Liberty, Utah or equal		1 per 3 years				X		Prior Authorization
L7360	Six-volt battery, Otto Bock , each		1 per 2 years				X		Prior Authorization
L7362	Battery charger, six-volt, each		1 per 2 years				X		Prior Authorization
L7364	Twelve-volt battery, each		1 per 2 years				X		Prior Authorization
L7366	Battery charger, twelve-volt, each		1 per 2 years				X		Prior Authorization
L7367	Lithium ion battery, replacement								Not Covered
L7368	Lithium ion battery charger								Not Covered
L7400	Addition to upper extremity prosthesis; below elbow wrist disarticulation, ultralight material (titanium, carbon fiber or equal)		2 per year				X		
L7401	Addition to upper extremity prosthesis; above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)		2 per year				X		
L7402	Addition to upper extremity prosthesis; shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal)		2 per year				X		
L7403	Addition to upper extremity prosthesis; below elbow wrist disarticulation, acrylic material		2 per year				X		
L7404	Addition to upper extremity prosthesis; above elbow disarticulation, acrylic material		2 per year				X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L7405	Addition to upper extremity prosthesis; shoulder disarticulation/interscapular thoracic, acrylic material		2 per year				X		
L7499	Upper extremity prosthesis, not otherwise specified						X		Prior Authorization Cost Invoice
L7500	Repair of prosthetic device, hourly rate (excludes V5335 repair of oral or laryngeal prosthesis or artificial larynx)		12 units per year				X		
L7510	Repair of prosthetic device, repair or replace minor parts		1 unit per year				X		
L7520	Repair prosthetic device, labor component, per 15 minutes		24 units per 6 months				X		
L7600	Prosthetic donning sleeve, any material , each						X		Prior Authorization Cost Invoice
L7611	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined, or unlined, pediatric		2 units per year				X		Prior Authorization Covered for members up to age 16 Cost Invoice New Code 01/01/2008
L7612	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric		2 units per year				X		Prior Authorization Covered for members up to age 16 Cost Invoice New Code 01/01/2008
L7613	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric		2 units per year				X		Prior Authorization Covered for members up to age 16 Cost Invoice New Code 01/01/2008
L7614	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric		2 units per year				X		Prior Authorization Covered for members up to age 16 Cost Invoice New Code 01/01/2008
L7621	Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined		2 units per year				X		Prior Authorization Cost Invoice New Code 01/01/2008
L7622	Terminal device, hook or hand, heavy duty, mechanical voluntary closing any material, any size lined or unlined		2 units per year				X		Prior Authorization Cost Invoice New Code 01/01/2008
L8000	Breast prosthesis; mastectomy bra		4 per year			X	X		
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral		2 per year			X	X		
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral		2 per year			X	X		
L8010	Breast prosthesis mastectomy sleeve		3 per year			X	X		

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy		2 per year			X	X		
L8020	Breast prosthesis; mastectomy form		2 per year			X	X		
L8030	Breast prosthesis silicone or equal		2 per year			X	X		
L8035	Custom breast prosthesis, post mastectomy, molded to patient model		2 per year			X	X		Prior Authorization
L8039	Breast prosthesis, not otherwise specified					X	X		Prior Authorization Cost Invoice
L8040	Nasal prosthesis, provided by a nonphysician								Not Covered
L8100	Gradient compression stocking, below knee, 18-30 mmHg, each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8110	Gradient compression stocking, below knee, 30-40 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8120	Gradient compression stocking, below knee, 40-50 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8130	Gradient compression stocking, thigh length, 18-30 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8140	Gradient compression stocking, thigh length, 30-40 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8150	Gradient compression stocking, thigh length, 40-50 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8160	Gradient compression stocking, full length/chap style, 18-30 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8170	Gradient compression stocking, full length/chap style, 30-40 mmHg. each		4 per 6 months	X	X				Closed by CMS 12/31/2005
L8190	Gradient compression stocking, waist length, 18-30 mmHg. each		2 per 6 months	X	X				Closed by CMS 12/31/2005
L8210	Gradient compression stocking, custom made			X	X				Closed by CMS 12/31/2005
L8230	Gradient compression stocking, garter belt		2 per year	X	X				Closed by CMS 12/31/2005
L8239	Gradient compression stocking, not otherwise specified			X	X				Closed by CMS 12/31/2005
L8300	Truss, single with standard pad		4 per year	X	X				
L8310	Truss, double with standard pad		4 per year	X	X				
L8320	Truss, addition to standard pad, water pad		4 per year	X	X				
L8330	Truss, addition to standard pad, scrotal pad		4 per year	X	X				

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
L8400	Prosthetic sheath, below knee, each		12 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8410	Prosthetic sheath, above knee, each		6 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8415	Prosthetic sheath, upper limb, each		10 per year				X		
L8417	Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each		4 per year				X		Prior Authorization
L8420	Prosthetic sock, multiple ply, below knee, each		12 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8430	Prosthetic sock, multiple ply, above knee, each		12 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8435	Prosthetic sock, multiple ply, upper limb, each		6 per year				X		
L8440	Prosthetic shrinker; below knee, each		4 per year				X		
L8460	Prosthetic shrinker; above knee, each		4 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8465	Prosthetic shrinker; upper limb, each		4 per year				X		
L8470	Prosthetic sock, single ply, fitting; below knee, each		24 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8480	Prosthetic sock, single ply, fitting; above knee, each		12 per year				X		Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07
L8485	Prosthetic sock, single ply, fitting; upper limb, each		10 per year				X		
L8499	Unlisted procedure for miscellaneous prosthetic services						X		Prior Authorization Cost Invoice

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	G O	G 5	G 7	G 9	P E	SPECIAL INSTRUCTIONS
S1040	Cranial remolding orthosis, rigid, with soft interface material, custom fabricated, includes fitting and adjustments			X					Prior Authorization Medical Necessity Review will be based on InterQual Criteria effective 03/01/07

CHAPTER 516
ORTHOTIC/PROSTHETIC SERVICES
MARCH 1, 2007

ATTACHMENT II
WVMI MEDICAID ORTHOTIC/PROSTHETIC
AUTHORIZATION REQUEST FORM
PAGE 1 OF 3

REVISED JANUARY 1, 2008

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity for Orthotics and Prosthetics

SECTION I

MEMBER DATA	**SERVICING PROVIDER**	**CMN STATUS**
ID#_____	**Provider #**_____	____**Initial**
Name_____	**Provider Name**_____	____**Revised**
D.O.B._____	**Contact Person**_____	____**Renewed**
Phone # (___)_____	**Phone #** (____)_____	

SECTION II - MEMBER INFORMATION

Answer all questions that are applicable to **ORTHOTIC / PROSTHETIC** services being requested. If answer is Yes, you must describe/ attach additional information to support medical justification. (Additional Space on Reverse).

DOES PATIENT:	YES	NO
1. Have impaired mobility?	____	____
2. Have impaired endurance?	____	____
3. Have restricted activity?	____	____
4. Have skin break down? (Describe site, Size, Depth, and Drainage on reverse side of form)	____	____
5. Have impaired respiration? (Identify most recent PO2/ saturation level for Pts. on O2) (Room air)	____	____
6. Require assistance with ADL's?	____	____
7. Have impaired speech?	____	____
8. Is item suitable for use in home and does the Patient/Care giver demonstrate willingness and ability to use the equipment?	____	____

ICD 9- CODES **CLINICAL DIAGNOSIS** **DATE OF ONSET**

_____
_____
_____
_____
_____

DATE PATIENT LAST EXAMINED BY PRACTITIONER: _____/_____/_____

FUNCTIONAL LEVEL: (As per Medicare standard classification for specific prosthetic components) Attach supporting documentation.

_____Level – 0 ____Level – I __Level - II __Level - III __Level - IV

SECTION III (Additional space on reverse side)

Begin Service Date	HCPCS Code	Description of HCPCS Code	Length of Time Needed	Quantity Ordered	Frequency of Use	Dollar Amount

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective," and is not a convenience item for the recipient, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

_____ _____ ____/____/_____ _____ (___)_____

Prescribing Practitioner's Name Practitioner's Signature Date ID# Phone #

(Please Print)

Form Number: O/P Chp500 01/08/04

CONFIDENTIAL

WVMI / WV MEDICAID ORTHOTICS / PROSTHETICS AUTHORIZATION REQUEST FORM

Fax: 304-346-8185 **or** 1-877-762-4338 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____Member's Medicaid ID #:_____ Date of Birth: _____

(If Medicaid not primary, denial for requested items must be attached)

A. **Member** Name: _____ Phone: (_____)_____

Member Address: _____

B. **Prescribing Practitioner N**ame: _____ Provider #_____

Mailing Address: _____

Contact Name: _____ Phone: (_____) _____ Ext: _____

Fax: (_____) _____ E-Mail Address:_____

C. Name of **Supplier** Selected by Member: _____

Physical Address: _____

Provider #: _____ Contact Name: _____

Phone: (_____)_____ Fax: (_____)_____

D.

ICD-9 Codes	Clinical Diagnosis	Date of Onset

E.

* Status	HCPCS Code	Item Description	Quantity Requested	* Quantity Approved

***** WVMI Use Only. Key: P=Pending, D=Denied

F. **Clinical Indication(s) for Item(s) requested:** _____

_____

_____

_____

G. **Functional Levels (circle one): I II III IV**

Date last seen by physician: _____

H. **PRACTITIONER CERTIFICATION**

I certify that I have examined the member within the past 6 months and the equipment and/or supplies requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not a convenience item for the member or any individual involved with the member's care. I certify that the member or his representative have been offered a choice of vendors.

_____ _____ _____

Prescribing Practitioner's Signature ***(required)*** Medicaid ID# Date

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

For WVMI Use Only:

Approved: _____ Authorization Number: _____ Date: _____

DENIED: _____ DETAILED LETTER TO FOLLOW

NOTICE OF CONFIDENTIALITY The information contained in this facsimile is legally privileged and confidential and only for the use of the intended recipient. If you have received this in error you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. Please immediately notify us by phone at 1-800-642-8686, ext. 3273 and confirm the original message has been destroyed. Thank you.

CHAPTER 517 - COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	XXXX	January 1, 2014

Table of Contents

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for payment of Personal Care services provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein are regulations governing the provision of Personal Care services by Personal Care providers in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of *Title XIX* of the *Social Security Act* and *Chapter 9* of the *Public Welfare Law of West Virginia*.

All forms for this program can be found at http://www.dhhr.wv.gov/bms/Pages/default.aspx.

517.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Common Chapter 200, *Acronyms and Definitions*, of the Provider Manual. In addition, the following definitions apply to the requirements for payment of services in the Personal Care Program described in this chapter.

Abuse: the infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Activities of Daily Living (ADLs): activities that a person ordinarily performs during the course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

Anchor Date: the annual date by which the member's eligibility for continuing Personal Care services must be recertified. Anchor Date will be the first of the month in which the member's PAS determined medical eligibility.

Assisted Living Residence: any living facility, residence or place of accommodation, however named, available for four or more residents which is advertised, offered, maintained or operated by the ownership or management, whether for payment or not, for the express or implied purpose of having personal assistance or supervision, or both, provided to any residents therein who are dependent upon the services of others by reason of physical or mental impairment and who may also require nursing care at a level that is not greater than limited and intermittent nursing care as defined in the State Code §16-5D-1.

Behavioral Health Center: any inpatient, residential or outpatient facility for the care and treatment of persons with mental illness, intellectual/developmental disabilities or addiction which is operated, or licensed to operate, by the Department of Health and Human Resources.

Certificate of Need (CON): a regulatory program originally enacted in 1977 which reviews and determines the need for certain medical services, the financial feasibility, and whether the service(s) is consistent with the WV State Health Plan. For more information on the CON process please see the West Virginia Healthcare Authority web page.

Community Integration: the full participation of all people in community life.

Competency Based Curriculum: a training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas.

Direct Access: physical contact with a resident or beneficiary or access to the resident or beneficiary's property, personally identifiable information, or financial information.

Direct Care Staff: the individuals who provide the day-to-day care to Personal Care members.

Dual Services: when a Medicaid member is receiving Medicaid Waiver services and Personal Care services at the same time.

Emergency Plan: a written plan which details who is responsible for what activities in the event of an emergency, whether it is a natural, medical or man-made incident.

Environmental Maintenance: activities such as light house cleaning, making and changing the member's bed, dishwashing, and member's laundry.

Felony: a serious criminal offense punishable by imprisonment in a correctional facility.

Financial Exploitation: illegal or improper use of an elder's or incapacitated adult's resources. Obvious examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other document.

Fiscal Agent: agency contracted by the Bureau for Medical Services to verify coverage, prior authorization requirements, service limitations and practitioner information as well as pay claims.

Group Residential Facility: a facility which is owned, leased or operated by a behavioral health service provider and which provides residential services and supervision for members who are developmentally or behaviorally disabled**.**

Home and Community Based Services (HCBS): services which enable Medicaid members to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

Informal Supports: family, friends, neighbors or anyone who provides a service to a Medicaid member but is not reimbursed.

Instrumental Activities of Daily Living (IADLs): skills necessary to live independently, such as the ability to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

Legal Representative: a personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Member: a person who is eligible for Medicaid services.

Minor Child: a child under the age of 18.

Misdemeanor: a less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail.

Neglect: "the failure to provide the necessities of life to an incapacitated adult or child" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or child (WV State Code §9-6-1). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Operating Agency: the agency contracted by the Bureau for Medical Services, to manage the Personal Care Program. The Operating Agency is responsible for approving providers who have a valid Certificate of Need, assisting with member transfers when requested, monitoring and reviewing Personal Care agencies and conducting member case reviews.

Person-Centered Planning: a process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available.

Quality Management Plan: a written document which defines the acceptable level of quality, and describes how the provider will ensure this level of quality in its deliverables and work processes.

Remediation: act of correcting an error or a fault.

Representative Sample: a small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Residential Care Community: any group of seventeen (17) or more residential apartments, however named, which are part of a larger independent living community and which are advertised, offered, maintained or operated by an owner or manager, regardless of payment for the expressed or implied purpose of providing residential accommodations, personal assistance and supervision on a monthly basis to 17 or more persons who are or may be dependent upon the services of others by reason of physical or mental impairment or who may require limited and intermittent nursing care who are capable of self-preservation and are not bedfast.

Scope of Services: the range of services deemed appropriate and necessary for an individual member. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

Self-Preservation: Protection of oneself from harm or destruction.

Sexual Abuse: any act towards an incapacitated adult or child in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

1) Sexual intercourse/intrusion/contact; and
2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult or child for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or child, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult or child to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

Specialized Family Care Provider (SFCP): an individual who operates a foster-care home which has received certification through the WVDHHR Specialized Family Care Program. Both the home and the individual providing services must be certified by a Specialized Family Care Family Based Care Specialist.

Utilization Management Contractor (UMC): the contracted agent of the Bureau for Medical Services, who receives requests for Personal Care Services, determines eligibility and issues prior authorizations for Personal Care services.

517.2 PROGRAM DESCRIPTION

Personal Care services are available to assist an eligible member to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the member's home, place of employment or community. To be medically eligible for Personal Care services, Medicaid members must have three (3) deficits and require hands-on assistance/supervision/cueing in ADLs/IADLs ordered by a physician and be provided by a qualified Personal Care provider(s). Members can receive a maximum of two hundred and ten (210) hours per month based on assessed needs. Services may not solely involve ancillary tasks such as housekeeping or assistance with chores. There are no age restrictions for members of Personal Care services.

517.3 PROVIDER CERTIFICATION

In order to provide Personal Care services under West Virginia Medicaid, a provider agency must have a Certificate of Need (CON) from the WV Health Care Authority. Exempt from this provision are Senior Centers, WV licensed Comprehensive Behavioral Health Care Centers, and Specialized Family Care Providers.

After receiving a CON from the WV Health Care Authority, Personal Care provider applicants (excluding Specialized Family Care Providers) must submit a Certification Application to the Operating Agency.

In addition, applicants must submit and maintain the following:

A. A valid Certificate of Need (CON);
B. A business license issued by the State of West Virginia;
C. A federal tax identification number (FEIN)
D. A competency based curriculum for required training areas for direct care staff *(Chapter 517.8 and its subparts.);*
E. An organizational chart;
F. A list of the Board of Directors (if applicable);
G. A list of all provider staff, which includes their qualifications. *(Chapter 517.5, Chapter 517.8, Chapter 517.9 and Chapter 517.10 and all of their subparts);*
H. A list of county or counties served:

I. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances.
J. A physical office that meets the criteria outlined in *Chapter 517.3.1;*
K. Written policies and procedures for processing member grievances;
L. Written policies and procedures for processing member and staff complaints;
M. Written policies and procedures for member transfers;
N. Written policies and procedures for the discontinuation of member services;
O. Written policies and procedures to avoid conflict of interest;
P. Office space that allows for member confidentiality; and
Q. An Agency Emergency Plan (for members and for office operations).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

Following the receipt of a completed Certification Application, the Operating Agency will schedule an onsite review to verify that the applicant meets the certification requirements outlined above. Upon satisfactory completion of the onsite review, the BMS fiscal agent will provide the applicant with an enrollment packet, including the Provider Agreement. The applicant must return the Provider Agreement signed by an authorized representative to BMS. After reviewing and signing the Provider Agreement BMS will return a copy to the applicant and forward a copy to the fiscal agent. The fiscal agent will assign a provider number and send a letter informing the provider that it may begin providing and billing for Personal Care services. **No Personal Care services may be billed by a provider until receipt of this letter.** A copy of this letter is also sent to the Operating Agency.

517.3.1 OFFICE CRITERIA

Personal Care providers (excluding Specialized Family Care Providers) must designate and staff at least one physical office location. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. Be located in West Virginia;
B. Meet Americans with Disabilities Act requirements for accessibility (Refer to 28 CFR 36, as amended);
C. Be readily identifiable to the public;
D. Maintain a primary telephone that is listed under the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone);
E. Maintain a secure (Health Insurance Portability and Accountability Act (HIPAA) compliant) e-mail address for communication with BMS and the Operating Agency;
F. Have hours posted in a visible area showing the business is open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion;

G. Contain space for securely maintaining member and personnel records. (Refer to *Common Chapter 800(A), General Administration*, and *Common Chapter 300, Provider Participation Requirements*, for more information on maintenance of records); and
H. Maintain a 24-hour contact method.

When a provider is physically moving their agency to a new location, opening a satellite office, and/or proposing to expand services into another county, they must notify the Operating Agency **prior** to the change. The Operating Agency will schedule an on-site review of any new office location from which members will be served to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified.

517.4 CONTINUING CERTIFICATION

Once certified and enrolled as a Medicaid provider, Personal Care providers must continue to meet the requirements listed in *Section 517.3 and its subparts* as well as the following:

A. Employ adequate, qualified, and appropriately trained personnel who meet minimum standards as set forth in *Chapter 517.8, Chapter 517.9 and Chapter 517.10* and all of their subparts (excluding Specialized Family Care providers);
B. Provide services based on each member's individually assessed needs, including evenings and weekends;
C. Maintain adequate documentation demonstrating the time, place, and services administered, and records that demonstrate compliance with state and federal regulations, including this chapter.
D. Furnish information to BMS, or its designee, as requested. (Refer to *Common Chapter 800(A), General Administration*; *Common Chapter 800(B), Quality and Program Integrity;* and *Common Chapter 300, Provider Participation Requirements* for more information on maintenance of records;
E. Maintain a current list of members receiving Personal Care services; and
F. Comply with the Incident Management System (*Chapter 517.14 and its subparts*) and maintain an administrative file of Incident Reports.

517.5 RECORD REQUIREMENTS

Providers must meet the following record requirements:

517.5.1 MEMBER RECORDS

A. The provider must keep a file on each Medicaid member for whom the Department of Health and Human Resources is billed. Member files must contain all original and/or required documentation for services provided to the member including documentation supporting the Pre-Admission Screening (PAS), Member Assessments, Contact Notes, Plan of Care, Daily Logs, etc. Required on-site documentation may be maintained in an electronic format in accordance with Common Chapter 300, Section 320.5.

B. Original documentation on each member must be kept by the Medicaid provider for 5 years or 3 years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

517.5.2 PERSONNEL RECORDS

A. Original and legible copies of personnel documentation including training records, licensure, confidentiality agreements, Criminal Investigation Background checks (CIB) *(Chapter 517.10),* etc. must be maintained on file by the certified provider. (For Specialized Family Care providers, the Bureau for Children and Families will maintain these files.)
B. Minimum credentials for professional staff must be verified upon hire and thereafter based upon their individual professional license requirements.
C. All documentation on each staff member must be kept by the Medicaid provider in the designated office that represents the county where services were provided.
D. Verification that OIG Medicaid Exclusion List was checked as appropriate for the position as well as the WV DHHR Protective Services Record check.

In regards to all records, Certified Personal Care providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the Personal Care Program as well as requirements described in Common *Chapter 100, General Information*; Common *Chapter 300, Provider Participation; and* Common *Chapter 800(A), General Administration* of the Provider Manuals. These can be found at the BMS Web Site (http://www.dhhr.wv.gov/bms/Pages/ProviderManuals.aspx). Providers must also agree to make themselves, Board Members, their staff, and any and all records pertaining to member services and personnel records available to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

517.6 PROVIDER CERTIFICATION REVIEWS

The following applies only to providers who must meet the Operating Agency certification standards listed in *Chapter 517.3* and its subparts.

Providers are required to submit designated evidence to the Operating Agency every 12 months to document continuing compliance with all certification requirements as specified under *Chapter 517.3* and all of its subparts. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not received by the Operating Agency either prior to or on the established date a pay hold may be placed on the provider's claims until documentation is received. If after 60 days, documentation is not received steps may be taken to execute an emergency transfer of Personal Care members. If the provider wants to resume/continue service provision, they must submit all required documentation and an on-site continuing certification review will be conducted by the Operating Agency staff.

The Operating Agency will review all submitted certification documentation and provide a report to BMS. BMS may request payback for any of the certification requirements which are not met. The provider must remove employees who do not meet requirements from member homes until certification standards are met and submit required documentation to the Operating Agency. If the documentation is not received within 30 days of the request BMS may:

- Place a payment hold on all future claims until the provider can prove they meet all certification requirements; and
- Terminate the provider's participation as a Personal Care provider if all issues are not resolved within 60 calendar days of request.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

517.7 MEMBER RECORD REVIEWS

The Operating Agency will review member records using the Personal Care Monitoring tool. This tool is available on the Operating Agency's website. A representative random sample will also be utilized to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when a member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider within 30 calendar days. Providers will have 30 days to respond to draft review findings or to submit a corrective action plan if requested. Sanctions will be imposed as findings dictate.

517.8 DIRECT CARE STAFF TRAINING REQUIREMENTS

Medicaid prohibits the spouse of a member or parents of a minor child (under the age of 18) from providing Personal Care services for purposes of reimbursement.

All Personal Care direct care staff, including Specialized Family Care Providers, must be at least 18 years of age. All Personal Care direct care staff, including Specialized Family Care Providers, must have the following competency based training before providing service:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by the provider agency nurse who is a certified CPR instructor, or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by the Operating Agency and can be found on their website. All CPR courses must include a skills based demonstration.
B. First Aid – may be provided by the provider agency nurse, a certified trainer or a qualified internet provider.

C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
D. Training on assisting members with ADLs – must be provided by the provider agency nurse or a documented specialist in this content area.
E. Abuse, Neglect and Exploitation - must be provided by the provider agency nurse or a documented specialist in this content area, or a qualified internet training provider.
F. HIPAA – training must include provider agency staff responsibilities regarding securing Protected Health Information - must be provided by the provider agency nurse or a documented specialist in this content area or a qualified internet training provider.
G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the provider agency nurse or a documented specialist in this content area, or a qualified internet training provider.
H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to the member's special needs - must be provided by the provider agency nurse or a documented specialist in this content area.

Specialized Family Care Providers who are providing Personal Care Services must have a home that meets the definition of a Specialized Family Care Home as established by the Bureau for Children and Families (BCF) and must be certified by BCF, or its contractor, initially and annually thereafter. All training documentation necessary to be a certified Specialized Family Care Home must be up-to-date in accordance with the Bureau for Children and Families' Specialized Family Care policy manual.

517.8.1 ANNUAL STAFF TRAINING

CPR, First Aid, OSHA, Abuse, Neglect, Exploitation and HIPAA training must be kept current.

A. CPR is current as defined by the terms of the certifying agency.
B. First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, current is defined by the terms of that entity. If provided by the provider agency nurse certified CPR instructor, must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (Example: if First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.)
C. OSHA, Abuse, Neglect and Exploitation, and HIPAA must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)

In addition, four hours of training focused on enhancing direct care service delivery knowledge and skills must be provided annually. Member specific on-the-job-training can be counted toward this requirement.

517.8.2 TRAINING DOCUMENTATION

Documentation for training conducted by the provider agency nurse or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee. Training documentation for internet based training must include the person's name, the name of the internet provider and either a certificate or other documentation proving successful completion of the training. A card from the American Heart Association, the American Red Cross or other Operating Agency approved training entity is acceptable documentation for CPR and First Aid. All documented evidence of training for each direct care employee must be kept on file by the Personal Care provider and be available, upon request, for review by BMS or the Operating Agency. The documented evidence of training requirements for Specialized Family Care providers must be kept on file by the Bureau for Children and Families or their contractor and be available, upon request, for review by BMS or the Operating Agency.

517.9 REGISTERED NURSE QUALIFICATIONS

An RN must be employed by a certified Personal Care provider and have a current West Virginia RN license. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present. (For example – if an employee has been with the provider for three years – documentation of licensure must be present for all three years.) All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information,*) and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing Personal Care services meet the minimum qualifications. The Office of Inspector General (OIG) Medicaid Exclusion List must be checked for every RN employee prior to employment and monthly thereafter. A provider cannot employ an RN on the OIG Medicaid Exclusion List. This list can be obtained at http://exclusions.oig.hhs.gov.

517.10 CRIMINAL INVESTIGATION BACKGROUND CHECKS (CIB)

For the Personal Care Program the Criminal Investigation Background (CIB) check consists of three things:

1. A fingerprint based criminal history check conducted by the WV State Police contracted entity;
2. A check of the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities List (Medicaid Exclusion List), CNA Registry, Board of Nursing; and
3. A check of the WV DHHR Protective Services Record.

At a minimum, a state level CIB check which includes a fingerprint check must be conducted by the West Virginia State Police contracted entity initially and again every three years for all Personal Care staff who have direct access to members. If the prospective employee has lived out of state within the last five years, he/she must initiate an FBI background check.

Prior to providing any Personal Care service, the prospective employee or the employer must have initiated the fingerprint check process with the WV State Police contracted entity. “Initiated” means the prospective employee has had a live fingerprint scan taken at an approved location, or if submitting hard copies of fingerprints, the day the copies are mailed for processing. Personal Care providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing Personal Care services cannot be considered to provide services if ever convicted of:

A. Abduction;
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery;
C. Any type of felony battery;
D. Child/adult abuse or neglect;
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation;
F. Felony arson;
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
H. Felony drug related offenses within the last 10 years;
I. Felony DUI within the last 10 years;
J. Hate crimes;
K. Kidnapping;
L. Murder/ homicide;
M. Neglect or abuse by a caregiver;
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
O. Purchase or sale of a child;
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
Q. Healthcare fraud; and
R. Felony forgery.

If aware of a recent conviction or change in status appropriate action must be taken and BMS notified about the change.

The Medicaid Exclusion List must be checked for every provider agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All Personal Care provider agency staff hired after the implementation date of this manual having direct contact with members must have a WVDHHR Protective Services Record Check. These must be initiated (sent to WVDHHR) on each individual upon hire. The Authorization and

Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the *DHHR Bureau for Children and Families, Division of Children and Adult Services* or at http://www.wvdhhr.org/bcf/. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the provider agency staff's personnel file.

All payments for services provided by excluded individuals will be recovered by BMS.

517.11 VOLUNTARY AGENCY CLOSURE

A provider may terminate participation in the Personal Care Program with 30 calendar days written notification of voluntary termination. The written termination notification must be submitted to the BMS fiscal agent and to the Operating Agency. The provider must provide the Operating Agency with a complete list of all current Personal Care members that will need to be transferred.

The Operating Agency will contact the members and assist them with acquiring services through another Personal Care provider.

A joint visit, if possible, with the member will be made by both the provider agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by the Operating Agency.

The provider agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible.

517.12 INVOLUNTARY AGENCY CLOSURE

BMS may terminate a provider from participation in the Personal Care Program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Personal Care Program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to *Common Chapter 800(A), General Administration, and Common Chapter 800(B), Quality and Program Integrity* for more information on this procedure.

517.13 ADDITIONAL SANCTIONS

If BMS or the Operating Agency receives information that indicates a provider is unable to serve new members due to staffing issues, member health and safety risk, etc. or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the provider information list on the Operating Agency website until the issues are addressed to the

satisfaction of BMS. Health and safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

517.14 INCIDENT MANAGEMENT

Personal Care providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to prevent harm to the health and safety of all members served. Incidents shall be classified by the provider as one of the following:

- **Abuse/Neglect or Exploitation -** Anyone providing services to a Personal Care member who suspects an incidence of abuse or neglect, as defined in *Chapter 517.1* must report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-372-6513, 7 days a week, 24 hours day. This initial report must then be followed by a written report, submitted to the local Department of Health and Human Resources, within forty-eight (48) hours following the verbal report. An Adult Protective Services (APS) or a Child Protective Service (CPS) Worker may be assigned to investigate the suspected or alleged abuse.

- **Critical incidents** are incidents with a high likelihood of producing real or potential harm to the health and welfare of the Personal Care member. These incidents include, but are not limited to, the following:

    - Attempted suicide, or suicidal threats or gestures.
    - Suspected and/or observed criminal activity by members, members' families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
    - An unusual event such as a fall or injury of unknown origin requiring medical intervention, if abuse and neglect is not suspected.
    - A significant interruption of a major utility, such as electricity or heat in the member's residence, which compromises the health or safety of the member.
    - Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
    - Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
    - Unsafe physical environment in which the personal care direct care staff and/or other provider staff are threatened or abused, and the staff's welfare is in jeopardy.
    - Disruption of the delivery of Personal Care services, due to involvement with law enforcement authorities by the Personal Care member and/or others residing in the member's home that compromises the health or safety of the member.

- Disruption of the delivery of Personal Care services, due to involvement with law enforcement authorities by the direct care staff that compromises the health and safety of the member.
- Medication errors by a member or of his/her family member that is providing care that compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that compromises the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, which compromises the health or safety of the member.
- Any incident attributable to the failure of Personal Care provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services (APS) or Child Protective Services (CPS).

- **Simple incidents** are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse, neglect or exploitation. Examples of simple incidents include, but are not limited to, the following:

  - Minor injuries of unknown origin with no detectable pattern.
  - Dietary errors with minimal or no negative outcome.

517.14.1 INCIDENT MANAGEMENT DOCUMENTATION AND INVESTIGATION PROCEDURES

Until such time that the WV Incident Management System is available to Personal Care providers, the Incident Report form must be completed within incident reporting timeframes for each member incident that occurs. Completed incident reports must be placed in an agency administrative file and must be available for review by the Operating Agency.

The Provider Agency Director or designated Registered Nurse will immediately review each incident report. All critical, abuse, neglect or exploitation incidents must be investigated by a Registered Nurse. All incidents involving abuse, neglect and /or exploitation must be reported to Adult Protective Services (APS) or Child Protective Services (CPS) within mandated time frames. An Incident Report documenting the outcomes of the investigation must be completed and submitted to the Operating Agency within 14 calendar days of the incident.

When the WVIMS is available to Personal Care providers, the Incident Report must be entered into the WVIMS within 24 hours of learning of the incident and the follow up must be entered within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file.

Providers are to report monthly if there were no incidents in the WV IMS. Until such time that the WV IMS is available, the provider must compete the No Monthly Incidents form and place in the agency administrative file.

The WVIMS does not supersede the reporting of incidents to APS or CPS. At any time during the course of an investigation, should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS or CPS.

A provider is responsible for investigating all incidents, including those reported to APS or CPS. If requested by APS or CPS, a provider shall delay its own investigation and document such request in the online WVIMS.

517.14.2 INCIDENT MANAGEMENT TRACKING AND REPORTING

Providers must review and analyze Incident Reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the providers Quality Management Plan. The Quality Management Plan must be made available to the Operating Agency monitoring staff at the time of the provider monitoring review or upon request.

517.15 PERSONAL CARE SERVICES

Personal Care services are medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by an RN. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis. Personal Care services can be provided on a continuing basis or on episodic occasions: Services must be:

- Prescribed by a physician on the 2000 Pre-Admission Screening (PAS) tool;
- Necessary to the long-term maintenance of the member's health and safety;
- Provided pursuant to a Nursing Plan of Care developed and monitored by an RN;
- Rendered by an individual who has met the basic training requirements of this manual; and
- Prior authorized by BMS's UMC

517.16 LOCATION OF SERVICES

Personal Care Services may be delivered in the member's home, place of employment or in the community. Personal Care hours provided in the community may not exceed 20 hours per month. Hours can be used to assist the member with completion of essential errands and medical appointments.

Personal Care Services may be provided to assist eligible individuals to obtain and retain competitive employment of at least 40 hours per month. Services are designed to assist an individual with a disability perform daily activities on and off the job; these would include

activities that the individual would typically perform if he/she did not have a disability. Locations for obtaining employment may include employment agencies, human resource offices, accommodation preparation appointments, and job interview sites.

Personal Care services cannot be provided in a hospital, nursing facility, ICF/IDD site, I/DD Waiver group homes with 4 or more members, I/DD Waiver Intensively Supported Setting (ISS) homes, or any other settings in which personal assistance and/or nursing services are provided. This exclusion does not include I/DDW, ADW or TBIW member's natural homes or Specialized Family Care Homes.

517.16.1 ASSISTED LIVING RESIDENCES AND GROUP RESIDENTIAL FACILITIES

Generally, Personal Care services may not be provided in assisted living residences or in group residential facilities. However, there may be instances where the provision of Personal Care services in these types of facilities would be allowed. Before providing services in assisted living residences and/or group residential facilities the following criteria must be met:

A. Medicaid Personal Care services shall not duplicate or replace those services for which a provider is required by law or regulation to provide. By definition, assisted living residences and group residential facilities must provide a certain level of personal care services; therefore these services cannot be replaced or duplicated. This includes private pay facilities.

B. If a Medicaid member who resides in an assisted living residence or a group residential facility requests Personal Care services the following documentation must be in the member chart:

    a. A detailed itemization of all services the facility must provide according to state regulations or contract;
    b. A detailed itemization of all services the Personal Care provider will be undertaking for the member and why the additional services are necessary.
    c. This information must be submitted to the UMC as part of the prior authorization process.

517.17 SERVICES AND/OR COSTS NOT ELIGIBLE FOR REIMBURSEMENT UNDER PERSONAL CARE SERVICES

A. Room and Board Services including the provision of food, shelter, maintenance and supplies.
B. Personal Care services which have not been certified by a physician on a PAS or are not in the approved Plan of Care.
C. Hours which have not received prior authorization.
D. Supervision and other activities that are considered normal child care that is appropriate for a child of a similar age.

517.18 FAMILY MEMBER RESTRICTION

Personal Care Services cannot be provided by a member's spouse or parents of a minor child (under age 18) for purposes of reimbursement by Medicaid.

517.19 MEMBER ELIGIBILITY

Applicants for the Personal Care Program must meet all of the following criteria to be eligible for the program:

A. Be a resident of West Virginia. The individual may be discharged or transferred from a nursing home or other institution in any county of the state, or in another state, as long as his/her residence is in West Virginia.
B. Be approved as medically eligible as described in *Chapter 517.19.*
C. Meet Medicaid financial eligibility criteria for the program as determined by the county DHHR office.

517.19.1 MEDICAL ELIGIBILITY DETERMINATION

The Pre-Admission Screening (PAS) is used to certify an individual's medical eligibility for Personal Care service. The PAS may be completed by either an RN or a physician; however, it must be signed and dated by a physician. The PAS is valid for 60 days after the date of the physician's signature. If services have not begun within that 60 day period a new PAS must be conducted. A Physician Certification Form is needed if the PAS was completed by an RN. This form and the PAS must both be in the member's chart.

Following the physician's signature, the RN must sign and date the PAS and submit it to the UMC who will determine medical eligibility (*517.20 A*). The effective date of medical eligibility is the date of the physician's signature. If found ineligible, the UMC will follow procedures outlined in 517.20 B. The PAS must be completed annually in accordance with the member's anchor date to certify continuing medical eligibility for services.

517.19.2 MEDICAL ELIGIBILITY CRITERIA FOR PERSONAL CARE SERVICES

An individual must have three (3) deficits as described on the Pre-Admission Screening Form (PAS) to qualify medically for the Personal Care Program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	**Observed Level**	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)

Section	Observed Level	
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, bowel Continence, Bladder	Level 3 or higher; (must be incontinent)
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transferring	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)

An individual may also qualify for Personal Care services if he/she has two (2) functional deficits identified as listed above (items refer to PAS) and any one (1) or more of the following conditions indicated on the PAS:

Section	Observed Level
#24	Decubitus; Stage 3 or 4
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
#28	Individual is not capable of administering his/her own medications.

517.19.3 SERVICE LEVEL CRITERIA

There are two Service Levels for Personal Care services. Points will be determined as follows based on the following sections of the PAS:

Section	Description of Points
#24	Decubitus - 1 point
#25	1 point for b., c., or d.
#26	Functional Abilities: Level 1 - 0 points Level 2 - 1 point for each item **a** through **i**. Level 3 - 2 points for each item **a** through **m**

Section	Description of Points
	i (walking) must be at Level 3 or Level 4 in order to get points for **j** (wheeling) Level 4 – 1 point for **a**, 1 point for **e**, 1 point for **f**, 2 points for **g** through **m**
#27	Professional and Technical Care Needs - 1 point for continuous oxygen.
#28	Medication Administration - 1 point for b. or c.

Total number of points possible is 30.

517.19.4 SERVICE LEVEL LIMITS

The service limit for T1019 Personal Care (Direct Care) Level 1 Services is sixty (60) hours per calendar month. In the event that the PAS reflects fourteen (14) or more points as described in 517.19.3, and the member assessments fully document the need, the Personal Care Agency may request additional hours at Service Level 2.

Service Level	Points Required	Range of Hours Per Month
1	0 – 13	0 - 60
2	14-30	61-210

517.20 RESULTS OF PAS EVALUATION

A. APPROVAL

All requests for Personal Care services (Levels I and 2) must be submitted prior to the UMC and include:

- The completed APS Healthcare Prior Authorization Fax sheet;
- The PAS with the dated physician's signature and the dated provider agency's RN signature;
- The Physician Certification Form; and
- The number of months services are needed for up to a maximum of twelve (12) months or until the current PAS expires, whichever is less.

Additionally, if requesting a Service Level 2 prior authorization request, the provider must submit to the UMC:

- The completed APS Prior Authorization Fax sheet;

- The PAS with the dated physician's signature and the dated provider agency's RN signature;
- The Physician Certification form;
- Nursing Assessment and Plan of Care
- Other documentation the RN feels is relative to making a determination for a Service Level 2;
- The total number of units needed per month; and
- The number of months services are needed for up to a maximum of twelve (12) months or until the current PAS expires, whichever is less.

Service Level 1 requests will be reviewed by the Utilization Management Contractor (UMC) to ensure the three (3) required deficits in ADL's and all signatures and dates are present. Service Level 2 requests will be reviewed by UMC RN to confirm the presence of the three (3) required deficits in ADL's, and to confirm the need for Service Level 2 care. The UMC will notify the provider agency in writing within 5 working days of receipt of the request, their decision and if approved provide a prior authorization number.

Once authorization is received from the UMC, the Personal Care provider must complete the member's Personal Care Assessment and Personal Care Plan of Care, based on identified needs and member preferences, and initiate direct care services within 10 calendar days. At the time the provider receives the PAS from the physician, the RN must start to document actions on the Personal Care Initial Contact Form.

B. DENIAL

The Provider agency must submit the PAS to the Utilization Management Contractor (UMC). If the UMC determines the applicant/member does not meet medical eligibility or does not meet the criteria for the requested Service Level, the UMC will provide the applicant/member with a denial letter within 5 working days of the decision date. The letter will include: why he/she does not meet medical eligibility, a copy of the PAS, the applicable Personal Care policy manual section(s), notice of free legal services, a Request for Hearing Form to be completed if the applicant wishes to contest the decision and specific timeframes for filing an appeal.

If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, services cannot start earlier than the date of the hearing decision.

517.21 COVERED SERVICES

The following information describes the Personal Care Services and activities which are reimbursable by Medicaid. These apply to all Personal Care providers unless otherwise noted. For individuals who will receive Personal Care services as well as a Medicaid Waiver service, please see *Chapter 517.22, Provision of Dual Services.*

517.21.1 INITIAL MEMBER ASSESSMENT/REEVALUATION

Procedure Code: T1001
Service Unit: Event
Limit: 1 per year
Prior Authorization: No

Required Documentation: An initial or annual PAS signed and dated by a physician and the Agency RN, a Personal Care Assessment and a Personal Care Plan of Care. All activities must be conducted by the provider agency RN.

A. Review and submit the physician signed and dated PAS.
B. Conduct the initial and annual person centered face-to-face Personal Care Assessment, (except for dual services).
C. Development of the initial and annual Personal Care Plan of Care. The Plan of Care must be developed with the member and/or his/her legal representative and must address the member's needs and preferences.

517.21.2 ONGOING RN ASSESSMENT AND CARE PLANNING

Procedure Code: T1002
Service Unit: 15 minutes
Limit: 6 units per month
Prior Authorization: No

Required Documentation: A six month Personal Care Assessment (except for dual service members), a six month Personal Care Plan of Care, the Personal Care RN member contact form and the Personal Care Monthly Report.

A. A person centered face-to-face Personal Care Assessment must be conducted every six months. Additional Personal Care Assessments may be conducted if the member's condition indicates a need. The Personal Care Assessment must be signed and dated by the RN and the member (or legal representative).
B. The Plan of Care must consider any informal support (i.e. family, friends or community supports) that are available to address the member's needs identified on the PAS and the Personal Care Assessment. The Plan of Care must be modified as necessary to address changes in the member's condition.
C. Environmental maintenance (examples: housekeeping, washing dishes, laundry, etc.) may not exceed one-third (1/3) of the time spent providing Personal Care services.
D. The RN must monitor and assess the quality and appropriateness of the direct care service and assure that it is provided according to the Plan of Care.
E. The RN must review and sign the Personal Care Plan of Care once it is completed by the member (or legal representative), and the direct care worker, certifying all activities were performed as needed and met the member's preferences. One-on-one training of

the direct care worker by the RN is reimbursable if the purpose of the one-on-one training is to instruct the direct care staff in a specific care technique for the member. The RN must document the reason and the specific training provided on the RN contact form.

F. Submit the Personal Care Monthly Report to the Operating Agency by the sixth business day of the month.

Although the goal is to provide assistance to an individual who cannot carry out activities of daily living, when assessing and care planning, the RN assures that this goal is balanced with the goal of promoting independence and encouraging the highest possible level of function for the individual.

517.21.3 PERSONAL CARE SERVICES (DIRECT CARE SERVICES)

Procedure Code: T1019
Service Unit: 15 Minutes
Service Limit: 210 hours per month or 840 units
Prior Authorization: Yes

Required Documentation: Plan of Care signed and dated by direct care worker, provider agency RN and member (or legal representative) with a tentative schedule outlining the dates/times when the member will receive Personal Care services.

The functions of the Personal Care direct care staff include providing direct care services as defined by the Plan of Care, recording services and time spent with the member and communicating to the RN any member changes.

Personal Care direct care staff duties and responsibilities as described in the Plan of Care may include:

A. Assist member with ADLs, in the home or community.
B. Assist member with environmental tasks necessary to maintain the member in the home.
C. Assist member with completion of errands that are essential for the member to remain in the home (IADLs) — Examples: grocery shopping, medical appointments, Laundromat, and trips to the pharmacy. The member may accompany the personal care direct care staff on these errands.
D. If ADLs or IADLs tasks are provided in the community, the amount may not exceed 20 hours per month.
E. Assist members in obtaining or retaining competitive employment of at least 40 hours a month by providing Personal Care services in locations for obtaining employment such as employment agencies, human resource offices, accommodation preparation appointments, job interview sites, and work sites.
F. Report significant changes in member's condition to the RN.
G. Report any incidents to the RN. (Examples: member falls (whether direct care staff was present or not), bruises (whether direct staff knows origin or not), etc.)

H. Report any environmental hazards to the RN. (Examples: no heat, no water, pest infestation or home structural damage).
I. Prompt for self-administration of medications.
J. Maintain records as instructed by the RN.
K. Perform other duties as assigned by the RN within program guidelines.
L. Accurately complete Personal Care Plan of Care and other records as instructed by the RN.

Personal care direct care staff cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's Plan of Care. Functions/tasks that cannot be performed include, but are not limited to, the following:

A. Care or change of sterile dressings.
B. Colostomy irrigation.
C. Gastric lavage or gavage.
D. Care of tracheostomy tube.
E. Suctioning.
F. Vaginal irrigation.
G. Administer injections, including insulin.
H. Administer any medications, prescribed or over-the-counter.
I. Perform catheterizations, apply external (condom type) catheter.
J. Tube feedings of any kind.
K. Make medical judgments or give advice on medical or nursing questions.
L. Application of heat.

517.22 PROVISION OF DUAL SERVICES

Individuals who are receiving either *Aged and Disabled Waiver (ADW)* services, *Intellectual/Developmental Disabilities Waiver (I/DDW)* services or *Traumatic Brain Injury Waiver (TBIW)* services may also receive Personal Care Services, if they have unmet direct support needs and meet Personal Care criteria.

517.22.1 DUAL SERVICE PROVISION FOR ADW MEMBERS

Approval of the provision of both ADW and Personal Care services to the same person will be considered if the following criteria are met:

A. An ADW member must be receiving services at Service Level D.
B. The Personal Care RN may use the current PAS used to determine ADW eligibility. However, it must be reviewed to assure the information is current and reflective of the member's needs. If not, the Personal Care RN should complete a new one.
C. For members who receive services from an ADW provider agency the ADW Member Assessment, and the ADW Nursing Plan of Care must be used in order to determine member need of Personal Care services. For members who receive services through Personal Options the Participant Directed Service Plan must be used to determine

member need of Personal Care services. A Personal Care RN Assessment is not required.

D. For members who are receiving ADW services through an ADW provider agency the coordination of the dual service request is the responsibility of the Case Manager. This includes coordinating the planning meeting which includes the ADW RN, the Personal Care RN and the member (or legal representative).
E. For members who are receiving ADW services through Personal Options the initiation of dual service request is the responsibility of the Resource Consultant. Coordination of the dual services is the responsibility of the Personal Care RN. This includes coordinating the planning meeting with the ADW member (or legal representative), the Resource Consultant, and the Personal Care RN.
F. The Personal Care RN is responsible for development of the Personal Care Nursing Plan of Care and for submitting the prior authorization to the UMC. There must be a Personal Care Nursing Plan of Care and a Participant Directed Service Plan. Both plans must be coordinated between the two agencies providing direct services to ensure that services are not duplicated. Personal Care and ADW Personal Assistance/Homemaker services cannot be provided during the same hours on the same day. A service planning meeting between the Resource Consultant, the Personal Care RN and the Case Manager, if applicable, must be held with the member in the member's residence and documented on the "Request for Dual Service Provision" form.
G. The Resource Consultant or the ADW Case Manager, if applicable, will be responsible for assuring that the two programs are being administered according to the member needs. The Personal Care Nursing Plan of Care with a tentative schedule outlining when all direct support services (PC and Waiver) are expected to be delivered must be attached to the Plan of Care. At no time can a duplication of services occur.

517.22.2 DUAL SERVICE PROVISION FOR I/DDW MEMBERS

Approval of the provision of both I/DDW and PC Services to the same person will be considered if the following criteria are met:

A. A I/DDW member must be utilizing the maximum number of Direct Care Service hours in the Waiver program available based on the member's age and type of residence prior to applying for Personal Care. See the *I/DDW* manual (*Chapter 513*) for the definition of which services are considered to be Direct Care Services AND must have an ICAP Service Score of 1, 2, 3 or 4. Individuals in 24-hour staffed settings are not eligible for Personal Care.
B. A PAS must be completed as outlined in *Chapter 517.19 and all of its subparts* to determine medical eligibility for Personal Care services. When determining the need for Personal Care services the PAS, the ICAP as completed by the I/DD Waiver Operating Agency and the WV-BMS I/DD/05 (Individual Program Plan) must be used.
C. A Personal Care Plan of Care must be developed between the agencies providing direct care services to ensure that services are not duplicated. Personal Care and I/DDW services cannot be provided during the same hours on the same day. A service planning meeting between the I/DDW Service Coordinator and the Personal Care RN must be

held with the member and legal representative (when applicable) in the member's residence and documented on the Request for Dual Service Provision form.

D. The I/DDW Service Coordinator is responsible for coordination of the dual service request. This includes coordinating the planning meeting which must include the I/DDW Service Coordinator, the Personal Care RN, the member (or legal representative). The Service Coordinator must attach the Plan of Care to the IPP and upload the plan into the members file in CareConnection®.
E. The Personal Care RN is responsible for completing the PAS, development of the Personal Care Plan of Care and submitting the prior authorization to the UMC.
F. The I/DDW Service Coordinator will be responsible for assuring that the two programs are being administered according to the member needs and the respective plans of care. A tentative schedule will be included in the Plan of Care. At no time can a duplication of services between the two programs occur.

517.22.3 DUAL SERVICE PROVISION FOR TBIW MEMBERS

Approval of the provision of both Traumatic Brain Injury Waiver services and PC Services to the same person will be considered if the following criteria are met:

A. A TBIW member must need more than the maximum Personal Attendant Services hours in the Waiver program prior to applying for Personal Care and has direct care needs that cannot be met by the Waiver.
B. The RN may use the current PAS completed by the TBI Waiver Operating Agency to determine medical eligibility for the TBIW services. However, it must be reviewed to assure the information is current and reflective of the member's needs. If not, the Personal Care RN should complete a new one. When determining the need for Personal Care services the PAS and the TBI Member Assessment and TBIW Service Plan must be used. Personal Care services must be reflected on the member's TBIW Service Plan and tentative schedule.
C. For members who are receiving TBIW service through a TBI provider agency, the coordination of the dual service request is the responsibility of the Case Manager. This includes coordinating the planning meeting with the Personal Care RN, the Case Manager and the member and/or legal representative. If the member chooses not to have a Case Manager, the Operating Agency may assist the member in fulfilling that role.
D. For members who are receiving TBIW services through Personal Options the initiation of dual service request is the responsibility of the Resource Consultant. Coordination of the dual services is the responsibility of the Personal Care RN. This includes coordinating the planning meeting with the TBIW member (or legal representative), the Resource Consultant, and the Personal Care RN.
E. The Personal Care RN is responsible for development of the Personal Care Nursing Plan of Care and for submitting the prior authorization to the UMC.
F. There must be a Personal Care Nursing Plan of Care and a Participant Directed Service Plan. Both plans must be coordinated between the two agencies providing direct services to ensure that services are not duplicated. Personal Care and TBIW Personal

Attendant services cannot be provided during the same hours on the same day. A service planning meeting between the Resource Consultant, the Personal Care RN and the Case Manager, if applicable, must be held with the member in the member's residence and documented on the "Request for Dual Service Provision" form.

G. The Resource Consultant or the TBIW Case Manager, if applicable, will be responsible for assuring that the two programs are being administered according to the member needs. The Personal Care Nursing Plan of Care must include a tentative schedule outlining when all direct support services (PC and Waiver) are expected to be delivered. At no time can a duplication of services between the two programs occur.

517.23 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, Personal Care agencies must communicate in writing to each member (or legal representative) their right to:

A. Transfer to a different provider agency.
B. Address dissatisfaction with services through the provider agency's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding Personal Care services.
G. Access to all of their files maintained by providers.

And their responsibility to:

H. Notify the Personal Care provider within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers promptly of changes in Medicaid coverage.
J. Comply with the Plan of Care.
K. Cooperate with all scheduled in-home visits
L. Notify the Personal Care provider of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the Personal Care provider of any change of medical status or direct care need.
N. Maintain a safe home environment for the Personal Care provider to provide services.
O. Verify services were provided by initialing and signing the Plan of Care.
P. Communicate any problems with services to the Personal Care provider.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Control Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the Personal Care provider or the Adult Protective Services hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

517.24 TRANSFER TO DIFFERENT AGENCY

A Personal Care member may request a transfer to another provider agency at any time. The Operating Agency will assist with transfers if needed.

Transferring Provider Agency Responsibilities:

- To provide the receiving agency with the current PAS, the Member Assessment (Personal Care or ADW, or TBIW), Personal Care Plan of Care, Individual Program Plan, ICAP (when applicable) and Participant Directed Service Plan (when applicable). In addition, the transferring provider agency should share other documents as needed.
- To maintain all original documents for monitoring purposes.
- Continue to provide services to member until transfer process is completed.

Receiving Provider Agency Responsibilities:

- Develop the Personal Care Plan of Care within seven (7) business days.

Note: The existing Personal Care Plan of Care from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new Personal Care Plan of Care to prevent a gap in services.

517.25 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by the Operating Agency:

A. No services have been provided for 180 continuous days – example, an extended placement in long-term care or rehabilitation facility.
B. Unsafe Environment – an unsafe environment is one in which the direct care staff and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:

    1) The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal assistant direct care staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
    2) The member or other household members display an abusive use of alcohol and/or drugs or engages in the manufacture, buying and/or selling of illegal substances.
    3) The physical environment is either hazardous or unsafe.

C. The member is persistently non-compliant with the Personal Care Nursing Plan of Care.

D. Member no longer desires services (must include a signed statement from the member (or legal representative) indicating they no longer desire services). If a signature is not attainable due to death or other reason, that must be documented.

If the closure is due to an unsafe environment the Personal Care provider will contact the Operating Agency for assistance. The provider must notify APS or CPS if an unsafe situation warrants such notification.

The Request for Discontinuation of Services Form must be submitted to the Operating Agency. The Operating Agency will review all requests for a discontinuation of services. If it is an appropriate request, and the Operating Agency approves the discontinuation, the Operating Agency will send notification of discontinuation of services to the member (or legal representative). Fair hearing rights will also be provided except if the member (or legal representative) no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the Operating Agency notification letter, if the member (or legal representative) does not request a hearing. If it is an unsafe environment, services may be discontinued immediately.

All discontinuation of services (closures) must be reported on the Personal Care Monthly Report to the Operating Agency.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Personal Care Monthly Report:

A. Death
B. Moved Out of State
C. Medically Ineligible
D. Financially Ineligible

517.26 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance about the provision of services. All Personal Care providers will have a written member grievance procedure. Providers will provide members grievance procedure information and grievance forms at the time of application and annual medical eligibility re-evaluation. These forms will also be provided upon request by the member in addition to the time of application and the annual re-evaluation.

The grievance procedure consists of two levels:

A. **Level One: Personal Care Provider**
A Personal Care Provider has ten (10) business days from the date they receive a Member Grievance Form to hold a meeting, in person or by telephone with the member or their legal representative. The meeting will be conducted by the provider

agency director or their designee. The provider has five (5) days from the date of the meeting to respond in writing to the grievance.

If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the Operating Agency for a Level Two review and decision.

B. **Level Two: Operating Agency**
If a Personal Care provider is not able to address the grievance in a manner satisfactory to the member, the member may request a Level Two review. The Operating Agency will, within ten (10) business days of the receipt of the Member Grievance Form, contact the member (or legal representative if applicable) and the Personal Care provider to review the Level One decision, and issue a Level Two decision. Level Two decisions are based on Medicaid policy and/or health and safety issues.

518.00 How to Obtain Information

Service	Person or Company	Phone Number	Fax Number
Operating Agency	Bureau of Senior Services 1900 Kanawha Boulevard East Charleston, WV 25305	304-558-3317 877-987-3646	304-558-6647
Personal Care Program Manager	Bureau for Medical Services	304-356-4913	304-558-4398
Fiscal Agent	Molina Medicaid Solutions	304-888-483-0793 **(for providers)** 304-348-3380 **(for members)**	304-348-3380
Utilization Management Contractor: **Prior Authorizations**	Innovative Resource Group LLC (IRG) d/b/a APS Healthcare	866-385-8920	866-521-6882
UMC- Dual Services Provision Requests for AD Waiver and I/DD Waiver	IRG d/b/a/ APS Healthcare	800-982-6334 **(Option 3)**	866-212-5053
UMC-Dual Services Provision Requests for TBI Waiver	IRG d/b/a/ APS Healthcare	866-385-8920	866-521-6882
UMC-Specialized Family Care Home	IRG d/b/a/ APS Healthcare	866-385-8920	866-521-6882
Personal Options	Public Partnerships	888-775-9801	304-296-1932

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PERSONAL CARE SERVICES
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ATTACHMENT 3
NURSING PLAN OF CARE--7 DAY
PAGE 1 OF 2

INSTRUCTIONS

RN has choice of 7-day or 31-day plan if no prior authorization (P.A.) is needed.

If prior authorization is needed, both plans need to be completed to submit for P.A.

Both the 7 & 31 Day Plan of Care must include total amount of time plan justifies and marked for total or partial assistance.

RN signature and provider's name must be on both forms.

Activities which are non-billable in personal care should not appear on the plan of care .

Personal care standards and terms should be used when writing a plan of care.

Plan of care should reflect how member is rated on the PCMEA.

NURSING PLAN OF CARE

Agency:	Agency #:	90-Day Review Date:
Member Name:		Medicaid #:
Member Address:		
R.N. Signature:		Date:

PERSONAL CARE ACTIVITIES	Level of Services to be Provided		Daily Planned Time							Date Service Started
	Part Assist	Total Assist	Mon	Tue	Wed	Thur	Fri	Sat	Sun	
PERSONAL HYGIENE/GROOMING										
A. Grooming										
B. Bathing										
C. Toileting										
D. Dressing										
E. Laundry (incontinent)										
NON-TECH PHYSICAL ASSISTANCE										
A. Repositing/Transfer										
B. Walking										
C. Medical Equipment										
D. Assistance with Medication										
E. ROM (Per Phys. order)										
F. Vitals (Per Phys. order)										
G. Other (Per Phys. order)										
NUTRITIONAL SUPPORT										
A. Meal Prep										
B. Feeding										
C. Special Dietary Needs										
ENVIRONMENTAL										
A. Housecleaning										
B. Laundry/Ironing										
C. Making/Changing Bed										
D. Dishwashing										
E. Shopping										
F. Payment of Bills										
TOTAL NUMBER OF MINUTES: _____					TOTAL NUMBER OF UNITS: _____					

NOTE: Environmental tasks are incidental to the other tasks identified on the plan of care. The "times planned" on this plan of care are an estimate of the time/services provided to/for the MEMBER. (This excluded time/services normally provided by other members.

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PERSONAL CARE SERVICES
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ATTACHMENT 4
NURSING PLAN OF CARE--31 DAYS
PAGE 1 OF 3

INSTRUCTIONS

RN has choice of 7-day or 31-day plan if no prior authorization (P.A.) is needed.

If prior authorization is needed, both plans need to be completed to submit for P.A.

Both the 7 & 31 Day Plan of Care must include total amount of time plan justifies and marked for total or partial assistance.

RN signature and provider's name must be on both forms.

Activities which are non-billable in personal care should not appear on the plan of care .

Personal care standards and terms should be used when writing a plan of care.

Plan of care should reflect how member is rated on the PCMEA.

Nursing Plan of Care 31 Days

Member's name:	Agency & Phone Number:
Provider Name:	Approved Hours for Member:
Medicaid #:	Number of Units:
30 Day Review Completed by: RN (Please Print)	Date:
Signature of Completing RN:	

P - Partial Assistance T - Total Assistance

PERSONAL CARE TASKS

PERSONAL HYGIENE/GROOMING	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Grooming																																			
B. Bathing																																			
C. Toileting																																			
D. Dressing																																			
E. Laundry (incontinent)																																			
TOTAL																																			

NON-TECH PHYSICAL ASSISTANCE	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Repositing/Transfer																																			
B. Walking																																			
C. Medical Equipment																																			
D. Assistance with Medication																																			
E. ROM (Per Phys. order)																																			
F. Vitals (Per Phys. order)																																			
G. Other (Per Phys. order)																																			
TOTAL																																			

Nursing Plan of Care 31 Days

NUTRITIONAL SUPPORT	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Meal Prep																																				
B. Feeding																																				
C. Special Dietary Needs																																				
TOTAL																																				
ENVIRONMENTAL	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Housecleaning																																				
B. Laundry/Ironing																																				
C. Making/Changing Bed																																				
D. Dishwashing																																				
E. Shopping																																				
F. Payment of Bills																																				
TOTAL																																				
																																			TOTAL HOURS	
																																			TOTAL UNITS	

CHAPTER 517
PERSONAL CARE SERVICES
SEPTEMBER 1, 2005

ATTACHMENT 5
PERSONAL CARE DAILY LOG SHEETS
PAGE 1 OF 3

INSTRUCTIONS

All Information must be complete and reflect activities as they are written on the plan of care, i.e., marked partial or total with times filled in on the left hand column.

A registered nurse's signature is required when log is complete.

The provider who is named on the daily log must also sign the log sheet verifying the activities were provided as outlined.

Any variance from the plan must be explained at the bottom of page 2.

Member's Name:	Agency & Phone Number:
Provider Name:	Approved Hours for Member:
Medicaid #:	Number of Units:
30 Day Review Completed by:	Date:
Signature of Completing RN:	

P - Partial Assistance T - Total Assistance

PERSONAL CARE TASKS

PERSONAL HYGIENE/GROOMING	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Grooming																																			
B. Bathing																																			
C. Toileting																																			
D. Dressing																																			
E. Laundry (incontinent)																																			
TOTAL																																			

NON-TECH PHYSICAL ASSISTANCE	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Repositing/Transfer																																			
B. Walking																																			
C. Medical Equipment																																			
D. Assistance with Medication																																			
E. ROM (Per Phys. order)																																			
F. Vitals (Per Phys. order)																																			
G. Other (Per Phys. order)																																			
TOTAL																																			

NUTRITIONAL SUPPORT	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Meal Prep																																			
B. Feeding																																			

Personal Care Daily Logs

C. Special Dietary Needs																																		
TOTAL																																		
ENVIRONMENTAL	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Housecleaning																																			
B. Laundry/Ironing																																			
C. Making/Changing Bed																																			
D. Dishwashing																																			
E. Shopping																																			
F. Payment of Bills																																			
TOTAL																																			

Total Units	
Total Hours	

COMMENTS ABOUT MEMBER FOR RN TO CHECK. ALSO EXPLAIN ANY VARIANCE FROM PLAN OF CARE:

Provider Signature:_____Date: _____

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PERSONAL CARE SERVICES

SEPTEMBER 1, 2005

ATTACHMENT 6

PERSONAL CARE NURSING ASSESSMENT

PAGE 1 OF 4

INSTRUCTIONS

Form must be completed at least every 6 months.

Nursing assessment should reflect member's needs as they are on the PCMEA.

If member's condition has changed, a new assessment may be needed.

Nursing assessment should justify time shown on plan of care.

Signature of RN and member are required.

PERSONAL CARE NURSING ASSESSMENT

Attachment 6

Name:	Medicaid Number:
Date of Birth ____ / ____ / _____	Sex: ____ F ____ M
Address:	

TYPE OF RESIDENCE

Lives Alone:	Lives w/ Natural Family:
Shares an Apartment:	Group Home:
Other (please specify):	

MEDICATIONS (Including name, dosage, and time)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

VITAL SIGNS

Height:	Weight:	Blood Pressure:
Temperature:	Pulse:	Respiratory Rate:

PERSONAL CARE NURSING ASSESSMENT

DESCRIBE THE CLIENT'S ABILITY TO PERFORM PERSONAL CARE TASKS

1. Grooming/Skin Care - to include care of hair, mouth, nails, skin and teeth.
   Partial Assistance - what does this entail? _____
   _____
   _____
   Total Assistance - what does this entail? _____
   _____
   _____

2. **Bathing**

Tub ___	Shower ___	Bed Bath ___	Bathe Self ___	Sponge ___

3. **Bladder/Bowel Functions**

Continent ___	Incontinent - How often? ___	Bladder ___	Bowel ___
Wears diapers/protective undergarments ___		Needs assistance for toileting ___	
Colostomy ___	Catheter ___	Other ___	

4. **Non-Technical Physical Assistance**

Ambulates by Self _____	Needs Medical Assistance to ambulate _____	
Uses Wheelchair - please circle one	Manual	Electric
Uses Crutches _____	Uses Cane _____	Uses Walker _____

5. Describe personal care activities which are ordered by the patient's physician as it relates to the medical diagnosis: _____
   _____
   _____
   _____

PERSONAL CARE NURSING ASSESSMENT

6. NUTRITION

Self-feed ____	Part. Assist. ____	Total Assist. ____	N/G Tube ____
G-Tube ____	Regular Diet ____	Diabetic Diet ____	Other Diet ____

7. OTHER SOURCES

SSI ____	Veterans _____	Basic Living Skills (Rehab. Services) _____
SSDI ____	Black Lung ____	Day Treatment (Rehab. Services) _____
Means on Wheels _____		Behavior Management (Rehab Services) ____
Other		

8. Employment Appraisal/if applicable**:** _____
_____
_____
_____

9. Additional comments: _____
_____
_____
_____

_____ _____

Client Signature RN Signature

_____ _____

Date Date

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ATTACHMENT 7

PERSONAL CARE EMPLOYMENT SUPPORT RECORD SHEET

Instructions:

The top section must be filled out completely,

Indicate whether the individual is in Job Seeking Status, or Full Employment Status.

Specific documentation is required for each status; place an X next to the item that applies to the individual.

Personal Care Employment Support Record Sheet

(This is intended to be the cover sheet for employment section of the member's file.)

Name: _____ Social Security Number: _____

Medicaid Number: _____ Date: _____

Agency Completing Form: _____

Name/Title of Person Completing Form: _____
_____

Member Personal Care Employment Support Status

Job Seeking Status

_____ Member has provided documentation of registration with their local Workforce WV AND one of the following:

_____ Member has agreed to participate in an Individual Job Search. This Agency will monitor the Job Seeking Agreement. (See Job Seeking Agreement)

_____ Member has provided documentation of eligibility for vocational rehabilitation services from the Division of Rehabilitation Services.

_____ Member has provided documentation of participation in a Social Security (Ticket to Work) Employment Network.

Employment Status

_____ **Partial Employment**: Member has obtained partial employment working less than forty (40) hours per month earning at least minimum wage. The member agrees to maintain a Member Wage and hour Report Form. (See Employment Status Agreement)

_____ Member is progressing toward full employment of forty (40) hours per month with their current employer within three (3) months.

_____ Member is still job seeking to find full employment of at least forty (40) hours per month and agrees to participate in a Job Seeking Agreement.

_____ **Full Employment:** Member has obtained full employment of at least forty (40) hours per month earning at least minimum wage. The member agrees to maintain a Member Wage and Hour Report form. (See Employment Status Agreement.)

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ATTACHMENT 8
JOB SEEKING AGREEMENT
PAGE 1 OF 2

Instructions:

The member must complete the top section of the form.

The member must select and agree to specific job search activities listed on the form.

The member must agree to the Job Seeking Agreement statement and sign the form.

A provider agency signature and date is also required

Job Seeking Agreement

(Agreement to be completed before member begins job seeking.)

Name: _____ SSN: _____

Medicaid Number: _____Date: _____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____To:_____

(Check all applicable categories)

____ I agree to register and maintain active status with my local Workforce WV AND one of the following:

____ Individual Job Search

I agree to: 1) Contact Workforce WV when notified of an opening and appear for interviews as schedule. 2) Contact _____ (number) of potential employers per month and record results of an employer contact summary sheet to be reviewed by the agency every three months. 3) Contact at least one half of the employers in person. Or 4) other . (Please describe)_____
_____
_____

_____ **Vocational Rehabilitation Services from the Division of Rehabilitation Services**

I agree to: 1) Make application at the local Division of Rehabilitation Services Office; 2) Provided documentation of eligibility for Vocational Rehabilitation Services; 3) Provide documentation of continued participation in DRS Vocational services to this agency every three months.

____ Participation in a Social Security (Ticket- to –Work)Employment Network

I agree to: 1) Participate in a TWWIIA Employment Network Program; 2) Provide documentation of eligibility for a TWWIIA Employment Network Program; 3) Provide documentation of continued participation in the **Social Security (Ticket- to –Work)**Employment Network to this agency every three months. (This option is not available at this time.)

Job Seeking Agreement: I understand that personal care services will be provided outside the home ewhen I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am seeking employment or partially employed, working less than forty (40) hours per month. I agree to adhere to the Job Seeking Agreement and to inform my provider agency of any change in my job seeking status. My provider agency will monitor the Job Seeking Agreement and maintain record of the Agreement in my Medicaid file for review by the Bureau for Medical Services.

Member's Signature:_____ Print Name:_____

Agency: _____ Signature: _____Date:_____

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ATTACHMENT 9

EMPLOYMENT STATUS AGREEMENT

Instruction

The member must complete the top section of the form

Indicate whether the member has obtained full employment or partial employment

Specific documentation and/ or information provided by the member is required

The member must agree with the Employment Status Agreement statement and sign the form

A provider agency signature and date is required

Employment Status Agreement

(Agreement to be completed after member becomes employed.)

Name: _____ SSN: _____

Medicaid Number: _____Date: _____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____ To: _____

(Check all applicable categories)

_____ I have obtained full employment.

I am working at least forty (40) hours per month at or above minimum wage. I agree to provide this agency documentation of my employment on a Member Wage and Hour Report Form every three months.

____ I have obtained partial employment. My employer has indicated he/she will be able to offer full employment at a later date.

I am working less than forty (40) hours per month due to: _____

_____

I expect to be working at least forty (40) hours per month on or about _____. I agree to provide this agency documentation on my employment on a Member Wage and Hour Report Form every three (3) months.

_____ I have obtained partial employment. However, my employer has indicated that he/she will <u>not</u> be able to offer full employment.

I am working less than forty (40) hours per month due to : _____

_____

I agree to continue Job Seeking and have entered into a Job Seeking Agreement. I agree to provide this agency documentation of my employment on a Member Wage and Hour Report Form every three (3) months.

I understand that personal care services will be provided outside the home when I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am partially employed, working less than forty (40) hours per month. I agree to notify my provider agency immediately of any change in my enrollment status. My provider agency will monitor the Employment Status Agreement and maintain records of the agreement in my Medicaid file for review by the Bureau for Medical Services.

Member's Signature: _____ Print Name: _____

Agency: _____Signature: _____ Date: _____

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ATTACHMENT 10
EMPLOYER CONTACT SUMMARY SHEET

Instructions

The member must complete this form.

The member must provide the most accurate and complete information as possible

Employer Contact Summary Sheets
(Form for member to document employer contacts)

Name: _____ SSN: _____

Medicaid Number: _____ Date:_____

Month: _____

Employer: _____ Phone: _____

Address: _____

Contact Person: _____ Title: _____

Position Applied for: _____

Type of Contact (phone, in-person, follow-up, etc.): _____

Source of Lead (newspaper, phone book, Workforce WV, etc.): _____

Results: _____

Employer: _____ Phone: _____

Address: _____

Contact Person: _____ Title: _____

Position Applied for: _____

Type of Contact (phone, in-person, follow-up, etc.): _____

Source of Lead (newspaper, phone book, Workforce WV, etc.): _____

Results: _____

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ATTACHMENT 11
EMPLOYER FOLLOW-UP SHEET
PAGE 1 OF 2

Instructions

The provider agency must complete this form

Record information on this form to verify an individual's employer contact

The provider agency should obtain appropriate release of information before contacting an member's employer contact

Employer Follow-up Sheet
(Form for provider agency to document member's employer contact)

Name: _____ SSN: _____

Medicaid Number: _____ Date: _____

Person/Title Completing Follow-up Form: _____

Agency: _____

Employer Name & Address:
_____

_____

Person Contacted/Title: _____

Results of Contact with Employer: _____

_____

Employer Name & Address:
_____

_____

Person Contacted/Title: _____

Results of Contact with Employer: _____

_____

Employer Name & Address:
_____

_____

Person Contacted/Title: _____

Results of Contact with Employer: _____

_____

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ATTACHMENT 12
RELEASE OF INFORMATION
PAGE 1 OF 2

INSTRUCTIONS

THE MEMBER MUST FILL OUT THIS FORM COMPLETELY WITH SIGNATURE AND DATE.

(Agency Letterhead)

RELEASE OF INFORMATION

Name: _____

Social Security Number: _____ Date of Birth: _____

I authorize you to furnish any information regarding my application or employment status with your company to _____

(Provider Agency, Address Phone Number)

Signature: _____

Print Name: _____ Date: _____

Address: _____

_____

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PERSONAL CARE SERVICES
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ATTACHMENT 13
MEMBER WAGE AND HOUR REPORT
PAGE 1 OF 2

INSTRUCTIONS

THIS FORM CAN BE COMPLETED BY THE WORKING MEMBER, THE EMPLOYER, OR THE PROVIDER AGENCY

THE EMPLOYER'S SIGNATURE IS REQUIRED

MEMBER WAGE AND HOUR REPORT

PERSONAL CARE - Job Seeking/Employment Status Form 1XX Revised 03-03

EMPLOYER	BEGINNING DATE	ENDING DATE	HOURS WORKED	GROSS PAY

Employer's signature _____ Date _____

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PERSONAL CARE SERVICES
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ATTACHMENT 14
NURSING PLAN OF CARE FOR EMPLOYMENT SUPPORT SERVICES
PAGE 1 OF 2

INSTRUCTIONS

THIS FORM MUST BE COMPLETED BY THE RN RESPONSIBLE FOR NURSING ASSESSMENTS

INDICATE THE PERSONAL CARE ACTIVITIES THAT ARE NEEDED AT THE WORKSITE, THE LEVEL OF SERVICES, AND THE SCHEDULE FOR THE SERVICES ON THE CHART

COMPLETE THE REMAINING ITEMS ON THE FORM, INCLUDING COMMENTS, IF NECESSARY

THE RN MUST SIGN THE FORM

NURSING PLAN OF CARE
EMPLOYMENT SUPPORT SERVICES

PROVIDER: _____Provider # : _____90 Day Review Date:_____

Member Name: _____ Medicaid # : _____

Member Address: _____ RN Signature:_____

Personal Care Activities	**Level of Services to be provided**		**Daily Planned Time**							**Date Services Started**	**Comments**
	Partial Assis	Total Assist	Sun	Mon	Tue	Wed	Thu	Fri	Sat		
Grooming											
Toileting											
Reposition/Transfer											
Walking											
Medical Equipment											
Assist w/meds											
Meal Prep											
Feeding											
Special Dietary Needs											

Total Number of Minutes: _____ Total Number of Units: _____

Mode of Transportation: _____

Name of Person Providing the Services: _____

Member's Employer (if applicable) : _____

COMMENTS:

_____

_____

_____

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ATTACHMENT 15
DEFINITIONS OF PERSONAL CARE TERMS
USED WITH STANDARDS IN DEVELOPMENT OF PLAN OF CARE

DEFINITIONS OF PERSONAL CARE TERMS

(to be considered when a Plan of Care is written)

1. Partial Assistance: Hand-on assistance with an activity; however, the members can participate to a limited degree.

2. Total Assistance: Hands-on activity where member is incapable of participating in the activity and the provider must perform all services.

3. Medically Necessary: Those services indicated on the Physician's order that must be ordered by the Physician as needed services for member.

Personal Hygiene/Grooming

1. Toileting: Diapering does not apply to babies up to three (3) years old unless extenuating medical circumstances apply.

   Partial Assistance: Hands on assistance such as assisting on and off the toilet, bedpan, commode. Not necessary for provider to clean person.

   Total Assistance: Hands on. Physically placing member on toilet, cleaning after completing elimination and return to chair, bed, etc....

2 Dressing:

   Partial Assistance: Assisting member by laying out clothes, helping member put clothes on. Can dress themselves but needs some hands on assistance.

   Total Assistance: Provider must completely dress member from laying out clothes to physically putting on all wearing apparel.

3. Medically Incontinent Laundry:

   Laundry requested beyond normal weekly routine. The only approved laundry for incontinence will be that which is considered "Medically" necessary only. Incontinent Laundry is not appropriate for ages birth to three (3) unless extenuating medical circumstances apply.

4. Skin Care:

   Routine skin care such as applying body lotion after bathing, or application of suntan lotion is not considered medically necessary. Skin care that would be acceptable would be special lotions for psoriasis, skin break-down or other medically recognized skin conditions.

Non-Technical Physical Assistance:

1. Non-skilled Medical Care such as B/P monitoring for a Diagnosis of Hypertension must be "Medically" necessary as prescribed by the physician's order which clearly instructs all specifics necessary to carry out the function.

2. Range of Motion, Nebulizer treatments, or changing of a simple dressing are examples of activities needing a physician's order which specifically describes the activities needed and the number of times per day and length of time per session needed.

Definitions of Personal Care Services

3. Medical Equipment: Use and care of any medical equipment necessary to maintain member's needs in the home. List all equipment and how it pertains to the plan of care.

4. Walking: In order to have billable time for this activity on the Plan of Care, member needs to be rated a Level III on the PCMEA, indicating "hands-on-assistance."

Nutritional Support:

1. Feeding: Is considered normal activity for babies birth to two (2) years old except for extenuating medical circumstances.

   Partial Assistance: In regards to feeding; for example, means cutting up meat on plate or setting up plate.

   Total Assistance: In regards to feeding; for example, placing food on fork/spoon and placing in members mouth, prompting them to chew and swallow.

   In regards to drinking; for example, holding up of liquid, placing it to their mouth and prompting them to swallow.

2. Meal Preparation: Making preparations of food to be consumed by member.

   Partial Assistance: An example of this is taking a frozen dinner out of the paper carton or assisting the member to carrying food to table.

   Total Assistance: An example of this is the provider may be cutting up, cooking, watching and otherwise preparing an entire meal for the member who is physically/mentally incapable of assisting in the preparations.

In group home settings of three (3) or more members in one household, meal preparation must be pro-rated across all individuals who will eat the meal. For example, if there are six (6) members and it takes an hour to prepare a meal, each member maximum of ten (10) minutes per meal. If member participates in day program outside his/her residence, the maximum would be ten (10) minutes two (2) times to equal to 20 minutes.

Other:

1. Seizure activity - Is limited to protecting a member during or immediately after the seizure. **Monitoring for seizures is not billable.**

2. Room and Board Payments - Monies paid to an individual/agency on a monthly basis, from the members accounts (SSI) or the Department of Health and Human Resources (DHHR), Bureau of Social Services. Payments of Room and Board from either resource will exclude certain services as listed in the Personal Care Standards.

3. Incident - When an activity states 'per incident' it means each time the activity occurs. An example is taking medications. A member may be on medications that must be taken five (5) times a day. Each of those five (5) times would be a separate incident.

CHAPTER 517
PERSONAL CARE SERVICES
SEPTEMBER 1, 2005

ATTACHMENT 16
PERSONAL CARE STANDARDS

PERSONAL CARE ACTIVITIES	PARTIAL ASSISTANCE LEVEL II	TOTAL ASSISTANCE LEVEL III	TOTAL MAX. MINUTES/DAY Additional documentation required when using these times.

PERSONAL HYGIENE / GROOMING

Grooming/Routine Skin Care: Includes care of hair, skin, nails, teeth & mouth		up to 10 minutes per day	up to 15 minutes per day	up to 60 minutes per day
Bathing; in bed, the tub or in the shower		up to 15 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Toileting:	Diapering : Child	N/A	5 minutes per incident	up to 30 minutes per day
	Diapering: Adult	N/A	up to 30 minutes per incident	up to 180 minutes per day
	Assistance on and off the commode, bedpan, toilet	up to 5 minutes per incident	up to 15 minutes per incident	up to 75 minutes per day 24 hrs.
Dressing		up to 15 minutes per incident	up to 30 minutes per day	up to 30 minutes per day
Medically Incontinent Laundry	Urine, feces (drooling)	up to 30 minutes 2 X a week – occasional incontinence	up to 30 minutes per day	up to 30 minutes per day
NON-TECH. PHYSICAL ASSISTANCE				
Repositioning / Transfer; i.e. in & out of bed, on or off seats		5 minutes per incident	5 minutes per incident	up to 1 hour in 24 hours
Walking: with or without assistance of medical equip, in home		N/A	up to 30 minutes per day	up to 30 minutes per day
Medical Equip: list use and care of equipment in the home		15 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Wheelchair: assistance pushing, loading & unloading in vehicle		up to 30 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Range of Motion: assist with active & or passive ROM **(Per P.O.)**		Up to 60 minutes per day	up to 60 minutes per day	up to 60 minutes per day
Assist with Medication: includes prompting at right time, provide liquid & assistance in self-medication. Documentation of who prepares medication.		5 minutes per incident	5 minutes per incident	will depend: based on the number of times medications are ordered in 24 hours
Vital Signs: **(As per Physician's Orders)**		5 minutes per incident	5 minutes per incident	up to 30 minutes in 24 hr. period
Other: As per Physician's orders				

PERSONAL CARE ACTIVITIES	PARTIAL ASSISTANCE LEVEL II	TOTAL ASSISTANCE LEVEL III	TOTAL MAX. MINUTE/ DAY Additional documentation required when using these times

**** The Following Standards apply only to those consumers that DO NOT pay for room and board to their provider of service:**

NUTRITIONAL SUPPORT:

Meal Preparation: *Please note: only for those consumers who DO NOT pay for room & board (If a member lives in a group home situation, please refer to definitions.)	up to 15 minutes per meal	up to 15 minutes per meal	up to 45 minutes per day
Feeding	up to 15 minutes per meal	up to 30 minutes per meal	up to 90 minutes per day
Special Dietary Need: Pureed food, extra hydration with documentation	up to 15 minutes	up to 30 minutes	up to 30 minutes per meal

Environments: can count only 1/3 of time spent. ** can only count units for those consumers who DO NOT pay for board and room.

ENVIRONMENTAL:

House cleaning: i.e. dusting & vacuuming rooms consumer uses	up to 10 minutes per day	up to 10 minutes per day	up to 60 minutes per week
Laundry / Ironing & Mending:	up to 60 minutes per week	up to 60 minutes per week	up to 60 minutes per week
Making and Changing Beds:	5 minutes per day	5 minutes per day	15 minutes per day
Dishwashing: This time based on only washing consumer's dishes	up to 10 minutes per meal	up to 10 minutes per meal	up to 10 minutes per meal
Shopping: Time based on shopping for the consumer	up to 60 minutes per week	up to 60 minutes per week	up to 60 minutes per week

Payment of Bills: Only those bills of the consumer	up to 30 minutes per month	up to 30 minutes per month	up to 30 minutes per month
Seizure Activity; this time includes protecting consumer during & right after the seizure **only with supporting documentation**	5 to 30 minutes per incident	5 to 30 minutes per incident	5 to 30 minutes per incident

CHAPTER 517
PERSONAL CARE SERVICES
SEPTEMBER 1, 2005

ATTACHMENT 17
DUAL SERVICES PROVISION REQUEST
PAGE 1 OF 4

Instructions:
Please see section 519.19 for complete information about request to provide the same member with ADW and Personal Care Services.

WEST VIRGINIA MEDICAID

AGED & DISABLED WAIVER AND PERSONAL CARE

DUAL SERVICE PROVISION REQUEST

MEMBER INFORMATION Submission Date: _____

Name: _____ Medicaid #: _____

Current ADW LOC: _____

REQUEST INFORMATION

Period for this Request (NO LONGER THAN 6 MONTHS): _____ to _____

Requested PC units per month: _____Total Number of PC units for the Requested Period: _____

AGENCY INFORMATION

Current ADW HMA: _____ Current CMA: _____

PC Agency: _____Provider #: _____

PC Address: _____

PC Phone #: _____ FAX #: _____

DATE OF HM RN, CM, PC RN, AND MEMBER MEETING: _____

_____ _____

SIGNATURE OF ADW HM RN **SIGNATURE OF CM**

_____ _____

SIGNATURE OF REQUESTING PC RN **SIGNATURE OF MEMBER OR REPRESENTATIVE**

REQUIRED DATA TO BE SUBMITTED WITH THIS FORM:

1. A completed copy of this cover sheet with original signatures.
2. A narrative describing how services will be utilized and verification that the ADW & PC services will not be duplicated.
3. Documentation of caregivers for both programs and their relationship to member.
4. Current ADW PAS 2005, or PAS 2000 if prior to 11/2005.
5. Current PC Medical Eligibility Assessment, or PAS 2000 if prior to 11/2005.
6. Current ADW and PC RN Assessments.
7. Current ADW RN POC.
8. Proposed PC POC.
9. Any additional documentation that substantiates the request.

SENIOR CENTER PROVIDERS SEND REQUESTS TO:

WV Bureau of Senior Services

State Capitol Complex

1900 Kanawha Blvd. E.

Charleston, WV 25305

FAX: (304) 558-6647

ALL OTHER PROVIDERS SEND REQUESTS TO:

WV Bureau for Medical Services

350 Capitol Street, Room 251

Charleston, WV 25301

FAX: (304) 558-1509

CHAPTER 518 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PHARMACY SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 518.1	Definitions Medicaid AWP Definitions State MAC (SMAC)	May 1, 2013	January 1, 2013
Throughout	Website Address update: BMS's website updated from www.wvdhhr.org/bms to www.dhhr.wv.gov/bms	May 1, 2013	January 1, 2013
Section 518.3.1.1	Mountain Health Choices (MHC)	May 1, 2013	April 1, 2013
Section 518.3.1.3	Medicaid Members Enrolled in Medicaid Managed Care Organizational Plans	May 1, 2013	April 1, 2013
Section 518.3.2.1	AIDS Drug Assistance Program (ADAP) or Ryan White Program	May 1, 2013	April 1, 2013
Section 518.4	Description of Covered Services	May 1, 2013	July 1, 2013
Section 518.4.2	Over-the-Counter Drugs	May 1, 2013	April 1, 2013
Section 518.4.3	Diabetic Testing Supplies and Syringes/Needles	May 1, 2013	April 1, 2013
Section 518.4.5	Home Infusion Therapy Pharmacy Services	May 1, 2013	January 1, 2013
Section 518.4.6	Tobacco Cessation Program	May 1, 2013	April 1, 2013
Section 518.4.7	Buprenorphine-Naloxone (Suboxone®) / Buprenorphine (Subutex®) Coverage	May 1, 2013	January 1, 2013
Section 518.5	Service Limitation	May 1, 2013	January 1, 2013
Section 518.6	Coverage of Brand Name Versus Generic Drugs	May 1, 2013	May 1, 2013
Section 518.7	Non-Covered Services	May 1, 2013	January 1, 2013
Section 518.8	Prior Authorization (PA)	May 1, 2013	May 1, 2013
Section 518.8.1	Process of Requesting Prior Authorization	May 1, 2013	May 1, 2013
Section 518.9.1	Prospective Drug Utilization	May 1, 2013	January 1, 2013

	Review (DUR)		
Section 518.9.2.1	Pharmacy Lock-in Program	May 1, 2013	July 1, 2013
Section 518.10.4	Shipping/Receiving	May 1, 2013	May 1, 2013
Section 518.11.1	Point-of-Sale System	May 1, 2013	January 1, 2013
Section 518.11.2	National Council on Prescription Drug Programs (NCPDP) Payer Sheet	May 1, 2013	January 1, 2013
Section 518.11.3	Paper Claim Submission for Pharmacy Services	May 1, 2013	January 1, 2013
Section 518.11.10	Compounded Prescriptions	May 1, 2013	January 1, 2013
Section 518.11.11	Abuse and Inappropriate Utilization	May 1, 2013	January 1, 2013
Section 518.12	Reimbursement	May 1, 2013	January 1, 2013
Section 518.12.1	Ingredient Cost	May 1, 2013	January 1, 2013
Section 518.12.2	Application of Dispensing Fee	May 1, 2013	January 1, 2013
Section 518.12.3	Co-Payments	May 1, 2013	January 1, 2013
Section 518.12.4	Third-Party Liability (TPL) or Coordination of Benefits (COB)	May 1, 2013	January 1, 2013
Section 518.12.4.2	Medicare Covered Drugs, Part D	May 1, 2013	January 1, 2013
Section 518.13.4	Additional Information	May 1, 2013	January 1, 2013
Section 518.4	Description of Covered Services	November 19, 2012	October 1, 2010
Section 518.3.1.4	Medicaid Members with End Stage Renal Disease (ESRD)	April 1, 2012	April 1, 2012
Section 518.3.2.6	Juvenile Services	April 1, 2012	April 1, 2012
Section 518.4.5	Home Infusion Therapy Pharmacy Services, formerly In-Home Parenteral Therapy (IHPT) Pharmacy Services	April 1, 2012	April 1, 2012
Section 518.4.7	Buprenorphine-Naloxone(Suboxone®)/Buprenorphine(Subutex®) Coverage	April 1, 2012	April 1, 2012
Section 518.5.1	Bulk Chemicals	April 1, 2012	April 1, 2012

Section 518.7	NON COVERED SERVICES	April 1, 2012	April 1, 2012
Section 518.10.4	Shipping/Receiving	April 1, 2012	April 1, 2012
Section 518.11.13	Wasted Medication	April 1, 2012	April 1, 2012
Section 518.2.5	Pharmacy Change of Ownership	September 15, 2010	November 1, 2010
Section 518.3.1.1	Mountain Health Choices	September 15, 2010	November 1, 2010
Section 518.3.1.7	Incarcerated Members	September 15, 2010	November 1, 2010
Section 518.5	Service Limitations	September 15, 2010	November 1, 2010
Section 518.10.2	Prescriptions Returned to Stock	September 15, 2010	November 1, 2010
Section 518.11	Billing Procedure	September 15, 2010	November 1, 2010
Section 518.11.14	False Claims	September 15, 2010	November 1, 2010
Appendix 1	In-Home Parenteral Therapy	September 15, 2010	November 1, 2010
Section 518.4	Description of Covered Services	September 15, 2010	October 1, 2010
Section 518.7	Non-Covered Services	September 15, 2010	October 1, 2010
Section 518.12.3	Co-Payments	September 15, 2010	October 1, 2010
Section 518.5.1	Coverage of Brand Name versus Generic Drugs	March 31, 2010	June 1, 2010
Section 518.6	Non-covered services	March 31, 2010	June 1, 2010
Section 518.7	Prior Authorization (PA)	March 31, 2010	June 1, 2010
Section 518.7.2	Prior Authorization Appeal Process	March 31, 2010	June 1, 2010
Section 518.8.3	Reporting of Cash Payments	March 31, 2010	June 1, 2010
Section 518.9.1	Tamper-Resistant Prescription Pad Requirement	March 31, 2010	June 1, 2010

Section 518.9.4	Shipping/Receiving	March 31, 2010	June 1, 2010
Section 518.10.10	Compounded Prescription	March 31, 2010	June 1, 2010
Section 518.10.11	Abuse and Inappropriate Utilization	March 31, 2010	June 1, 2010
Section 518.11.3	Co-payments	March 31, 2010	June 1, 2010
Section 518.11.4	Third-Party Liability (TPL) or Coordination of Benefits (COB)	March 31, 2010	June 1, 2010
Entire Manual	Entire Manual	November 10, 2009	January 1, 2010
Entire Manual	Entire Manual	November 10, 2009	January 1, 2010

2013

Section 518.1 Definitions

Old Policy: Medicaid AWP: Average wholesale prices established by the Federal Office of the Inspector General.

New Policy: Remove Section

Old Policy: State MAC (SMAC): Maximum allowable cost for drug products established by the state Medicaid agency.

New Policy: State MAC (SMAC): Maximum allowable cost for drug products or supplies established by the state Medicaid agency.

Email address listed throughout the Manual

Old Policy: BMS website, www.wvdhhr.org/bms.

New Policy: BMS website, www.dhhr.wv.gov/bms.

Section 518.3.1.1 Mountain Health Choices (MHC)

Old Policy: Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program.

New Policy: Pharmacy services are covered for all benefit plans, either through Medicaid fee-for-service or Medicaid Managed Care Organizations (MCO). Members enrolled in the Medicaid MCOs must follow the rules and policies of their respective MCO. The managed care plans are required to provide pharmacy benefits consistent with the Medicaid Preferred Drug List (PDL), both in the selection of preferred/non-preferred drugs and criteria for coverage. The plans are responsible for policies for drugs not included in the Medicaid PDL. There is no copayment requirement for pharmacy services covered through the managed care organization plans.

Section 518.3.1.3 Medicaid Members Enrolled in Medicaid Managed Care Organization Plans

Old Policy: With the exception of drugs used for in-home parenteral therapy and physician/outpatient facility- administered drugs, West Virginia Medicaid members enrolled in a Managed Care Organization (MCO) receive fee-for-service pharmacy benefits. These members will have two identification cards – the managed care identification card for medical services, i.e. physician, hospital, etc., and the Medicaid identification card for pharmacy and other carved-out services. In-home parenteral therapy and physician/outpatient facility- administered drug services are covered by the MCO and are subject to the plans' requirements.

New Policy: Effective April 1, 2013, Medicaid members enrolled in the Medicaid managed care organization plans receive pharmacy services from the managed care plan. These members will have two identification cards – the managed care identification card for managed care covered services, and the Medicaid identification card for carved-out services. The managed care plans are required to provide pharmacy benefits consistent with the Medicaid Preferred Drug List (PDL), both in the selection of preferred/non-preferred drugs and criteria for coverage. The plans are responsible for policies for drugs not included in the Medicaid PDL. There is no copayment requirement for pharmacy services covered through the managed care organization plans.

Section 518.3.2.1 AIDS Drug Assistance Program (ADAP) or Ryan White Program

Old Policy: The AIDS Drug Assistance Program (ADAP) is funded by the Ryan White Title II CARE Act in West Virginia, and claims are processed through the BMS claims processing system. The program assists eligible persons with HIV infection in obtaining drugs covered by the ADAP formulary. To be eligible for the ADAP, a person must meet the following:

- be an HIV infected resident of West Virginia;
- with a family income less than 325% of the federal poverty level (FPL), and;
- not be eligible for other forms of reimbursement such as Medicaid or full insurance coverage, and;
- have completed the ADAP and Medicaid application at their Department of Health and Human Resources county office.

ADAP participants do not receive a medical identification card, but do receive a letter that verifies eligibility and includes their identification number with a prefix of "69". All claims except those for vaccines may be submitted online through the pharmacy Point-of-Sale system or by

using the approved paper claim form. Covered drugs are limited to a 30-day supply. Claims must be submitted within 60 days from the date of service. Formulary drugs must be dispensed in generic form if available. Brand-name drugs that have generic equivalents require prior authorization. There are no co-payment requirements for this program. ADAP may cover co-pays for eligible residents who are covered by insurance or Medicare Part D. Claims for vaccines must be submitted on the approved pharmacy paper claim form and mailed to HIVCC, P. O. Box 6360, Wheeling, West Virginia 26003. Certain drugs may require prior authorization and emergency supplies of these drug may not be dispensed. Please refer to the BMS website, www.wvdhhr.org/bms, for the ADAP formulary. More information regarding ADAP can be found at the Bureau for Public Health's website at www.wvdhhr.org/bph.

New Policy: The AIDS Drug Assistance Program (ADAP) is funded under Part B of the Ryan White HIV/AIDS Treatment Extension Act in West Virginia, and claims are processed through the BMS claims processing system. The program assists eligible persons with HIV infection in obtaining drugs covered by the ADAP formulary. To be eligible for the ADAP, a person must meet the following:

- be an HIV infected resident of West Virginia;
- with a family income less than 400% of the federal poverty level (FPL), and;
- not be eligible for other forms of reimbursement such as Medicaid or full insurance coverage, and;
- have completed the ADAP and Medicaid application at their Department of Health and Human Resources county office.

ADAP participants do not receive a medical identification card, but do receive a letter that verifies eligibility and includes their identification number with a prefix of "69". All claims except those for vaccines may be submitted online through the pharmacy Point-of-Sale system or by using the approved paper claim form. Covered drugs are limited to a 30-day supply. Claims must be submitted within 60 days from the date of service. Formulary drugs must be dispensed in generic form if available. Brand-name drugs that have generic equivalents require prior authorization. There are no co-payment requirements for this program. ADAP may cover co-pays for eligible residents who are covered by insurance or Medicare Part D. Claims for vaccines must be submitted on the approved pharmacy paper claim form and mailed to ATF, P.O. Box 6360, Wheeling, West Virginia 26003. Certain drugs may require prior authorization and emergency supplies of these drug may not be dispensed. Please refer to the BMS website, www.dhhr.wv.gov/bms, for the ADAP formulary. More information regarding ADAP can be found at the Bureau for Public Health's website at www.dhhr.wv.gov/bph or by calling the AIDS Task Force at 304-232-6822.

518.4 DESCRIPTION OF COVERED SERVICES

Old Policy: Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions

- Drugs that require prior authorization, when approved by BMS
- Family planning supplies, including certain over-the-counter supplies
- Certain diabetic supplies
- Influenza and pneumonia vaccines for adults over 19 years of age administered by a pharmacist.

New Policy: Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions
- Drugs that require prior authorization, when approved by BMS
- Family planning supplies, including certain over-the-counter supplies
- Certain diabetic supplies
- Influenza, pneumonia, Hepatitis A, Hepatitis B, tetanus, tetanus-diphtheria (Td), and tetanus-diphtheria-and-pertussis (Tdap) vaccines for adults nineteen (19) years of age and older administered by a pharmacist. (Members up to nineteen (19) years of age have access to vaccines via the Vaccines for Children Program.)
- Herpes zoster vaccine for adults fifty (60) years of age and older administered by a pharmacist

Section 518.4.2 Over-the-Counter Drugs

Old Policy: N/A

New Policy: Coverage of over-the-counter drugs for members enrolled in Medicaid managed care plans will follow each plan's coverage policies, unless the OTC drug is included in the Medicaid Preferred Drug List.

Section 518.4.3 Diabetic Testing Supplies and Syringes/Needles

Old Policy: N/A

New Policy: Medicaid members enrolled in Medicaid managed care plans will have coverage of diabetic supplies through their managed care plan.

Section 518.4.5 Home Infusion Therapy Pharmacy Services

Old Policy: N/A

New Policy: Total Parenteral Nutrition (TPN) services are not pharmacy point of sale (POS) covered services. Please see *Chapter 506, DME/Medical Supplies* for information regarding these services.

Section 518.4.6 Tobacco Cessation Program

Old Policy: West Virginia Medicaid makes tobacco cessation services available to members enrolled in the Traditional Benefits Package and those enrolled with a participating West Virginia Medicaid MCO. For a member not enrolled with a participating West Virginia Medicaid MCO to participate in the program, members are required to enroll through the WV YNOTQUIT Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available through the quit line program. Additional information regarding the YNOTQUIT Line can be accessed through the beBetter Network at www.ynotquit.com.

For members enrolled in Medicaid managed care plans, West Virginia Medicaid covers tobacco cessation for members in the Enhanced Benefit Package and all children's' benefit packages. Medicaid does not cover tobacco cessation programs for those enrolled in the Basic Adult Benefit Package. The West Virginia Division of Tobacco Prevention, administered through the West Virginia Department for Health and Human Resources' Bureau for Public Health, may also assist in providing services for those who are uninsured or under-insured.

West Virginia Medicaid operates a tobacco cessation program to assist members to discontinue use of tobacco products. In order for members to have access to drugs and other tobacco cessation services, the member is required to see their primary care provider and enroll in the program their managed care plan uses. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are also available through the program. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate.

Additional information regarding the tobacco cessation program can be accessed through www.wvdtp.com or www.wvquitline.com.

If a Medicaid member is enrolled in a MCO, please contact the member's MCO for service limitations and all other requirements related to this benefit.

Drugs to treat tobacco cessation are limited to members who register with Medicaid's quit line program. Dual eligible members have coverage of legend drugs through their Medicare Part D plans and coverage of the over-the-counter drugs and quit line services through Medicaid.

New Policy: West Virginia Medicaid makes tobacco cessation services available to members enrolled in the fee-for-service Medicaid Program (except for those enrolled in the Basic Adult Package) and those enrolled with a participating West Virginia Medicaid MCO.

Members enrolled in the fee-for-service Medicaid Program are required to enroll through the WV Tobacco Cessation Quitline Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available

through the Quitline program. Additional information regarding the WV Tobacco Cessation Quitline can be accessed through at www.ynotquit.com.

Members enrolled in Medicaid managed care plans have tobacco cessation services provided by their plans, including drug treatments.

In order for members to have access to drugs and other tobacco cessation services, the member is required to see their primary care provider. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco Quitline.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate.

Additional information regarding the tobacco cessation program can be accessed through www.wvdtp.com or www.wvquitline.com or by calling the Quitline at 1-877-966-8784 for assistance.

If a Medicaid member is enrolled in a MCO, please contact the member's MCO for service limitations and all other requirements related to this benefit.

Drugs to treat tobacco cessation are limited to members who register with the tobacco Quitline program. Dual eligible members have coverage of legend drugs through their Medicare Part D plans and coverage of the over-the-counter drugs and Quitline services through Medicaid. Medicaid does not cover tobacco cessation programs for those enrolled in the Basic Adult Benefit Package.

Section 518.4.7 Buprenorphine-Naloxone (Suboxone®) / Buprenorphine (Subutex®) Coverage

Old Policy: Buprenorphine-Naloxone and Buprenorphine are covered through the Pharmacy program, and must be written by a prescriber enrolled with WV Medicaid or employed by a facility enrolled with WV Medicaid, or enrolled with one of the Medicaid MCOs. Buprenorphine-Naloxone and Buprenorphine is obtained only through a prior authorization. Other limitations may apply.

New Policy: Buprenorphine-Naloxone and Buprenorphine are covered through the Pharmacy program, and must be written by a prescriber enrolled with WV Medicaid or employed by a facility enrolled with WV Medicaid, or enrolled with one of the Medicaid MCOs. Buprenorphine-Naloxone and Buprenorphine is obtained only through a prior authorization. All members treated with Buprenorphine-Naloxone or Buprenorphine are required to participate in the pharmacy lock-in program. Other limitations may apply.

Section 518.5 SERVICE LIMITATIONS

Old Policy: Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

- Benzodiazepines
- Barbiturates
- Over-the-counter medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

New Policy: Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

- Barbiturates (if not for treatment of epilepsy, cancer, or mental health disorder, as Medicare Part D covers these conditions)
- Over-the-counter medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

Section 518.6 COVERAGE OF BRAND NAME VERSUS GENERIC DRUGS

Old Policy: **DAW 4** - A generic equivalent is not available or not stocked at the time of dispensing. This code shall only be used when a generic drug is sold out or a generic drug is unavailable on a wide-spread basis. *It shall not be used routinely to circumvent the mandatory generic program for reasons other than these.*

New Policy: **DAW 4** - A generic equivalent is not available or not stocked at the time of dispensing. This code shall only be used when a generic drug is sold out or a generic drug is unavailable on a wide-spread basis. *It shall not be used routinely to circumvent the mandatory generic program for reasons other than these.* A call to the Rational Drug Therapy Program help desk is required for the use of DAW 4 and appropriate justification must be provided. The brand name rate will be reimbursed when approved.

Section 518.7 NON-COVERED SERVICES

Old Policy: The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI).

- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purpose
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug. Excipients must be eligible for federal rebates in order to be eligible for reimbursement.
- Vaccines via the pharmacy POS, except for influenza and pneumonia vaccines for adults over the age of 19 years administered by a pharmacist
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services
- Methadone for the treatment of drug dependence/addiction

New Policy: The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI).
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purpose
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date

- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug. Excipients must be eligible for federal rebates in order to be eligible for reimbursement.
- Vaccines via the pharmacy POS, except for influenza, pneumonia, Hepatitis A, Hepatitis B, tetanus, tetanus-diphtheria (Td), and tetanus-diphtheria-and-pertussis (Tdap) vaccines for adults nineteen (19) years of age and older administered by a pharmacist; and herpes zoster vaccine for adults fifty (60) years of age and older administered by a pharmacist.
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services,* for additional information regarding hemophilia services.)
- Methadone for the treatment of drug dependence/addiction

Section 518.8 PRIOR AUTHORIZATION (PA)

Old Policy: Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.wvdhhr.org/bms. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable until appealed by the prescribing practitioner on behalf of the member.

New Policy: Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.dhhr.wv.gov/bms. Drugs which require

prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable unless, upon appeal by the prescribing provider, the Medicaid Medical Director determines that the drug meets the appropriateness and medical necessity criteria.

Section 518.8.1 Process of Requesting Prior Authorization

Old Policy: The Rational Drug Therapy Program (RDTP) is the agency contracted to provide prior authorization services to the West Virginia Medicaid Pharmacy Program. RDTP is a non-profit organization affiliated with the West Virginia University School of Pharmacy.

Prior authorization may be initiated either by the dispensing pharmacist, the prescriber, or the prescriber's designee. Requests may be made by telephone, fax, or mail. If all the necessary information is provided, requests will be addressed within 24 hours. It is the responsibility of the provider of the service, either the physician or pharmacist, to obtain the authorization before rendering the service. Requests for prior authorization after the service is rendered will be denied, except in cases of back-dated eligibility. If the service is provided before prior authorization is obtained, the Medicaid member must be informed that he/she will be responsible for the bill. There is a maximum approval limit of one year.

Prior authorization requests shall include the following:

- Member name and address
- Member Medicaid identification number
- Name of drug, strength, dosage, and duration of treatment
- Diagnosis
- Pertinent laboratory information
- Justification for the use of the drug
- Return fax number
- Signature of prescriber or pharmacist

Rational Drug Therapy Program's operating hours are:
Monday through Saturday – 8:30 AM until 9:00 PM
Sunday – 12 noon until 6:00 PM

Prior authorization forms can be downloaded from the Rational Drug Therapy Program's website at www.hsc.wvu.edu/sop/rdtp/. These forms may be duplicated.

New Policy: The Rational Drug Therapy Program (RDTP) is the agency contracted to provide prior authorization services to the West Virginia Medicaid Pharmacy Program. RDTP is a non-profit organization affiliated with the West Virginia University School of Pharmacy.

Prior authorization may be initiated either by the dispensing pharmacist, the prescriber, or the prescriber's designee. Prior authorization requests from third party vendors or contractors will be denied. Requests may be made by telephone, fax, or mail. If all the necessary information is provided, requests will be addressed within 24 hours. It is the responsibility of the provider of the service, either the physician or pharmacist, to obtain the authorization before rendering the service. Requests for prior authorization after the service is rendered will be denied. In cases

of back-dated eligibility, prior authorizations may be considered on a case by case basis using coverage policies in place on the dates the services were rendered. If the service is provided before prior authorization is obtained, the Medicaid member must be informed that he/she will be responsible for the bill.

There is a maximum approval limit of one year.

Prior authorization requests shall include the following:

- Member name and address
- Member Medicaid identification number
- Name of drug, strength, dosage, and duration of treatment
- Diagnosis
- Pertinent laboratory information
- Justification for the use of the drug
- Return fax number
- Signature of prescriber or pharmacist

Rational Drug Therapy Program's operating hours are:

Monday through Saturday – 8:30 AM until 9:00 PM
Sunday – 12 noon until 6:00 PM

Prior authorization forms can be downloaded from the Bureau for Medical Services' website at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx. These forms may be duplicated. Providers enrolled to access the BMS MediWeb portal may complete PA forms electronically and submit them via the portal.

Section 518.9.1 Prospective Drug Utilization Review (DUR)

Old Policy: Pharmacists may continue to process claims that contain prospective DUR messages by using DUR outcome and intervention codes. A call to the RDTP help desk may be required in certain instances as determined by BMS. More detailed information regarding DUR procedures is found in the Health PAS-RX Pharmacy Point-of-Sale (POS) User Guide, found on BMS' link to the fiscal agent website, www.wvdhhr.org/bms.

New Policy: Pharmacists may continue to process claims that contain prospective DUR messages by using DUR outcome and intervention codes. A call to the RDTP help desk may be required in certain instances as determined by BMS to obtain an edit override. Requests for edit overrides after the service is rendered will be denied, except in cases of back-dated eligibility. More detailed information regarding DUR procedures is found in the Health PAS-RX Pharmacy Point-of-Sale (POS) User Guide, found on BMS' link to the fiscal agent website, www.dhhr.wv.gov/bms.

Section 518.9.2.1 Pharmacy Lock-in Program

Old Policy: N/A

New Policy: Criteria for Lock-in determination can be found on the Bureau's website, www.dhhr.wv.gov/bms.

Members, upon discharge from a substance abuse program, or while receiving outpatient substance abuse treatment, will be locked into a single pharmacy provider. Upon admission to a facility for treatment of substance abuse or during the initial visit for outpatient substance abuse services, the member will be required to choose a pharmacy from which to receive all controlled substances. The lock-in form may be found on the Bureau website at www.dhhr.wv.gov/bms.

Section 518.10.4 Shipping/Receiving

Old Policy: Claims for medications not received by the member in a timely manner may be reversed for billing by a local pharmacy provider to meet the member's needs.

New Policy: Claims for medications not received by the member in a timely manner may be reversed by the fiscal agent, if necessary, in order to allow for billing by a local pharmacy provider to meet the member's needs.

Section 518.11.1 Point-of-Sale System

Old Policy: Currently, online processing for Medicaid pharmacy claims is available for all pharmacies using NCPDP Version 5.1.

See the Pharmacy Point-of-Sale (POS) NCPDP Version 5.1 Vendor Specification Document, for specifications and information for switch vendors.

New Policy: Currently, online processing for Medicaid pharmacy claims is available for all pharmacies using NCPDP Version D.0.

See the Pharmacy Point-of-Sale (POS) NCPDP Version D.0 Vendor Specification Document, for specifications and information for switch vendors.

Section 518.11.2 National Council on Prescription Drug Programs (NCPDP) Payer Sheet

Old Policy: West Virginia Medicaid accepts pharmacy Point-of-Sale claims submitted using NCPDP Version 5.1 or Batch Version 1.1. … (See the Pharmacy Point-of-Sale (POS) NCPDP Version 5.1 Vendor Specification Document, located on BMS' link to the fiscal agent website, for the West Virginia Medicaid payer sheet.)

New Policy: West Virginia Medicaid accepts pharmacy Point-of-Sale claims submitted using NCPDP Version D.0 or Batch Version 1.1. … (See the Pharmacy Point-of-Sale (POS) NCPDP Version D.0 Vendor Specification Document, located on BMS' link to the fiscal agent website, for the West Virginia Medicaid payer sheet.)

Section 518.11.3 Paper Claim Submission for Pharmacy Services

Old Policy: Pharmacies have the alternative of submitting a manual claim using a paper claim form, when necessary. The Universal Claim Form (UCF) provides a standard format for paper submission of drug claims to Medicaid. The UCF adheres to the data elements found in the Telecommunication Standard and Data Dictionary. The new UCF that supports the Telecommunication Standard Version 5.1 is "DAH 2 PT". **Medicaid will not supply these forms to providers**. NCPDP has an agreement with R.R. Donnelley to distribute the UCF. Their telephone number is 1-800-635-9500. The order number for the UCF is Laser UCF form, number UCFL 1. Forms are also available from pharmaceutical wholesalers. An example of the UCF and completion instructions can be found in the Health PAS-RX Pharmacy Point-of-Sale (POS) User Guide, located on BMS' link to the fiscal agent website, www.wvdhhr.org/bms.

New Policy: Pharmacies have the alternative of submitting a manual claim using a paper claim form, when necessary. The Universal Claim Form (UCF) provides a standard format for paper submission of drug claims to Medicaid. The UCF adheres to the data elements found in the Telecommunication Standard and Data Dictionary. **Medicaid will not supply these forms to providers**.

Section 518.11.10 Compounded Prescriptions

Old Policy: Billing compounded prescriptions follows NCPDP Version 5.1 guidelines.

New Policy: Billing compounded prescriptions follows NCPDP Version D.0 guidelines.

Section 518.11.11 Abuse and Inappropriate Utilization

Old Policy: The following practices constitute abuse and inappropriate utilization, and are subject to audit:

- Excessive fees (commonly known as prescription splitting or incorrect or excessive dispensing fees): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
  - Supplying medication in amounts less than necessary to cover the period of the prescription; and/or
  - Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.
- Excessive filling: Billing for an amount of a drug or supply greater than the prescribed quantity.
- Prescription shorting: Billing for drug or supply greater than the quantity actually dispensed.
- Substitution to achieve a higher price: Billing for a higher priced drug than prescribed even though the prescribed lower priced drug was available.
- Automatic filling of prescriptions or automatic shipping of medications to the member is prohibited unless members request the filling or shipping of these medications each time.

New Policy: The following practices constitute abuse and inappropriate utilization, and are subject to audit:

- Excessive fees (commonly known as prescription splitting or incorrect or excessive dispensing fees): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
  - Supplying medication in amounts less than necessary to cover the period of the prescription; and/or
  - Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.
- Excessive filling: Billing for an amount of a drug or supply greater than the prescribed quantity.
- Prescription shorting: Billing for drug or supply greater than the quantity actually dispensed.
- Substitution to achieve a higher price: Billing for a higher priced drug than prescribed even though the prescribed lower priced drug was available.

Automated refills and automatic shipments are prohibited. Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. Any prescriptions filled without a request from a member or their responsible party will be subject to recovery. Any pharmacy provider with a policy that includes filling prescriptions on a regular date or any type of cyclical procedure will be subject to audit, claim recovery or possible suspension or termination of the provider agreement.

Section 518.12 REIMBURSEMENT

Old Policy: N/A.

New Policy: If a provider accepts the member as a Medicaid patient, the provider must bill WV Medicaid for covered services and must accept the Medicaid reimbursement amount as full payment. No charge may be billed to a Medicaid member for a covered service unless a co-payment is applicable by regulation. However, the provider may bill the member for services not covered by the WV Medicaid Program if the parties agree in writing to this payment arrangement before such services are rendered. Refer to *Chapter 300, Section 320.2* for more information about billing Medicaid members.

Section 518.12.1 Ingredient Cost

Old Policy: The Maximum Allowable Cost (MAC) plus a reasonable dispensing fee. The MAC for each multiple-source drug as defined in 42 CFR 447.332 and published in the Federal

Register, plus a dispensing fee. A listing of Federal Multiple Source Drug Limits is available on the CMS' website, www.CMS.hhs.gov/Reimbursement.

New Policy: The Maximum Allowable Cost (MAC) plus a reasonable dispensing fee. The MAC for each multiple-source drug as defined in 42 CFR 447.332 and published in the Federal Register, plus a dispensing fee. Information relating to Federal Multiple Source Drug Limits is available on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Federal-Upper-Limits.html.

Old Policy: (4) The Medicaid AWP (MAWP) established by the Federal Office of the Inspector General, plus a dispensing fee;

New Policy: (Remove bullet 4, MAWP)

Section 518.12.2 Application of Dispensing Fee

Old Policy: For covered legend and over-the-counter drugs, a professional dispensing fee of $2.50 per prescription for brand name drugs or a professional dispensing fee of $5.30 per prescription for generic drugs will be added to the federally established MAC, state established MAC, Medicaid AWP, or state established EAC of each prescribed drug.

For a compounded prescription, an additional $1.00 will be added to the dispensing fee. A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a legend drug

New Policy: For covered legend and over-the-counter drugs, a professional dispensing fee of $2.50 per prescription for brand name drugs or a professional dispensing fee of $5.30 per prescription for generic drugs will be added to the federally established MAC, state established MAC, or state established EAC of each prescribed drug.

For a compounded prescription, an additional $1.00 will be added to the dispensing fee. A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a legend drug. Compounding is considered an integral part of the prescription services and must not be billed separately.

Section 518.12.3 Co-Payments

Old Policy: Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility.

New Policy: Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility. Members are responsible for applicable copays, and providers are prohibited from waiving the copay requirement to attract business from other providers.

Section 518.12.4 Third-Party Liability (TPL) or Coordination of Benefits (COB)

Old Policy: See the User Guide for billing instructions for NCPDP Version 5.1 in regard to Coordination of Benefits.

New Policy: See the User Guide for billing instructions for NCPDP Version D.0 in regard to Coordination of Benefits.

Section 518.12.4.2 Medicare Covered Drugs, Part D

Old Policy: Dual eligible members have prescription drug coverage through Medicare Part D. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

- Benzodiazepines
- Barbiturates
- Over-the-counter medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

Medicaid does not reimburse for Medicare Part D co-payments. Medicaid does not pay as the secondary payer on Medicare Part D covered drugs.

New Policy: Dual eligible members have prescription drug coverage through Medicare Part D. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

- Barbiturates (if not for treatment of epilepsy, cancer, or mental health disorder, as Medicare Part D covers these conditions)
- Over-the-counter medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

Medicaid does not reimburse for Medicare Part D co-payments. Medicaid does not pay as the secondary payer on Medicare Part D covered drugs.

Section 518.13.4 Additional Information

Old Policy:
Person or Company: Goold Health Services
Phone Number: 800-340-5970

New Policy:
Person or Company: Magellan Medicaid Administration, Inc.
Phone Number: 800-763-7382

November 19, 2012

Introduction: Section 518.4 Description of Covered Services, Bullet item 7

Old Policy: Influenza and pneumonia vaccines for adults over 21 years of age administered by a pharmacist.

New Policy: Influenza and pneumonia vaccines for adults over 19 years of age administered by a pharmacist. (Note: Correction to age in policy wording.)

April 1, 2012

Introduction: Section 518.3.1.4, Medicaid Members with End Stage Renal Disease (ESRD)

Old Policy: Members diagnosed with End Stage Renal Disease (ESRD) may require additional over-the-counter drug treatments not usually covered by the pharmacy program. In order to accommodate these members, a letter signed and dated by the treating physician is required to verify the diagnosis of ESRD and must include the date dialysis began. This letter shall be directed to:

Bureau for Medical Services
Member Eligibility
350 Capitol Street, Room 251
Charleston, West Virginia 25301-2675

Refer to the BMS website, www.wvdhhr.org/bms, for a list of additional over-the-counter drugs covered for ESRD patients.

New Policy: Members diagnosed with End Stage Renal Disease (ESRD) may require additional vitamin/mineral supplements not usually covered by the pharmacy program. In order to accommodate these members, a letter signed and dated by the treating physician is required to verify the diagnosis of ESRD and must include the date dialysis began. This letter shall be directed to:

Bureau for Medical Services
Member Eligibility
350 Capitol Street, Room 251
Charleston, West Virginia 25301-2675

Refer to the BMS website, www.dhhr.wv.gov/bms, for a list of additional vitamin/mineral supplements covered for ESRD patients.

Once a member receives a kidney transplant, the member is no longer considered as having ESRD, and no longer qualifies for these additional supplements.

Introduction: Section 518.3.2.6, Juvenile Services

Old Policy: Certain individuals have pharmacy services coverage through Juvenile Services. A letter of eligibility will be presented to the pharmacy which includes the individual's identification number beginning with prefix "17". Claims for these services may be submitted through the online Point-of-Sale system or by using the approved paper claim form. Medicaid coverage rules apply.

New Policy: Incarcerated minors have pharmacy services coverage through Juvenile Services. A letter of eligibility will be presented to the pharmacy which includes the individual's identification number beginning with prefix "17". Claims for these services may be submitted through the online Point-of-Sale system or by using the approved paper claim form. Medicaid coverage rules apply.

Introduction: Section 518.4.5, Home Infusion Therapy Pharmacy Services, formerly In-Home Parenteral Therapy (IHPT) Pharmacy Services

Old Policy: Drugs used for in-home parenteral therapy services are covered under the Medicaid Pharmacy Program. These drugs require prior authorization and must be justified by the ordering practitioner, including why oral therapy is unsuitable for the patient. **Members enrolled in Medicaid managed care plans have coverage of IHPT pharmacy services through their managed care plan. Dual eligible members have coverage of IHPT pharmacy services through their Medicare Part D plans.**

See *Appendix 1* for detailed information regarding IHPT pharmacy services.

New Policy: Drugs used for home infusion therapy services are covered under the Medicaid Pharmacy Program. These drugs require prior authorization and must be justified by the ordering practitioner, including why oral therapy is unsuitable for the patient. **Members enrolled in Medicaid managed care plans have coverage of home infusion pharmacy services through their managed care plan. Dual eligible members have coverage of home infusion pharmacy services through their Medicare Part D plans.**

See *Appendix 1* for detailed information regarding Home Infusion Therapy pharmacy services.

Introduction: Section 518.4.7, Buprenorphine-Naloxone(Suboxone®)/Buprenorphine(Subuxtex®) Coverage

Old Policy: N/A

New Policy: Buprenorphine-Naloxone and Buprenorphine are covered through the Pharmacy program, and must be written by a prescriber enrolled with WV Medicaid or employed by a facility enrolled with WV Medicaid, or enrolled with one of the Medicaid MCOs. Buprenorphine-

Naloxone and Buprenorphine are obtained only through a prior authorization. Other limitations may apply.

See the BMS website at www.dhhr.wv.gov/bms for additional information and detailed coverage criteria.

Introduction: Section 518.5.1, Bulk Chemicals

Old Policy: N/A

New Policy: Per CMS Medicaid Drug Rebate Program Release No. 155, bulk chemicals are substances which when used in the manufacturing of a drug become the active ingredient of the drug product. As such they do not meet the definition of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act. However, bulk chemicals may be considered in rare circumstances if prescribed for an FDA-approved indication and/or medically accepted indication supported in official compendia. Prior authorization is required.

All rules, regulations, limitations, and exclusions set forth in the Pharmacy Services manual apply also to bulk chemicals.

Refer to the BMS website, www.dhhr.wv.gov/bms, for a list of covered bulk chemicals and criteria for coverage.

Introduction: Section 518.7, NON COVERED SERVICES

Old Policy: The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purpose
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary

- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS, except for influenza and pneumonia vaccines for adults over the age of 21 years administered by a pharmacist
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.

New Policy: The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purpose
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents

- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS, except for influenza and pneumonia vaccines for adults over the age of 21 years administered by a pharmacist
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.
- Methadone for the treatment of drug dependence/addiction

Introduction: Section 518.10.4, Shipping/Receiving

Old Policy: Drugs reimbursed by West Virginia Medicaid that are mailed or shipped to members require a signature of the individual receiving delivery of the medication. A log of these signatures must be maintained by the pharmacy for a period of 5 years for auditing purposes. Providers shall take the necessary steps to prevent loss of medications in the shipping process, as Medicaid will not reimburse for medications not received by the member.

New Policy: Drugs reimbursed by West Virginia Medicaid that are mailed or shipped to members require a signature of the individual receiving delivery of the medication. A log of these signatures must be maintained by the pharmacy for a period of 5 years for auditing purposes. Providers shall take the necessary steps to prevent loss of medications in the shipping process and to assure that the member receives the shipment when needed, as Medicaid will not reimburse for medications not received by the member.

Claims for medications not received by the member in a timely manner may be reversed for billing by a local pharmacy provider.

Introduction: Section 518. 11.13, Wasted Medication

Old Policy: Members who have wasted medication due to improper use or storage may have their medication replaced. This will be determined on a case-by-case basis. Members shall be properly instructed on the storage and use of their medications and any special delivery device used to administer their medications. Requests for replacement of wasted medications due to improper storage or delivery by the pharmacy will be denied.

New Policy: Members who have wasted medication due to improper use or storage may have their medication replaced. This will be determined on a case-by-case basis. Members shall be properly instructed on the storage and use of their medications and any special delivery device used to administer their medications. Requests for replacement of wasted medications due to improper storage or delivery by the pharmacy, or improper handling by the administrating provider will be denied.

November 1, 2010

Introduction: Section 518.2.5, Pharmacy Change of Ownership

Old Policy: N/A

New Policy: Change of ownership policy is addressed in *Common Chapter 300, Provider Participation Requirements,* and additional information may be found on the fiscal agent's website, see *Common Chapter 100, General Information,* for information on the fiscal agent. Although a pharmacy provider's NPI may be legally transferred from one owner to the next, BMS recommends that a new owner obtain a new NPI to facilitate a seamless transition.

Introduction: Section 518.3.1.1, Mountain Health Choices

Old Policy: Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained for a 34-day period. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Basic Benefit Package or Plan will be limited to 4 prescriptions per 34 day period.

Certain categories of drugs will not be included in the 4 prescription limit for members who choose the Basic Benefit Package. Drugs in the following therapeutic classes will not count toward the prescription limit for **children** with the Basic Benefit Package, which will be indicated by "BC" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Medications used for the treatment of seizures
c. Certain antibiotics-cephalosporins, macrolides, penicillins, and sulfonamides
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

The following therapeutic classes will not count toward the 4-prescription limit for **adults** with the Basic Benefit Package, which will be indicated by "BA" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Atypical antipsychotics
c. Antidepressants (all therapeutic classes)
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member's medication profile.

New Policy: Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained per calendar month. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Adult Basic Benefit Package or Plan will be limited to 4 prescriptions per calendar month period. Children under the age of 21 years are not limited in the number of prescriptions they may receive.

The following therapeutic classes will not count toward the 4-prescription limit for adults with the Basic Benefit Package, which will be indicated by "BA" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Atypical antipsychotics
c. Antidepressants (all therapeutic classes)
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member's medication profile.

Introduction: Section 518.3.1.7, Incarcerated Members

Old Policy: N/A

New Policy: Medicaid members who are incarcerated are restricted from coverage of pharmacy benefits until they are released from the correctional system. Claims submitted with dates of service during a period of incarceration will deny. If the member has been released before the restriction is updated, positive identification is required. A call to the Rational Drug Therapy Program help desk must be made to request an override.

Introduction: Section 518.5, SERVICE LIMITATIONS

Old Policy:

- Members enrolled in the Mountain Health Choice's (MHC) basic plans are limited to coverage of four prescriptions per calendar month, with the exception of the following therapeutic classes for children:
    - Diabetic supplies and all insulins,
    - Medications used in the treatment of seizures,
    - Certain antibiotics—cephalosporins, macrolides, penicillins, and sulfonamides

- Drugs used for the treatment of HIV/AIDS
- All contraceptives.

And for adults enrolled in the MHC basic plan, the following exceptions of therapeutic classes to the four prescription limit are:

- Diabetic supplies and all insulins,
- Atypical antipsychotics,
- Antidepressants (all therapeutic classes),
- Drugs used for the treatment of HIV/AIDS,
- All contraceptives.

New Policy:

- Members enrolled in the Mountain Health Choice's (MHC) Adult basic plan are limited to coverage of four prescriptions per calendar month.

  The following therapeutic classes will not count toward the 4-prescription limit:

  - Diabetic supplies and all insulins,
  - Atypical antipsychotics,
  - Antidepressants(all therapeutic classes),
  - Drugs used for the treatment of HIV/AIDS,
  - All contraceptives.

Introduction: Section 518.10.2, Prescriptions Returned to Stock

Old Policy: Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis. A log of these returns must be maintained by the pharmacy for a period of 5 years for auditing purposes.

New Policy: Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis, within 15 days. A log of these returns must be maintained by the pharmacy for a period of 5 years for auditing purposes.

Introduction: Section 518.11, BILLING PROCEDURE

Old Policy: N/A

New Policy: Claims must accurately report the NDC dispensed, the number of units dispensed, days' supply, and other required data for claims processing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause BMS to report false data to drug manufacturers when billed for drug rebates. BMS will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers or during claim reviews. Pharmacies are required to submit documentation for purchases of drugs reimbursed by BMS upon request.

Introduction: Section 518.11.14, False Claims

Old Policy: N/A

New Policy: Pharmacies are prohibited from submitting false claims to test for drug coverage, member eligibility, or for other purposes. Claims of this type result in false member drug history records and may result in the member or prescriber being included in lawsuits or reviews in error. All claims submitted for reimbursement must be the result of actual prescription requests.

Introduction: Appendix 1, In-Home Parenteral Therapy

Old Policy: Prior authorization form included

New Policy: See the BMS web site at www.wvdhhr.org/bms for the approved prior authorization form.

October 1, 2010

Introduction: Section 518.4, Description Of Covered Services

Old Policy: Except for certain limitations and exclusions, BMS will reimburse for the following:

• Outpatient legend drugs
• Specific over-the-counter drugs
• Compounded prescriptions
• Drugs that require prior authorization, when approved by BMS
• Family planning supplies, including over-the-counter supplies
• Certain diabetic supplies.

New Policy: Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions
- Drugs that require prior authorization, when approved by BMS
- Family planning supplies, including over-the-counter supplies
- Certain diabetic supplies
- Influenza and pneumonia vaccines for adults over 21 years of age administered by a pharmacist.

Introduction: Section, 518.7, Non-Covered Services

Old Policy: The following list of drugs, drug products, and related services are not reimbursable. Noncovered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services,* for additional information regarding hemophilia services.

New Policy: The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes

- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS, except for influenza and pneumonia vaccines for adults over the age of 21 years administered by a pharmacist
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.

Introduction: Section 518.12.3, Co-Payments

Old Policy: A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the Program. The deduction will apply as follows:

• If the allowed total charge is $10.00 or less, the co-payment is $.50 per prescription
• If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription
• If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription
• If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription

Certain individuals or covered services are exempt from the co-payment requirement, as follows:

• Prescriptions for family planning services and supplies
• Prescriptions for members in long-term care facilities (i.e., nursing facilities or intermediate care facilities for mentally retarded)
• Prescriptions for pregnant women
• Prescriptions for members under 18 years of age
• 3-day emergency supplies
• Diabetic testing supplies and syringes/needles

• BMS approved home infusion supply

New Policy: A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the Program. The deduction will apply as follows:

- If the allowed total charge is $10.00 or less, the co-payment is $.50 per prescription
- If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription
- If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription
- If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription

Certain individuals or covered services are exempt from the co-payment requirement, as follows:

- Prescriptions for family planning services and supplies
- Prescriptions for members in long-term care facilities (i.e., nursing facilities or intermediate care facilities for mentally retarded)
- Prescriptions for pregnant women
- Prescriptions for members under 18 years of age
- 3-day emergency supplies
- Diabetic testing supplies and syringes/needles
- BMS approved home infusion supply
- POS-approved vaccines

May 15, 2010
Section 518.5.1

Introduction: Section 518.5.1, Coverage of Brand Name versus Generic Drugs

Old Policy: DAW 1 - Prescriber states that the brand name drug is “medically necessary”. This information must be supplied in writing by the **physician** via written prescriptions and by the **physician** on verbal prescriptions. Approval from the help desk is required for the use of DAW 1 and appropriate justification must be provided.

New Policy: Prescriber states that the brand name drug is “medically necessary”. This information must be supplied in writing by the **prescriber** via written prescriptions in their own handwriting, and must write on the prescription “Brand Medically Necessary”. A check-box or other methods to indicate that the brand should be dispensed shall not be accepted. Approval from the help desk is required for the use of DAW 1 and appropriate justification must be provided.

Introduction: Section 518.6, Non-covered services

Old Policy:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which require prior authorization and for which prior authorization criteria have not been met
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Inappropriate therapeutic/ingredient duplications, early refills, and other Drug Utilization Review events.
- Vaccines via the pharmacy POS
- Factors to treat hemophilia via the pharmacy POS
  (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.)

New Policy:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth

- Drugs identified by CMS as being less-than-effective (DESI). The DESI list and more information about DESI drugs may be found on the Centers for Medicare and Medicaid Services' (CMS) website at www.cms.hhs.gov/MedicaidDrugRebateProgram.
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purposes
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug
- Vaccines via the pharmacy POS
- Factors to treat hemophilia via the pharmacy POS
  (Refer to *Chapter 519, Practitioner Services Manual,* for additional information regarding hemophilia services.)

Introduction: Section 518.7, Prior Authorization (PA)

Old Policy: Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.wvdhhr.org/bms.

New Policy: Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These

criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.wvdhhr.org/bms. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable until appealed by the prescribing practitioner on behalf of the member.

Old Policy: N/A

New Policy: The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Introduction: Section 518.7.2, Prior Authorization Appeal Process

Old Policy: Appeals will be processed within 3 business days of their receipt. Appeals shall be faxed to the Rational Drug Therapy Program (RDTP), Appeals Department at 1-800-531-7787. All appeals denied by RDTP will be sent to BMS for physician review.
If the outcome of the physician review upholds the denial, the Medicaid member is notified of this denial and of their right to request a fair hearing.

New Policy: Appeals will be processed within 3 business days of their receipt. Appeals shall be faxed to the Rational Drug Therapy Program (RDTP), Appeals Department at 1-800-531-7787. All appeals denied by RDTP will be sent to BMS for physician review. Any denial resulting from physician review is final. The Medicaid member is notified of this denial and of their right to request a fair hearing.

Introduction: Section 518.8.3, Reporting of Cash Payments

Old Policy: N/A

New Policy: Pharmacies are encouraged to report to BMS when a member pays cash for prescriptions that would otherwise be covered by Medicaid or considered for reimbursement upon a call to the RDTP, or when the pharmacy provider suspects overutilization by the member. A form used for this reporting can be found on the BMS website, www.wvdhhr.org/bms. The form should be faxed to BMS at 304-558-1542. Information collected through this process may be used for member lock-in consideration and continued eligibility.

Introduction: Section 518.8.4, Member Counseling

Old Policy: N/A

New Policy: Renumber entire section due to addition of section 518.8.3, Reporting of Cash Payments

Introduction: Section 518.9.1, Tamper-Resistant Prescription Pad Requirement

Old Policy: As of October 1, 2008, all prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meets all 3 characteristics set forth in the guidelines from the Centers for Medicare and Medicaid Services (CMS).

New Policy: All prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meet all 3 characteristics set forth in the guidelines from the Centers for Medicare and Medicaid Services (CMS). The three characteristics to meet the tamper-resistant prescription requirement:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription, and;
3. Prevent the use of counterfeit prescription forms.

Old Policy: N/A

New Policy: Computer-generated prescriptions, EMR, or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of tamper resistance, provided they contain the features listed in the table below. Prescribers are urged to contact their software companies to ensure that computer generated prescriptions have all requirements necessary for tamper resistance.

Computer-generated prescriptions must contain the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax. *This requires the purchase of special paper.*
OR	
Micro print signature line	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.

2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.

Feature	Description

UNIFORM NON-WHITE BACKGROUND COLOR – *PREFERABLY GREEN* OR "Toner-lock" paper for laser printed prescriptions, or plain bond paper for inkjet printed prescriptions	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If someone tries to erase copy – the consistent background color will look altered. Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from the inkjet printers is absorbed into normal "bond" paper.
QUANTITY WRITTEN AND QUANTITY WITH BORDER CHARACTERISTICS FOR COMPUTER GENERATED PRINTED PRESCRIPTIONS	Quantity written and Quantity surrounded by special characters such as asterisks to prevent modification, e.g. *QTY Fifty ***50****.*
Refill written and refill with border characteristic for computer generated printed prescriptions	Refills written and Refill surrounded by special characters such as asterisks to prevent modification, e.g. *Five refills ****5 refills*****.*

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Feature	Description
SECURITY FEATURES AND DESCRIPTIONS LISTED ON THE PRESCRIPTION	A complete list of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the paper.

Prescriptions for West Virginia Medicaid members written by prescribers that reside outside of West Virginia may meet the federal tamper-resistant prescription requirement if the prescription addresses the three distinct characteristics outlined above, and may contain the same or other features than those adopted by BMS.

Introduction: Section 518.9.4, Shipping/Receiving

Old Policy: N/A

New Policy: Drugs reimbursed by West Virginia Medicaid that are mailed or shipped to members require a signature of the individual receiving delivery of the medication. A log of these signatures must be maintained by the pharmacy for a period of 5 years for auditing purposes. Providers shall take the necessary steps to prevent loss of medications in the shipping process, as Medicaid will not reimburse for medications not received by the member.

Introduction: Section 518.10.10, Compounded Prescription

Old Policy: N/A

New Policy: Products such as suppository molds and other items identified as supplies included in a compounded prescription will not be reimbursed by West Virginia Medicaid.

Introduction: Section 518.10.11, Abuse and Inappropriate Utilization

Old Policy: N/A

New Policy: Automatic filling of prescriptions or automatic shipping of medications to the member is prohibited unless members request the filling or shipping of these medications each time.

Introduction: Section 518.11.3, Co-payments

Old Policy: N/A

New Policy: Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility.

Introduction: Section 518.11.4, Third-Party Liability (TPL) or Coordination of Benefits (COB)

Old Policy: N/A

New Policy: Medicaid covered drugs which currently require a prior authorization (PA) from BMS will continue to require a PA if a primary insurer approves that service, and Medicaid reimburses any part of the cost.

Medicaid co-payment is still required, if applicable, for claims considered by third party payers and reimbursed by BMS.

CHAPTER 518—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PHARMACY SERVICES

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CHAPTER 518–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PHARMACY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) mandated major changes in coverage and reimbursement for Medicaid-covered outpatient drugs. West Virginia Medicaid reimbursement is limited to drugs whose manufacturers have entered into and have in effect a rebate agreement with the Secretary, Department of Health and Human Services.

West Virginia Medicaid offers a comprehensive scope of Pharmacy services to Medicaid members as an optional program, subject to medical necessity, appropriateness criteria, and prior authorization requirements. The West Virginia Medicaid Pharmacy Program is funded by both West Virginia State and Federal funds. All covered drugs, whether legend or non-legend, prescribed by a physician or other authorized practitioner, are addressed within the program. Applicable state and federal laws governing dispensing of drugs and biologicals must be followed.

This manual identifies and explains covered services, their limits, eligibility requirements, and polices that are required to be followed by providers of outpatient prescription drugs in order to obtain reimbursement from federal and state funds.

518.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to the Provider Manual, *Chapter 200, Definitions*. In addition, the following definitions apply and/or relate to Pharmacy Services.

340b Program: a federal program administered by Health Resources and Services Administration (HRSA) whereby certain designated facilities purchase prescription medications at

deep discounts, allowing these facilities to offer some medications to their patients at greatly reduced prices.

Dispensed As Written (**DAW):** a numerical value used by providers to explain the dispensing of a brand-name product instead of a generic one.

Drug Efficacy Study and Implementation Program (**DESI):** Drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness.

End Stage Renal Disease (ESRD): the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

First Data Bank (**FDB):** a database company for drug pricing and drug utilization review (DUR) edits.

Federal Drug Rebates: a payment made by pharmaceutical manufacturers to the states for drugs dispensed to Medicaid members.

Federal Upper Limit (**FUL):** maximum allowable cost (MAC) established by the Centers for Medicare and Medicaid Services for certain prescribed drugs.

Home IV: Intravenous medications administered in the home, provided by specialized pharmacies, which require the services of a nurse or trained caregiver.

Lock-In: Program administered through the retrospective drug utilization review process to limit members to the use of one pharmacy provider.

Mountain Health Choices: The name of West Virginia Medicaid's program where members have a choice of benefit packages. This program promotes member choice, member responsibility and health improvement. This program was developed as a result of the Deficit Reduction Act 2005 and allows for the tailoring of benefit packages to meet the needs of certain populations. This program is a part of the redesign of Medicaid to promote wellness and to prevent and/or manage the progression of chronic diseases by encouraging healthier lifestyles for Medicaid members.

Multi-Source Drugs: Drugs that are marketed or sold by two or more manufacturers or labelers.

National Provider Identifier (NPI): A standard unique healthcare provider identification number mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Orange Book: Publication by the Food and Drug Administration which establishes therapeutic equivalency ratings for drugs.

Pharmaceutical and Therapeutics Committee (**P & T Committee):** an advisory body that recommends drugs to Medicaid for inclusion or exclusion relating to the Preferred Drug List.

Rational Drug Therapy Program (**RDTP):** agency designated by the Bureau for Medical Services for prior authorizing prescription drugs.

Retrospective Drug Utilization Review (**RETRO DUR):** review of member drug history records against predetermined standards to improve quality of healthcare and to educate physicians and pharmacists on common drug therapy issues.

Single-Source Drug: A drug that is available from only one manufacturer.

State MAC (SMAC): Maximum allowable cost for drug products or supplies established by the state Medicaid agency.

Supplemental Drug Rebate: A payment from a pharmaceutical manufacturer, negotiated by the state, in addition to the federal rebate.

518.2 PROVIDER PARTICIPATION REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, pharmacy providers must:

- Meet and maintain all applicable licensing, accreditation, and certification requirements;
- Meet and maintain all BMS enrollment requirements;
- Have a valid trading partner agreement on file that is signed by the provider and BMS upon application for enrollment into the West Virginia Medicaid Program; and
- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services and all applicable State and Federal Laws governing the provision of their services

Provider enrollment requirements in general are detailed in *Common Chapter 300, Provider Participation Requirements*.

518.2.1 Certification

A pharmacy eligible to participate in Medicaid must hold a current permit from the West Virginia State Board of Pharmacy and adhere to all state and federal regulations. Pharmacies located out-of-state and filling prescriptions for West Virginia Medicaid members must be licensed by the state in which they are located. Pharmacies located out-of-state and shipping or mailing prescriptions into West Virginia must be licensed by the state in which they are located **and** hold a permit from the West Virginia Board of Pharmacy. Pharmacies are required to file a copy of their current permits with BMS annually. Failure to do so may result in the withholding of payments and/or enrollment termination.

When the current license and/or permit is not on file, the provider shall not be reimbursed by Medicaid until such time the BMS' Provider Enrollment Unit receives a copy of the current license and/or permit.

Pharmacies completing West Virginia Medicaid enrollment applications must indicate on the form the pharmacy designation, i.e. retail; institutional; hospital outpatient - open to the public; hospital outpatient - closed to the public; mail order; in-home parenteral therapy (home infusion pharmacy).

518.2.2 Dispensing Physicians

Reimbursement for self-administered prescription drugs is limited to licensed and participating pharmacies. BMS does not enroll dispensing physicians for reimbursement as a pharmacy provider type.

518.2.3 In-Home Parenteral Therapy Pharmacy Requirements

Pharmacies requesting reimbursement for in-home parenteral therapy compounding services must meet all state and federal licensure and certification requirements. See Appendix 1 for information pertaining to this program.

518.2.4 Pharmacies Participating in the 340B Program

Pharmacies participating in the program established by Section 340B of the Public Health Services Act of 1992 must notify BMS of their participation in the 340B program by completing the required certification form and supplying 3 recent comprehensive invoices annually. This form is available on the BMS website, www.dhhr.wv.gov/bms. Drugs with discounts generated from participation in this program are not eligible for federal drug rebates and drug claims from these pharmacies must be exempted from drug rebate invoices that Medicaid sends to the drug manufacturers. Pharmacies participating in this program must submit their actual acquisition costs when billing the Medicaid program. Submission of additional invoices may be required for audit purposes.

518.2.5 Pharmacy Change of Ownership

Change of ownership policy is addressed in *Common Chapter 300, Provider Participation Requirements,* and additional information may be found on the fiscal agent's website, see *Common Chapter 100, General Information* for information on the fiscal agent. Although a pharmacy provider's NPI may be legally transferred from one owner to the next, BMS recommends that a new owner obtain a new NPI to facilitate a seamless transition.

518.3 MEMBER ELIGIBILITY

Medicaid covers pharmacy services for all individuals who meet Medicaid eligibility guidelines. Drug coverage may also be available to other eligibility groups as described below. Refer to Common *Chapter 400, Member Eligibility*, for more information regarding eligibility requirements.

518.3.1 Medicaid Members Eligible for Pharmacy Services

Medicaid members eligible for pharmacy services have access to legend and over-the-counter drugs as defined in the State Plan filed with CMS. An eligibility card is issued to these individuals. This card must be presented to assure eligibility of the member. Any person requesting services without a Medicaid identification card shall be advised that he/she is responsible for furnishing his or her identification card to the provider prior to services being rendered. If the card is unavailable, eligibility may be verified through the Medicaid Voice Response System at 1-888-483-0793 or by sending an electronic NCPDP E-1 transaction through the pharmacy Point-of-Sale (POS) billing system.

518.3.1.1 Mountain Health Choices (MHC)

Pharmacy services are covered for all benefit plans, either through Medicaid fee-for-service or Medicaid Managed Care Organizations (MCO). Members enrolled in the Medicaid MCOs must follow the rules and policies of their respective MCO. The managed care plans are required to provide pharmacy benefits consistent with the Medicaid Preferred Drug List (PDL), both in the selection of preferred/non-preferred drugs and criteria for coverage. The plans are responsible for policies for drugs not included in the Medicaid PDL. There is no copayment requirement for pharmacy services covered through the managed care organization plans.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained per calendar month. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Adult Basic Benefit Package or Plan will be limited to 4 prescriptions per calendar month period. Children under the age of 21 years are not limited in the number of prescriptions they may receive.

The following therapeutic classes will not count toward the 4-prescription limit for adults with the Basic Benefit Package, which will be indicated by “BA” on their Medicaid Identification Card:

- Diabetes supplies and all insulins
- Atypical antipsychotics
- Antidepressants (all therapeutic classes)
- Drugs used for the treatment of HIV/AIDS
- Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member’s medication profile.

518.3.1.2 Dual Eligible Members

Members eligible for both Medicare and Medicaid are called dual eligible members. Medicare is the primary payer for dual eligible members. Medicare, a federal health insurance program for the

aged and disabled, covers certain hospital (Part A), outpatient medical benefits and physicians' services (Part B) and prescription benefits (Part D) for participating individuals. Some dual eligible members may participate in Medicare Managed Care plans (Advantage or Part C plans) which include pharmacy services.

Dual eligible members have prescription drug coverage through Medicare Part D, or Part C if enrolled in a Medicare Managed Care plan. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Medicaid does not reimburse for Medicare Part D or Part C co-payments. Medicaid does not pay as the secondary payer on Medicare Part D or Part C covered drugs.

518.3.1.3 Medicaid Members Enrolled in Medicaid Managed Care Organization Plans

Effective April 1, 2013, Medicaid members enrolled in the Medicaid managed care organization plans receive pharmacy services from the managed care plan. These members will have two identification cards – the managed care identification card for managed care covered services, and the Medicaid identification card for carved-out services. The managed care plans are required to provide pharmacy benefits consistent with the Medicaid Preferred Drug List (PDL), both in the selection of preferred/non-preferred drugs and criteria for coverage. The plans are responsible for policies for drugs not included in the Medicaid PDL. There is no copayment requirement for pharmacy services covered through the managed care organization plans.

518.3.1.4 Medicaid Members with End Stage Renal Disease (ESRD)

Members diagnosed with End Stage Renal Disease (ESRD) may require additional vitamin/mineral supplements not usually covered by the pharmacy program. In order to accommodate these members, a letter signed and dated by the treating physician is required to verify the diagnosis of ESRD and must include the date dialysis began. This letter shall be directed to:

Bureau for Medical Services
Member Eligibility
350 Capitol Street, Room 251
Charleston, West Virginia 25301-2675

Refer to the BMS website, www.dhhr.wv.gov/bms, for a list of additional vitamin/mineral supplements covered for ESRD patients.

Once a member receives a kidney transplant, the member is no longer considered as having ESRD, and no longer qualifies for these additional supplements.

518.3.1.5 Qualified Medicare Beneficiary (QMB)

QMB members do not receive pharmacy coverage benefits through the Medicaid program. Medicaid does provide coverage of deductibles and co-insurance amounts for Medicare Part B covered drugs and other Medicare covered services with the exception of those covered under

Part D. These members receive a medical identification card, but coverage, as noted on the card, is limited to Medicare co-insurance and deductibles only.

518.3.1.6 Children in Foster and Adoptive Placement

Children in state custody and entered into foster, residential or adoptive placements may be Medicaid eligible. They receive a medical identification card. The eligibility number begins with "039". Drug claims may be submitted online through the pharmacy Point-of-Sale system or on the approved paper claim form. Medicaid coverage rules apply.

518.3.1.7 Incarcerated Members

Medicaid members who are incarcerated are restricted from coverage of pharmacy benefits until they are released from the correctional system. Claims submitted with dates of service during a period of incarceration will deny. If the member has been released before the restriction is updated, positive identification is required. A call to the Rational Drug Therapy Program help desk must be made to request an override.

518.3.2 Non-Medicaid Individuals Eligible for Pharmacy Services

Individuals who do not qualify for the Medicaid Program may have pharmacy coverage under other federal or state-funded programs. These individuals do not receive medical identification cards, but may receive a letter or other form of eligibility authorization.

518.3.2.1 AIDS Drug Assistance Program (ADAP) or Ryan White Program

The AIDS Drug Assistance Program (ADAP) is funded under Part B of the Ryan White HIV/AIDS Treatment Extension Act in West Virginia, and claims are processed through the BMS claims processing system. The program assists eligible persons with HIV infection in obtaining drugs covered by the ADAP formulary. To be eligible for the ADAP, a person must meet the following:

- be an HIV infected resident of West Virginia;
- with a family income less than 400% of the federal poverty level (FPL), and;
- not be eligible for other forms of reimbursement such as Medicaid or full insurance coverage, and;
- have completed the ADAP and Medicaid application at their Department of Health and Human Resources county office.

ADAP participants do not receive a medical identification card, but do receive a letter that verifies eligibility and includes their identification number with a prefix of "69". All claims except those for vaccines may be submitted online through the pharmacy Point-of-Sale system or by using the approved paper claim form. Covered drugs are limited to a 30-day supply. Claims must be submitted within 60 days from the date of service. Formulary drugs must be dispensed in generic form if available. Brand-name drugs that have generic equivalents require prior authorization. There are no co-payment requirements for this program. ADAP may cover co-pays for eligible

residents who are covered by insurance or Medicare Part D. Claims for vaccines must be submitted on the approved pharmacy paper claim form and mailed to ATF, P.O. Box 6360, Wheeling, West Virginia 26003. Certain drugs may require prior authorization and emergency supplies of these drug may not be dispensed. Please refer to the BMS website, www.dhhr.wv.gov/bms, for the ADAP formulary. More information regarding ADAP can be found at the Bureau for Public Health's website at www.dhhr.wv.gov/bph or by calling the AIDS Task Force at 304-232-6822.

518.3.2.2 Children with Special Health Care Needs (CSHCN)

Pharmacy services are available for certain children under 21 years of age receiving medical care under the Children with Special Health Care Needs Program. Services are not limited to children of families receiving public assistance grants. Coverage is limited to the formulary established under the program's policy administration. These members do not receive a medical identification card. An identification number with a prefix of "99" is assigned. Claims may be submitted online using the pharmacy Point-of-Sale system or by using the approved paper claim form. Policy questions regarding this program shall be directed to the CSHCN unit at 1-800-642-9704.

518.3.2.3 Individuals Eligible for Immunosuppressant or Antipsychotic Medications

Certain individuals who are not eligible for Medicaid services may be eligible for coverage of immunosuppressant or antipsychotic medications using all state funds. Eligibility for these services is determined at the individual's local county Department of Health and Human Resources office. A six-month eligibility period is established and it is the member's responsibility to reapply for these services. No identification card will be issued. Medicaid receives a written communication from the Division of Family Assistance defining the drug(s) that will be covered for a particular individual. A letter including the services to be covered and the individual's identification number, prefix "39", will be forwarded to the pharmacy provider and the individual. Claims for these services may be submitted online through the pharmacy Point-of-Sale system or on the approved paper claim form. Medicaid coverage rules apply to these claims. (Please note: Some individuals may also be eligible for coverage of immunosuppressant drugs by Medicare Part B. Medicare must be billed first. This state program will pay co-insurance and deductible amounts on Medicare Part B crossover claims only. All other Medicare eligible individuals must pursue coverage of immunosuppressant drugs and antipsychotic medications through their Part D plans.)

518.3.2.4 Tiger Morton Fund

Certain individuals who are not eligible for Medicaid services may be eligible for coverage of selected medications using state funds through the Tiger Morton Fund. These individuals will not have an identification card and coverage will be communicated to the pharmacy provider on a case-by-case basis. Claims for these services must be submitted using the approved paper claim form.

518.3.2.5 Emergency Medical Assistance or Other State Programs

Certain individuals who are not eligible for Medicaid services may be eligible for emergency medical assistance or other pharmacy services using state funds. These individuals will present a letter to the pharmacy provider listing particular drug(s) to be covered. A prefix of "15" or "38" along with the respective county code will be noted on the authorization letter to identify the eligible individual. Claims for these services must be submitted using the approved paper claim form with a copy of the eligibility letter attached.

518.3.2.6 Juvenile Services

Incarcerated minors have pharmacy services coverage through Juvenile Services. A letter of eligibility will be presented to the pharmacy which includes the individual's identification number beginning with prefix "17". Claims for these services may be submitted through the online Point-of-Sale system or by using the approved paper claim form. Medicaid coverage rules apply.

518.3.2.7 Adult Family Care and Protective Services

Children and adults receiving Protective Services as a result of abuse and/or neglect or other individuals in need of assistance may be provided limited eligibility for state-funded services. A Special Medical Authorization Letter is issued as needed by the field staff. This letter specifies the individual, the medical provider authorized to provide services, the services authorized and the coverage period. An identification number for use in billing the services is also provided. Pharmacy claims for these individuals may be submitted online or on the approved paper claim form. Medicaid coverage rules apply.

518.3.3 Denials Due to Eligibility

If an online denial occurs due to eligibility problems, and the member presents a valid Medicaid card or other proof of eligibility, take the following steps:

- Dispense the prescription for valid and covered services.
- Obtain a copy of a valid Medicaid card or other proof of eligibility.
- Choose one of two options:
  (1) Resubmit the claim online at a later date, using the original date of service; or
  (2) Submit the claim on the approved paper claim form and attach a copy of the valid Medicaid card or other proof of eligibility. Mail these claims to:

Molina Corporation
Pharmacy Claims
Post Office Box 3765
Charleston, West Virginia 25327-3709

518.4 DESCRIPTION OF COVERED SERVICES

Except for certain limitations and exclusions, BMS will reimburse for the following:

- Outpatient legend drugs
- Specific over-the-counter drugs
- Compounded prescriptions
- Drugs that require prior authorization, when approved by BMS
- Family planning supplies, including certain over-the-counter supplies
- Certain diabetic supplies
- Influenza, pneumonia, Hepatitis A, Hepatitis B, tetanus, tetanus-diphtheria (Td), and tetanus-diphtheria-and-pertussis (Tdap) vaccines for adults nineteen (19) years of age and older administered by a pharmacist. (Members up to nineteen (19) years of age have access to vaccines via the Vaccines for Children Program.)
- Herpes zoster vaccine for adults fifty (60) years of age and older administered by a pharmacist

Drugs covered under the Medicaid outpatient pharmacy program are those that have been approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, when used for medically accepted indications.

Medically accepted indication means any use that is supported by one or more of the following official compendia:

- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopoeia Drug Information or it's approved replacement;
- The DRUGDEX Information System

All covered drugs, whether legend or over-the-counter, must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and federal requirements.

The West Virginia Medicaid program follows the Office of Inspector General's (OIG) guidelines in excluding prescribers from participating with West Virginia Medicaid who are barred from participating in federal health programs. Reimbursement of prescriptions issued by these excluded prescribers is denied.

West Virginia Medicaid also excludes from reimbursement any prescription ordered by:

- prescribers not enrolled as providers with West Virginia Medicaid, nor enrolled with a participating West Virginia Medicaid MCO; or,
- prescribers not employed by or contracted with a facility or group practice that is enrolled as a Medicaid provider.

518.4.1 Preferred Drug List (PDL)

The West Virginia Preferred Drug List (PDL) is a list of medications recommended to BMS by the West Virginia Medicaid Pharmaceutical and Therapeutics (P & T) Committee and approved by the Secretary of the Department of Health and Human Resources. The P & T Committee is composed of actively practicing physicians, pharmacists, a nurse practitioner, and a physician's assistant. Meetings of the P & T Committee are held a minimum of 3 times per year and are open to the public.

The drugs that are designated as "preferred" have been selected for their clinical significance and overall cost efficiencies. All Medicaid-covered drugs noted as "non-preferred" continue to be available through the prior authorization process.

The PDL only addresses certain drug classes. Some classes of drugs will not be reviewed for preferential agents because there are no or limited cost savings associated with these classes. Drugs that meet the criteria for coverage and have no preferred status are considered covered drugs.

The PDL is updated at minimum annually and as needed. Newly released drugs in classes which are included in the PDL will be considered non-preferred until the drug itself has been reviewed.

The complete PDL, criteria for coverage of non-preferred drugs, minutes of P & T Committee meetings, and other pertinent information may be accessed on the Bureau for Medical Services' website at www.dhhr.wv.gov/bms.

518.4.2 Over-the-Counter Drugs

Certain over-the-counter (OTC) drugs are reimbursed for eligible Medicaid members when prescribed by a qualified practitioner. OTC drugs must be manufactured by companies participating in the federal drug rebate program and are limited to generic products when available. Any OTC drug available in packaging designed for OTC sale to the public must be dispensed in the original packaging. These products must be billed at the shelf price of the pharmacy. If a pharmacy is not accessible to, or frequented by the general public, or if the OTC drug is not on display for sale to the general public, then the product will be reimbursed at the same rate as legend drugs.

Over-the-counter drugs are not covered for residents of skilled nursing homes or ICF/MR facilities except for insulin. These drugs are included in the rates paid to these facilities.

Coverage of over-the-counter drugs for members enrolled in Medicaid managed care plans will follow each plan's coverage policies, unless the OTC drug is included in the Medicaid Preferred Drug List.

For a current list of covered OTC drugs, see the BMS website, www.dhhr.wv.gov/bms.

518.4.3 Diabetic Testing Supplies and Syringes/Needles

Certain supplies used by eligible diabetic Medicaid members are covered through the outpatient pharmacy program. A prescription issued by a licensed prescriber within the scope of his/her practice is required for coverage of these items. Verbal prescriptions that meet federal and state regulations are permitted. Prescriptions must define the number of tests to be performed per day. Co-payments are not required on prescriptions for these items. Covered supplies include:

- Blood glucose testing strips
- Urine testing tablets and strips
- Lancets
- Insulin syringe and needle combinations for the administration of insulin
- Needles for insulin pen systems

Needle and syringe combinations and disposable pen needles for insulin pens are reimbursed through the pharmacy POS program only for the administration of insulin.

Diabetic testing supplies and syringes/needles are not covered pharmacy services for members residing in skilled nursing or ICF/MR facilities.

The following limits apply for those members who have insulin dependent diabetes:

Urine and blood glucose testing tablets and strips	150 per 30 days
Lancets	200 per 30 days
Insulin syringe and needle combinations	100 per 30 days
Pen needles	100 per 30 days

The following limits apply for those members who have non-insulin dependent diabetes:

Urine and blood glucose testing tablets and strips	100 per 30 days
Lancets	100 per 30 days

Prescriptions for quantities greater than the above referenced amounts require prior authorization through the Rational Drug Therapy Program (RDTP). The prior authorization criteria shall follow the Medicare regional carrier guidelines in effect at the time. Pharmacies should access the CMS website for the carrier servicing West Virginia on the date of service.

Coverage of blood glucose testing monitors, other types of diabetic testing supplies, insulin pumps and supplies, and/or syringes and needles for other purposes may be available to members through the Durable Medical Equipment (DME) benefit. See *Chapter 506*, *DME/Medical Supplies Manual* for more detailed information.

Medicaid members enrolled in Medicaid managed care plans will have coverage of diabetic supplies through their managed care plan.

Dual eligible members have coverage of diabetic supplies through Medicare. Medicaid will not cover these supplies for dual eligible individuals, except for amounts that may be reimbursed on Medicare Part B crossover.

518.4.4 Medical Supplies

Pharmacies may also be enrolled with West Virginia Medicaid to provide other DME supplies. See *Chapter 506, DME/Medical Supplies Manual* for more information regarding these services.

518.4.5 Home Infusion Therapy Pharmacy Services

Drugs used for home infusion therapy services are covered under the Medicaid Pharmacy Program. These drugs require prior authorization and must be justified by the ordering practitioner, including why oral therapy is unsuitable for the patient. **Members enrolled in Medicaid managed care plans have coverage of home infusion pharmacy services through their managed care plan. Dual eligible members have coverage of home infusion pharmacy services through their Medicare Part D plans.**

Total Parenteral Nutrition (TPN) services are not pharmacy point-of-sale (POS) covered services. Please see *Chapter 506, DME/Medical Supplies* for information regarding these services.

See *Appendix 1* for detailed information regarding home infusion pharmacy services.

518.4.6 Tobacco Cessation Program

West Virginia Medicaid makes tobacco cessation services available to members enrolled in the fee-for-service Medicaid Program (except for those enrolled in the Basic Adult Package) and those enrolled with a participating West Virginia Medicaid MCO.
Members enrolled in the fee-for-service Medicaid Program are required to enroll through the WV Tobacco Cessation Quitline Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available through the Quitline program. Additional information regarding the WV Tobacco Cessation Quitline can be accessed through at www.ynotquit.com.

Members enrolled in Medicaid managed care plans have tobacco cessation services provided by their plans, including drug treatments.

In order for members to have access to drugs and other tobacco cessation services, the member is required to see their primary care provider. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco Quitline.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate.

Additional information regarding the tobacco cessation program can be accessed through http://www.wvdtp.com/ or www.wvquitline.com or by calling the Quitline at 1-877-966-8784 for assistance.

If a Medicaid member is enrolled in a MCO, please contact the member's MCO for service limitations and all other requirements related to this benefit.

Drugs to treat tobacco cessation are limited to members who register with the tobacco Quitline program. Dual eligible members have coverage of legend drugs through their Medicare Part D plans and coverage of the over-the-counter drugs and Quitline services through Medicaid. Medicaid does not cover tobacco cessation programs for those enrolled in the Basic Adult Benefit Package.

Drug products are limited to a maximum of:

- Nicotine gum – 24 pieces per day
- Nicotine patches – 1 patch per day
- Nicotine lozenges – 20 lozenges per day
- Nicotine inhalers – 168 inhalers per 30 days
- Nicotine nasal spray – 4 spray bottles per 30 days (This therapy is reserved for those who have failed other forms of nicotine replacement therapy.)
- Bupropion – 300 mg. daily

518.4.7 Buprenorphine-Naloxone(Suboxone®)/Buprenorphine(Subutex®) Coverage

Buprenorphine-Naloxone and Buprenorphine are covered through the Pharmacy program, and must be written by a prescriber enrolled with WV Medicaid. Buprenorphine-Naloxone and Buprenorphine is obtained only through a prior authorization. All members treated with Buprenorphine-Naloxone or Buprenorphine are required to participate in the pharmacy lock-in program. Other limitations may apply.

See the BMS website at http://www.dhhr.wv.gov/bms for additional information and detailed coverage criteria.

518.5 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid pharmacy services will apply for eligible members as follows:

- Covered drugs are limited to their Food and Drug Administration (FDA) approved or medically accepted indications and dosing limits.
- When appropriate, PDL-preferred drugs must be tried before non-preferred drugs are approved.
- All covered outpatient drugs must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and federal requirements.
- Prescriptions may be written or verbal, and must meet all the federal and state guidelines for legal prescriptions.
- Covered outpatient drugs are reimbursed up to a 34-day supply and may be refilled according to state and federal laws. Certain exceptions apply, for example, most oral systemic

antibiotics are covered for a 14-day supply with one refill. Exceptions to this policy may apply if the only available package size of the product is one that exceeds the 34-day supply limit.

- Only those legend drugs for the symptomatic relief of cough and colds that appear on the approved BMS list are covered for this therapeutic indication. Certain over-the-counter cough and cold medications are also covered. The list is available on the BMS website, www.dhhr.wv.gov/bms. Dual eligible members have coverage of cough and cold medications through Medicaid if these products are not covered by their Medicare Part D or Part C plans.
- Barbiturates are not covered except for phenobarbital and mephobarbital, unless the barbiturate is in combination with another active ingredient. Dual eligible members have coverage of phenobarbital; mephobarbital; and butalbital, acetaminophen, and caffeine combination products through Medicaid if these products are not covered by their Medicare Part D plans. (Note: Combination products of butalbital, acetaminophen, caffeine and *codeine* will be covered by Medicare Part D or Part C plans for dual eligible members.)
- Vitamins and minerals are limited to:
    - Legend vitamins A, D, K, folic acid, B-12 for injection, and niacin
    - Minerals including calcium, iron, magnesium, fluoride and additional mineral requirements for the treatment of End Stage Renal Disease
    - Multivitamins for children through age 20
    - Prenatal vitamins for women through age 45
    - Legend fluoride preparations
- Drugs to treat tobacco cessation are limited to members who register with the YNOTQUIT Program. Dual eligible members have coverage of over-the-counter tobacco cessation products through Medicaid if these products are not covered by their Medicare Part D plans; legend tobacco cessation agents are not covered for dual eligible members, as these are covered by the Medicare Part D plans.
- Other drugs may be limited in quantity, duration, or based on gender. See the BMS website, www.dhhr.wv.gov/bms, for information regarding these drug products and their limitations. Exceptions are considered on a case-by-case basis through the Rational Drug Therapy Program.
- Additional drugs may have quantity limits to assure accurate billing of units.
- Limitations apply to diabetic testing supplies and insulin syringes/needles depending on the member's diagnosis, i.e. insulin dependent or non-insulin dependent diabetes. Medicaid does not cover diabetic supplies for dual eligible members, except for coverage of Part B deductibles and coinsurance amounts. These individuals have coverage for diabetic supplies either through Medicare Part B or Part D.
- Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:
    - Barbiturates (if not for treatment of epilepsy, cancer, or mental health disorder, as Medicare Part D covers these conditions)
    - Over-the-counter medications
    - Agents for the symptomatic relief of cough and cold symptoms
    - Prescription vitamins and minerals
- Members enrolled in the Mountain Health Choice's (MHC) Adult basic plan are limited to coverage of four prescriptions per calendar month.

The following therapeutic classes will not count toward the 4-prescription limit:

- Diabetic supplies and all insulins,
- Atypical antipsychotics,
- Antidepressants(all therapeutic classes),
- Drugs used for the treatment of HIV/AIDS,
- All contraceptives.

518.5.1 Bulk Chemicals

Per CMS Medicaid Drug Rebate Program Release No. 155, bulk chemicals are substances which when used in the manufacturing of a drug become the active ingredient of the drug product. As such they do not meet the definition of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act. However, bulk chemicals may be considered in rare circumstances if prescribed for an FDA-approved indication and/or medically accepted indication supported in official compendia. Prior authorization is required.

All rules, regulations, limitations, and exclusions set forth in the Pharmacy Services manual apply also to bulk chemicals.

Refer to the BMS website, http://www.dhhr.wv.gov/bms, for a list of covered bulk chemicals and criteria for coverage.

518.6 COVERAGE OF BRAND NAME VERSUS GENERIC DRUGS

Brand name multi-source legend drugs that have therapeutic equivalents available will be denied for payment. Generic drugs must be substituted, if available. In certain instances, pharmacies may indicate brand name drug usage on submitted electronic and paper pharmacy claims by using Dispensed as Written (DAW) codes. The DAW codes that are recognized by West Virginia Medicaid and can be used by providers to explain the dispensing of a brand name product instead of a generic one are as follows:

DAW 1 - Prescriber states that the brand name drug is “medically necessary”. This information must be supplied in writing by the **prescriber** via written prescriptions in their own handwriting, and must write on the prescription “Brand Medically Necessary”. A check-box or other methods to indicate that the brand should be dispensed shall not be accepted. Approval from the help desk is required for the use of DAW 1 and appropriate justification must be provided.

DAW 4 - A generic equivalent is not available or not stocked at the time of dispensing. This code shall only be used when a generic drug is sold out or a generic drug is unavailable on a wide-spread basis. *It shall not be used routinely to circumvent the mandatory generic program for reasons other than these.* A call to the Rational Drug Therapy Program help desk is required for the use of DAW 4 and appropriate justification must be provided. The brand name rate will be reimbursed when approved.

DAW 5 - Pharmacy uses this brand as a generic and realizes it will be paid at the generic rate.

DAW 6 - Pharmacy is dispensing a generic drug that has been identified by the drug database as a brand name drug due to pricing issues. These generic drugs have high Average Wholesale Prices (AWP) in relation to other generic drugs that are available. An effort shall be made to obtain lower-priced alternatives.

- For auditing purposes, documentation shall be made on the prescription to justify use of the DAW codes.
- All other DAW codes that are recognized by NCPDP are not active in the West Virginia Medicaid Program and will not affect the processing of claims if submitted.
- The use of DAW codes is not permitted for non-preferred drugs included in the Preferred Drug List program. Completion of an FDA MedWatch form is required for the failure of a generic product to produce the same outcome as the equivalent brand name drug. The MedWatch form shall be sent by mail or fax to the Rational Drug Therapy Program. The MedWatch form may be accessed from the FDA website at www.fda.gov/downloads/Safety/MedWatch/HowToReport/DownloadForms/ucm082725.pdf. Please note that some generic drugs may be classified as non-preferred by West Virginia Medicaid and require prior authorization. This occurs when brand name drugs are less expensive to Medicaid due to supplemental rebate negotiations. In this case, the pharmacy will be required to dispense the brand name drug instead of the generic equivalent.

518.7 NON-COVERED SERVICES

The following list of drugs, drug products, and related services are not reimbursable. Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (WVDHHR) fair hearing. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with CMS
- Agents used for weight loss or weight gain
- Agents used for cosmetic purposes or hair growth
- Drugs identified by CMS as being less-than-effective (DESI).
- Agents used for fertility
- Drugs used to treat erectile dysfunction
- Drugs that are investigational or approved drugs used for investigational purpose
- Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
- Drugs dispensed after their expiration date
- The cost of shipping or delivering a drug
- Herbal or homeopathic products
- Drugs which result in therapeutic duplication, ingredient duplication, early refills or other Drug Utilization Review events that are not medically necessary
- Drugs which are not medically necessary
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

- Nutritional supplements
- Free pharmaceutical samples
- Diagnostic agents
- Vacation supplies
- Allergenic extracts
- Excipients except when used in compounded prescriptions containing a covered legend drug. Excipients must be eligible for federal rebates in order to be eligible for reimbursement.
- Vaccines via the pharmacy POS, except for Influenza, pneumonia, Hepatitis A, Hepatitis B, tetanus, tetanus-diphtheria (Td), and tetanus-diphtheria-and-pertussis (Tdap) vaccines for adults nineteen (19) years of age and older administered by a pharmacist; and herpes zoster vaccine for adults fifty (60) years of age and older administered by a pharmacist.
- Factors to treat hemophilia via the pharmacy POS (Refer to *Chapter 519, Practitioner Services,* for additional information regarding hemophilia services.)
- Methadone for the treatment of drug dependence/addiction

518.8 PRIOR AUTHORIZATION (PA)

Prior authorization (PA) for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific PA criteria are based on review of the most current clinical information, FDA approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the Bureau for Medical Services. These criteria then form the basis of acceptable drug therapy for members of Medicaid pharmacy services. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization are found on the BMS website at www.dhhr.wv.gov/bms. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable unless, upon appeal by the prescribing provider, the Medicaid Medical Director determines that the drug meets the appropriateness and medical necessity criteria.

The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Federal regulations state that Medicaid-covered drugs that require PA must have a 24-hour turnaround for responses. In emergent situations, a 72-hour supply of medication must be made available to members until the PA process can be completed. No more than a 72-hour supply shall be dispensed. Submitting a quantity greater than a 72-hour supply constitutes an improper claim unless it is for a package that cannot be broken. If a product package cannot be broken, then the whole package may be dispensed, if necessary, to meet the member's needs. Documentation of this action shall be made on the prescription for auditing purposes. Repeated submissions of 72-hour supplies for the same patient and same drug to circumvent the prior authorization process constitute an improper billing method. This practice is subject to audit.

518.8.1 Process of Requesting Prior Authorization

The Rational Drug Therapy Program (RDTP) is the agency contracted to provide prior authorization services to the West Virginia Medicaid Pharmacy Program. RDTP is a non-profit organization affiliated with the West Virginia University School of Pharmacy.

Prior authorization may be initiated either by the dispensing pharmacist, the prescriber, or the prescriber's designee. Prior authorization requests from third party vendors or contractors will be denied. Requests may be made by telephone, fax, or mail. If all the necessary information is provided, requests will be addressed within 24 hours. It is the responsibility of the provider of the service, either the physician or pharmacist, to obtain the authorization before rendering the service. Requests for prior authorization after the service is rendered will be denied. In cases of back-dated eligibility, prior authorizations may be considered on a case by case basis using coverage policies in place on the dates the services were rendered. If the service is provided before prior authorization is obtained, the Medicaid member must be informed that he/she will be responsible for the bill.

There is a maximum approval limit of one year.

Prior authorization requests shall include the following:

- Member name and address
- Member Medicaid identification number
- Name of drug, strength, dosage, and duration of treatment
- Diagnosis
- Pertinent laboratory information
- Justification for the use of the drug
- Return fax number
- Signature of prescriber or pharmacist

Rational Drug Therapy Program's operating hours are:
Monday through Saturday – 8:30 AM until 9:00 PM
Sunday – 12 noon until 6:00 PM

Prior authorization forms can be downloaded from the Bureau for Medical Services' website at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx. These forms may be duplicated. Providers enrolled to access the BMS MediWeb portal may complete PA forms electronically and submit them via the portal.

518.8.2 Prior Authorization Denial Appeals Process

If a prior authorization request is not approved, the prescriber may appeal the decision to the Rational Drug Therapy Program Appeals Department in writing (first level appeal). Requests must include the following information:

- Member name and address
- Member Medicaid identification number
- Name of drug, strength, dosage, and duration of treatment

- Diagnosis
- Pertinent laboratory information
- Justification for the use of the drug, including any other treatments that have been tried
- Supporting literature
- Return fax number
- Signature of prescriber

Office and/or hospital notes, including signed ones, are not acceptable and do not constitute an appeal.

Appeals will be processed within 3 business days of their receipt. Appeals shall be faxed to the Rational Drug Therapy Program (RDTP), Appeals Department at 1-800-531-7787.

All appeals denied by RDTP will be sent to BMS for physician review. Any denial resulting from physician review is final. The Medicaid member is notified of this denial and of their right to request a fair hearing.

518.9 DRUG UTILIZATION REVIEW (DUR)

The Omnibus Budget Reconciliation Act (OBRA '90) required that states establish a Drug Utilization Review (DUR) program. The DUR program must consist of prospective and retrospective components as well as components to educate physicians and pharmacists on common drug therapy problems and assessments of whether usage complies with predetermined standards. In order to meet the requirements of the statute, the DUR program must assure that prescriptions are appropriate, are medically necessary, and are not likely to result in adverse medical results. The two primary objectives of DUR systems are (1) to improve quality of care; and (2) to assist in containing health care costs.

The establishment of a DUR Board was required by OBRA '90. This Board, consisting of local pharmacists, physicians, and other healthcare providers from around the state, is charged with making recommendations for educational interventions to prescribers and pharmacists to identify and reduce, for both providers and patients, the frequency of patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care. Specific drugs or classes of drugs may be targeted in regard to:

- Therapeutic appropriateness
- Over utilization
- Under utilization
- Appropriate use of generic products
- Therapeutic duplication (same or different prescriber)
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage
- Incorrect duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

The West Virginia Medicaid DUR Board meets quarterly to discuss methods of achieving the goals of assuring the appropriate use of drugs in the Medicaid program. These meetings are open to the public. The DUR Board also assists BMS in defining criteria for coverage of drugs that require prior authorization. Meeting agendas, minutes, and other DUR information are available on the Bureau for Medical Services' website, www.dhhr.wv.gov/bms.

Detailed DUR Event parameters can also be found on the BMS website at www.dhhr.wv.gov/bms.

518.9.1 Prospective Drug Utilization Review (DUR)

Prospective DUR is conducted at the pharmacy Point-of-Sale (POS) before delivery of a medication by the pharmacist to the Medicaid member or caregiver. Prescription claims are screened to identify potential drug therapy problems of the following types:

- Therapeutic duplication
- Ingredient duplication
- Adverse drug-drug interactions
- Early refill
- Late refill
- High dosage
- Low dosage
- Incorrect duration of drug treatment
- Age/gender precaution
- Pregnancy precaution
- Breast feeding precaution

Dispensing pharmacists use the information provided by the pharmacy POS and their professional judgment to determine if the prescription shall be filled. The pharmacist determines the appropriateness of the prescribed therapy and intervenes with the prescribing physician and/or member in the event of a suspected problem.

Pharmacists may continue to process claims that contain prospective DUR messages by using DUR outcome and intervention codes. A call to the RDTP help desk may be required in certain instances as determined by BMS to obtain an edit override. Requests for edit overrides after the service is rendered will be denied, except in cases of back-dated eligibility. More detailed information regarding DUR procedures is found in the Health PAS-RX Pharmacy Point-of-Sale (POS) User Guide, found on BMS' link to the fiscal agent website, www.dhhr.wv.gov/bms.

518.9.2 Retrospective Drug Utilization Review

Retrospective Drug Utilization Review is required in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid members, or associated with specific drugs or groups of drugs. West Virginia Medicaid conducts retrospective DUR with the assistance of a vendor. They provide patient profiles addressing drug use that may be inappropriate based on predetermined standards. A

Retrospective DUR Committee, consisting of healthcare professionals, meets monthly to review these patient profiles that are used to generate letters to physicians and pharmacists relating to these issues.

518.9.2.1 Pharmacy Lock-in Program

Members who use pharmacy services excessively or inappropriately may be assigned to a single pharmacy provider where they receive their Medicaid-covered medications. The purpose of this program is to assist beneficiaries in using pharmacy services appropriately.

As part of this program, the Retrospective DUR Committee reviews Medicaid member utilization profiles to determine if controlled substances are being used at a frequency or amount that results in a level that may be harmful or not medically necessary. Inappropriate utilization can include frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, overlapping prescription drugs within the same drug class and drug seeking behavior, i.e., doctor shopping.

A series of letters is sent to prescribers and/or the member to seek information regarding his/her drug utilization or to warn that continued over utilization may result in restricting the member to a single pharmacy provider. If the pharmacy lock-in criteria are met, the member is given the opportunity to select a pharmacy, but pharmacy participation is voluntary. Pharmacists serving these members are requested to use their professional judgment in regard to filling prescriptions for controlled substances.

Criteria for Lock-in determination can be found on the Bureau's website, www.dhhr.wv.gov/bms.

Members, upon discharge from a substance abuse program, or while receiving outpatient substance abuse treatment, will be locked into a single pharmacy provider. Upon admission to a facility for treatment of substance abuse or during the initial visit for outpatient substance abuse services, the member will be required to choose a pharmacy from which to receive all controlled substances. The lock-in form may be found on the Bureau's website at www.dhhr.wv.gov/bms.

518.9.3 Reporting of Cash Payments

Pharmacies are encouraged to report to BMS when a member pays cash for prescriptions that would otherwise be covered by Medicaid or considered for reimbursement upon a call to the RDTP, or when the pharmacy provider suspects overutilization by the member. A form used for this reporting can be found on the BMS website, www.dhhr.wv.gov/bms. The form should be faxed to BMS at 304-558-1542. Information collected through this process may be used for member lock-in consideration and continued eligibility.

518.9.4 Member Counseling

OBRA '90 requires that pharmacists offer counseling to Medicaid patients and must include the following:

- Name and description of the medication;
- The route of administration, dosage form, dosage, and duration of therapy;
- Special directions and precautions for preparation, administration and use by the patient;
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- Techniques for self-monitoring prescription therapy;
- Proper storage;
- Prescription refill information; and
- Action to be taken in the event of a missed dose.

The West Virginia Medicaid program relies on the West Virginia Board of Pharmacy to monitor these activities, but BMS may audit these requirements through routine or special reviews.

518.10 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, General Provider Participation Requirements*, and *Chapter 800, General Administration*, of the Provider Manual.

Prescriptions must comply with the regulations of the West Virginia State Board of Pharmacy as to content requirements and must be kept for a period of five years. Prescription records must be made available to BMS upon request.

518.10.1 Tamper-Resistant Prescription Pad Requirement

All prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meet all 3 characteristics set forth in the guidelines from the Centers for Medicare and Medicaid Services (CMS). The three characteristics to meet the tamper-resistant prescription requirement are:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription, and;
3. Prevent the use of counterfeit prescription forms.

Written prescriptions must contain **ALL** of the following:

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax.

Feature	Description
Uniform non-white background color – *preferably green*	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If an attempt is made to erase copy – the consistent background color will look altered.

Quantity check off boxes	In addition to the written quantity on the prescription, quantities are indicated in ranges of 25's (or some other, similar range). Box MUST be checked for this feature to be valid.
Refill indicator	Refill indicator (circle or check number of refills or "NR"). Refill indicator must be used to be a valid feature.

Feature	Description
Security features and descriptions listed on the front of the prescription	Listing of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the pads/paper.

Computer-generated prescriptions, EMR, or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of tamper resistance, provided they contain the features listed in the table below. Prescribers are urged to contact their software companies to ensure that computer generated prescriptions have all requirements necessary for tamper resistance.

Computer-generated prescriptions must contain the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax. *This requires the purchase of special paper.*
OR	
Micro print signature line	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.

2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.

Feature	Description
Uniform non-white background color – preferably green OR "Toner-lock" paper for laser printed prescriptions, or plain bond paper for inkjet printed prescriptions	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If someone tries to erase copy – the consistent background color will look altered. Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from the inkjet printers is absorbed into normal "bond" paper.

Quantity written and quantity with border characteristics for computer generated printed prescriptions	Quantity written and Quantity surrounded by special characters such as asterisks to prevent modification, e.g. *QTY Fifty ***50****.*
Refill written and refill with border characteristic for computer generated printed prescriptions	Refills written and Refill surrounded by special characters such as asterisks to prevent modification, e.g. *Five refills ****5 refills*****.*

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Feature	Description
Security features and descriptions listed on the prescription	A complete list of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the paper.

Prescriptions for West Virginia Medicaid members written by prescribers that reside outside of West Virginia may meet the federal tamper-resistant prescription requirement if the prescription addresses the three distinct characteristics outlined above, and may contain the same or other features than those adopted by BMS.

518.10.2 Prescriptions Returned to Stock

Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis, within 15 days. A log of these returns must be maintained by the pharmacy for a period of 5 years for auditing purposes.

518.10.3 Nursing Home Returns

Drugs dispensed to nursing home residents that are not used by the member must be either returned to the dispensing pharmacy or destroyed according to applicable rules and regulations.

Drugs that are returned unused by the Medicaid member and are available for re-dispensing, per West Virginia State Board of Pharmacy rules and regulations, must be credited to Medicaid.

Claims for these returned medications must be reversed and resubmitted for the quantity used by the member.

518.10.4 Shipping/Receiving

Drugs reimbursed by West Virginia Medicaid that are mailed or shipped to members require a signature of the individual receiving delivery of the medication. A log of these signatures must be maintained by the pharmacy for a period of 5 years for auditing purposes. Providers shall take the necessary steps to prevent loss of medications in the shipping process and to assure that the

member receives the shipment when needed, as Medicaid will not reimburse for medications not received by the member.

Claims for medications not received by the member in a timely manner, and which the member was compelled to obtain from a local pharmacy, may be reversed by the fiscal agent, if necessary, in order to allow for billing by a local pharmacy provider to meet the member's needs.

518.11 BILLING PROCEDURES

Claims for prescribed drugs dispensed to Medicaid members may be submitted electronically using the Point-of-Sale system or on paper claim forms. Claims must be filed within 12 months from the date of service.

Submitting claims via electronic media offers the advantage of speed and accuracy in processing. All claims, regardless of method of submission, are subject to drug utilization review edits, prior authorization, and other Medicaid requirements.

Medications for West Virginia Medicaid members must be dispensed at the facility from which the drug products are prepared and the services rendered.

Claims must accurately report the NDC dispensed, the number of units dispensed, days' supply, and other required data for claims processing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause BMS to report false data to drug manufacturers when billed for drug rebates. BMS will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers or during claim reviews. Pharmacies are required to submit documentation for purchases of drugs reimbursed by BMS upon request.

518.11.1 Point-of-Sale System

Currently, online processing for Medicaid pharmacy claims is available for all pharmacies using NCPDP Version D.0. The provider must complete and submit the provider trading partner agreement prior to use of Point-of-Sale submission for claims.

See the Molina Health PAS-Rx Pharmacy Point-of-Sale (POS) User Guide for complete billing instructions for the Point-of-Sale system. See the Pharmacy Point-of-Sale (POS) NCPDP Version D.0 Vendor Specification Document, for specifications and information for switch vendors. These documents and other information are located on the BMS' link to the fiscal agent website.

518.11.2 National Council on Prescription Drug Programs (NCPDP) Payer Sheet

West Virginia Medicaid accepts pharmacy Point-of-Sale claims submitted using NCPDP Version D.0 or Batch Version 1.1. According to the NCPDP accepted standards, some fields are required, optional, or conditional. See the Pharmacy Point-of-Sale (POS) NCPDP Version D.0 Vendor Specification Document, located on BMS' link to the fiscal agent website, for the West Virginia Medicaid payer sheet.

518.11.3 Paper Claim Submission for Pharmacy Services

Pharmacies have the alternative of submitting a manual claim using a paper claim form, when necessary. The Universal Claim Form (UCF) provides a standard format for paper submission of drug claims to Medicaid. The UCF adheres to the data elements found in the Telecommunication Standard and Data Dictionary. **Medicaid will not supply these forms to providers**.

518.11.4 Claim Reversals

Pharmacy claims submitted by Point-of-Sale cannot be adjusted. To correct information submitted on a Point-of-Sale claim, the claim shall be reversed online and then resubmitted using the corrected information. There is currently no paper reversal claim form. If a paper claim submission requires corrections, the pharmacy Help Desk shall be contacted.

518.11.5 Pharmacy Identification Number

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the use of the National Provider Identifier (NPI) as the standard for identifying covered healthcare providers, including pharmacies. Pharmacies must use their NPI number on electronic submissions for reimbursement of pharmacy claims. NCPDP numbers will no longer be accepted on electronic claims. The NPI or NCPDP number will continue to be used on the approved paper claim form. For additional NPI information or to complete an NPI application, visit the CMS website, https://nppes.cms.hhs.gov.

518.11.6 Prescriber Identification Number

The National Provider Identifier (NPI) is required for the prescriber identification information on electronic POS claims. Either the DEA number or the NPI is allowed on the manual claim form (UCF).

Only prescribing NPI entities are permissible. Claims submitted with non-prescribing NPI entities will be denied, including but not limited to pharmacies, laboratories, hospitals, and dialysis centers.

518.11.7 National Drug Codes (NDC)

All pharmacy claims submitted to West Virginia Medicaid must identify the 11-digit NDC printed on the stock container in which the drug was purchased. **Using the correct NDC is extremely important in order to avoid disputes with manufacturers for rebate payments**. For example, if a drug is purchased in a 5000-count bottle and repackaged in 100-count bottles prior to dispensing, submitting the NDC for a 100-count bottle is not permitted. Most drugs distributed by repackagers are not covered by Medicaid because the repackager has not signed a rebate agreement with CMS. A pharmacy may not dispense a repackager's drug and then bill Medicaid using the original manufacturer's NDC.

518.11.8 Decimal Units

The Medicaid pharmacy system is capable of accepting quantity amounts which contain decimal units. Pharmacy claims must be submitted using the standard units, including any decimal increments. Units must not be rounded up or down. Rounding results in over or under payments and creates inaccurate invoicing to manufacturers for the drug rebates owed to the state.

518.11.9 Days' Supply

Each Medicaid-covered prescription is limited to a maximum supply of 34-days, with some exceptions. These exceptions are to accommodate packaging that cannot be broken. The following are examples of drugs that may be submitted as specified below:

Seasonal	91-day supply
Depo-Provera 150mg/ml	90-day supply

The pharmacist is responsible for submitting prescription claims up to this limit. Should a prescription be written for a quantity that is greater than the allowed limit, the pharmacist is responsible for notifying the prescriber of this limit and asking permission to reduce the number of units to be dispensed.

If the prescriber does not allow the prescription quantity to be reduced, the member shall be told that the cost of the prescription is his/her responsibility. Filling a prescription for a 34-days' supply when the prescription is intended to last longer constitutes a false claim and is subject to recovery of the paid amounts.

518.11.10 Compounded Prescriptions

A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a covered legend drug. The covered legend drug must be the first NDC submitted on a compounded prescription claim. DESI drugs or non-covered drugs **not appearing as the first NDC** in a compounded product will not cause the claim to deny, but those ingredients will not be included in the reimbursement. Over-the-counter (OTC) ancillary products will be reimbursed provided the drug is manufactured by a company which participates in the federal drug rebate program. A compound may contain up to 25 ingredients.

Products such as suppository molds and other items identified as supplies included in a compounded prescription will not be reimbursed by West Virginia Medicaid.

Billing compounded prescriptions follows NCPDP Version D.0 guidelines. For a compounded prescription, an additional $1.00 will be added to the dispensing fee. Compounding is considered an integral part of the prescription services and must not be billed separately. More information can be found in the User Guide, located on BMS' link to the Fiscal agent website, www.dhhr.wv.gov/bms.

518.11.11 Abuse and Inappropriate Utilization

The following practices constitute abuse and inappropriate utilization, and are subject to audit:

- Excessive fees (commonly known as prescription splitting or incorrect or excessive dispensing fees): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
  - Supplying medication in amounts less than necessary to cover the period of the prescription; and/or
  - Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.
- Excessive filling: Billing for an amount of a drug or supply greater than the prescribed quantity.
- Prescription shorting: Billing for drug or supply greater than the quantity actually dispensed.
- Substitution to achieve a higher price: Billing for a higher priced drug than prescribed even though the prescribed lower priced drug was available.
- Automated refills and automatic shipments are prohibited. Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. Any prescriptions filled without a request from a member or their responsible party will be subject to recovery. Any pharmacy provider with a policy that includes filling prescriptions on a regular date or any type of cyclical procedure will be subject to audit, claim recovery or possible suspension or termination of the provider agreement.

518.11.12 Lost/Stolen Medications

For members who report to the pharmacy that their medications have either been lost or stolen, the following procedure applies:

- The member must supply the pharmacy with a police report for stolen controlled substances; the pharmacy must retain a copy for audit purposes.
- The prescribing practitioner must agree that the lost or stolen medication shall be replaced.
- Lost/stolen medication approvals are limited to one occurrence per drug per year.

518.11.13 Wasted Medication

Members who have wasted medication due to improper use or storage may have their medication replaced. This will be determined on a case-by-case basis. Members shall be properly instructed on the storage and use of their medications and any special delivery device used to administer their medications. Requests for replacement of wasted medications due to improper storage or delivery by the pharmacy or improper handling by the administrating provider will be denied.

518.11.14 False Claims

Pharmacies are prohibited from submitting false claims to test for drug coverage, member eligibility, or for other purposes. Claims of this type result in false member drug history records and may result in the member or prescriber being included in lawsuits or reviews in error. All claims submitted for reimbursement must be the result of actual prescription requests.

518.12 REIMBURSEMENT

Federal Medicaid regulations governing pharmacy services establish upper limits for payment; i.e., the payment shall be based on the lower of the allowable cost of the drug, plus a dispensing fee or the provider's usual and customary charge to the general public.

Reimbursement for outpatient drugs is limited to products manufactured by companies participating in the Federal Drug Rebate Program.

If a provider accepts the member as a Medicaid patient, the provider must bill WV Medicaid for covered services and must accept the Medicaid reimbursement amount as full payment. No charge may be billed to a Medicaid member for a covered service unless a co-payment is applicable by regulation. However, the provider may bill the member for services not covered by the WV Medicaid Program if the parties agree in writing to this payment arrangement before such services are rendered. Refer to *Chapter 300, Section 320.2* for more information about billing Medicaid members.

518.12.1 Ingredient Cost

Maximum reimbursement for each drug claim processed will be based on the lowest of:

(1) The usual and customary charge to the general public;

(2) The Maximum Allowable Cost (MAC) plus a reasonable dispensing fee. The MAC for each multiple-source drug as defined in 42 CFR 447.332 and published in the Federal Register, plus a dispensing fee. Information relating to Federal Multiple Source Drug Limits is available on the CMS' website, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Federal-Upper-Limits.html.

> **EXCEPTION**: The MAC shall not apply in any case where a physician certifies in his/her own handwriting that, in his/her medical judgment, a specific brand is medically necessary for a particular patient. A notation like "brand medically necessary" written by the physician on the prescription above his/her signature is an acceptable certification. A procedure for checking a box on a form will not constitute an acceptable certification. All such certified prescriptions must be maintained in the pharmacy files and are subject to audit by BMS.

(3) The State Maximum Allowable Cost (SMAC), plus a dispensing fee;

State Maximum Allowable Cost (SMAC) rates are established with the assistance of a vendor. Rates are determined by using 130% of the lowest Wholesale Acquisition Cost (WAC) as provided by national drug information suppliers for 3 manufacturers of the same drug product or, based upon a mean average of pharmacy provider costs obtained through a survey of a percentage of pharmacy providers that are representative of the overall geographical distribution, service volume, and business structures of all pharmacies serving the West Virginia Medicaid Program. This mean average methodology is used to adjust the pricing in accordance with drug market competition and to establish SMAC pricing in those instances where less than 3 manufacturers are supplying products in a specific drug market.

The SMAC rate is applied to all brand and generic drug products in each drug group. Non-AB rated drugs recognized by national drug information suppliers as comparable to a particular brand drug is subjected to the same SMAC rate applicable to the brand and "AB" rated generic drugs of the same chemical composition, package size, dose, and drug group.

The determination of which drugs will be part of the SMAC list will be designated by BMS. Drugs no longer available at the SMAC price are removed. New drugs will be added to the SMAC as they are identified. The vendor on behalf of BMS will continually monitor pharmacies and industry information and make changes to the SMAC to reflect current pharmaceutical market conditions.

The SMAC list is available on the BMS website at www.dhhr.wv.gov/bms. Comments and questions regarding the SMAC list can be made to the vendor.

(4) Estimated Acquisition Cost (EAC), plus a dispensing fee. The EAC is defined as Average Wholesale Price (AWP) minus 15% for brand name drugs and AWP minus 30% for generic drugs.

518.12.2 Application of Dispensing Fee

- For covered legend and over-the-counter drugs, a professional dispensing fee of $2.50 per prescription for brand name drugs or a professional dispensing fee of $5.30 per prescription for generic drugs will be added to the federally established MAC, state established MAC, or state established EAC of each prescribed drug.

- Pharmacies participating in the 340b program, upon completion of the Certification form and submission of the required documentation, are paid a dispensing fee of $8.25 for each paid prescription for drug items dispensed to Medicaid members. These pharmacies are required to submit their actual acquisition costs to Medicaid. This policy is limited to those pharmacies located within Federally Qualified Health Centers (FQHC).

- For a compounded prescription, an additional $1.00 will be added to the dispensing fee. A compounded prescription is defined as any prescription requiring the combination of two or

more substances, one of which must be a legend drug. Compounding is considered an integral part of the prescription services and must not be billed separately.

- The dispensing fee may only be paid once every 30 days per drug entity for members residing in ICF/MR or nursing facilities.

- Claims paid on the basis of the usual and customary charge to the general public do not include an additional dispensing fee.

518.12.3 Co-Payments

A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the Program. The deduction will apply as follows:

- If the allowed total charge is $10.00 or less, the co-payment is $.50 per prescription
- If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription
- If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription
- If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription

Certain individuals or covered services are exempt from the co-payment requirement, as follows:

- Prescriptions for family planning services and supplies
- Prescriptions for members in long-term care facilities (i.e., nursing facilities or intermediate care facilities for mentally retarded)
- Prescriptions for pregnant women
- Prescriptions for members under 18 years of age
- 3-day emergency supplies
- Diabetic testing supplies and syringes/needles
- BMS approved home infusion supplies
- POS-approved vaccines

Members have been informed of co-payment requirements and the exclusions from co-payment. Federal regulations stipulate that no provider may deny services to an eligible individual in situations when the member is unable to pay co-payment charges. However, this does not extinguish the liability of the member receiving the services for payment of the co-payment charge to the provider.

Providers may bill the member or refer the member to a collection agency, etc., in the same manner that the provider initiates collections from private pay customers. If it is the routine business practice of the provider to refuse service to any individual, regardless of payer source, for uncollected debt, the provider may refuse future services to Medicaid members if adequate prior notice is provided.

Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility. Members are responsible for applicable copays, and providers are prohibited from waiving the copay requirement to attract business from other providers.

518.12.4 Third-Party Liability (TPL) or Coordination of Benefits (COB)

Medicaid is payer of last resort. TPL ensures that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Before submitting claims to Medicaid, providers must pursue all requirements of the primary insurer including, but not limited to prior authorization, brand name justifications, and Drug Utilization Review events.

Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The "third party" may be an individual, institution, corporation, or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS, Medicare, Hospice, etc. Additionally, no Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan.

Medicaid covered drugs which currently require a prior authorization (PA) from BMS will continue to require a PA if a primary insurer approves that service, and Medicaid reimburses any part of the cost.

Medicaid co-payment is still required, if applicable, for claims considered by third party payers and reimbursed by BMS.

Chapter 600, Reimbursement Methodologies, of the Common Chapters of the Medicaid Manual provides more detailed information regarding Third Party Liability.

See the User Guide for billing instructions for NCPDP Version D.0 in regard to Coordination of Benefits.

518.12.4.1 Medicare-Covered Drugs & Supplies, Part B

Pharmacies are required to verify and pursue members' Medicare coverage and to submit pharmacy claims to Medicare for those pharmacy services covered by Medicare. Pharmacies can submit claims to Medicare Part B either on the acceptable paper claim form (CMS 1500) or electronically. Once the Medicare claim has been approved and processed, Medicare will automatically submit the balance of the claim as a "crossover" to Medicaid electronically, if the provider's Medicare number is on file with Medicaid. These claims should not be submitted to Medicaid separately if the claim crossed over from Medicare.

For Dually Eligible Beneficiaries and Qualified Medicare Beneficiaries (QMB), if the service is covered by Medicare and Medicaid, Medicaid will pay the lesser of:

- The full coinsurance and deductible amounts due, based upon the Medicare allowed amount, or
- Medicaid's maximum allowable fee for that service minus the amount paid by Medicare.

For Qualified Medicare Beneficiaries (QMB), if the service is not covered or is denied by Medicare, Medicaid will not reimburse.

Drugs that are not covered by Medicare Part B may be covered by Medicare Part D. Medicaid does not reimburse for Part D co-payments.

518.12.4.2 Medicare Covered Drugs, Part D

Dual eligible members have prescription drug coverage through Medicare Part D. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

- Barbiturates (if not for treatment of epilepsy, cancer, or mental health disorder, as Medicare Part D covers these conditions)
- Over-the-counter medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

Medicaid does not reimburse for Medicare Part D co-payments. Medicaid does not pay as the secondary payer on Medicare Part D covered drugs.

518.13 HOW TO OBTAIN INFORMATION

An effective medical assistance program is dependent upon the support and cooperation of the providers of medical care and services. The fiscal agent is responsible for establishing and maintaining communication with providers participating in the program. Appropriate staff is available to respond to inquiries regarding program issues.

518.13.1 Policy/Reimbursement

For assistance with issues of program policy or reimbursement, contact Provider Relations, P. O. Box 2002, Charleston, West Virginia 25327-2002; telephone 1-888-483-0793 or 1-888-483-0801, (West Virginia and border providers); all other providers, (304) 348-3360.

518.13.2 Point-of-Sale (POS)

For assistance with POS claims submission, contact the pharmacy POS help desk, Rational Drug Therapy Program. The telephone number is 1-800-847-3859.

518.13.3 Prior Authorization

For obtaining a prior authorization for a prescribed drug, contact the Rational Drug Therapy Program, Robert C. Byrd Health Sciences Center, Post Office Box 9511; Morgantown, West Virginia 26506-9511, telephone 1-800-847-3859, fax 1-800-531-7787.

518.13.4 Additional Information

For obtaining additional information, refer to the following:

SERVICE	PERSON OR COMPANY	PHONE NUMBER	FAX NUMBER
Pharmacy Program Director	Bureau for Medical Services	304-558-1700	304-558-1542
Drug Utilization Review	Bureau for Medical Services	304-558-1700	304-558-1542
Drug Rebate	Bureau for Medical Services	304-558-1700	304-558-1542
Point-of-Sale Help Desk	Rational Drug Therapy Program	800-847-3859	800-531-7787
Prior Authorization	Rational Drug Therapy Program	800-847-3859	800-531-7787
Eligibility	Voice Response System	888-483-0793	
Eligibility Assistance	Bureau for Medical Services	304-558-1700	304-558-1776
Technical support	Molina Help Desk	888-483-0801	
AIDS Drug Assistance Program (ADAP)	Program Director	304-232-6822	740-695-3252
Children with Special Health Care Needs	Office of Maternal, Child, and Family Health	800-642-9704	304-558-2866
Member Denials	Molina Client Services	888-483-0797 800-642-8589	
State Maximum Allowable Costs	Magellan Medicaid Administration, Inc.	800-763-7382	

CHAPTER 518
PHARMACY SERVICES

APPENDIX 1
WEST VIRGINIA MEDICAID PHARMACY PROGRAM
IN-HOME PARENTERAL THERAPY
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WEST VIRGINIA MEDICAID PHARMACY PROGRAM
IN-HOME PARENTERAL THERAPY (IHPT)

DEFINITIONS

Antineoplastic - an agent that prevents the development, growth or proliferation of malignant cells.

Chemotherapy - the administration of chemical agents designed to have a specific effect upon disease causing cells or organisms.

In-Home Parenteral Therapy or IHPT - the parenteral administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting.

Parenteral - all routes of administration of substances other than via the gastrointestinal canal. This includes intravenous, subcutaneous, intramuscularly, intrathecal, or epidural and less commonly, mucosal (as in intravaginal).

Total Parenteral Nutrition (TPN) - the administration of nutritional substances by intravenous infusion to nourish members who are not candidates for enteral support.

INTRODUCTION

In-home parenteral therapy (IHPT) is a Medicaid covered service. Medicaid coverage for this service will include drugs and services that are:

- Medically necessary
- Prescribed by a licensed physician
- Administered via central line, peripheral line, infusion port, epidural, intrathecal or subcutaneous site
- Provided by a licensed pharmacy enrolled with the State of West Virginia Department of Health and Human Services, Bureau for Medical Services (BMS)
- Billed via electronic transmission according to standard guidelines or on the approved pharmacy paper claim form
- Prior authorized as directed by BMS

PROVIDER REQUIREMENTS AND RESPONSIBILITIES

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, IHPT providers must:

- Submit an IHPT Medicaid Provider Enrollment Form to the Bureau for Medical Services.
- Submit a copy of the provider's West Virginia Board of Pharmacy (WV BOP) Sterile Compounding Permit or respective state Board of Pharmacy Sterile Compounding Permit.

Participating pharmacies that bill services for West Virginia Medicaid members shall be subject to the laws and regulations set forth by the WV BOP that govern the requirements to hold a Sterile Compounding Permit.

MEMBER REQUIREMENTS

Members receiving In-Home Parenteral Therapy must meet the following requirements:

- The member must reside in either a private home or domiciliary care facility, such as an adult care residence. Members who are residents or patients of a hospital, nursing home (including ICF/MR group homes), rehabilitation centers, and other institutional settings are not eligible for this service.
- The member must be under the care of a physician who prescribes the in-home infusion therapy and monitors the progress of the therapy.
- The member must have sites available for intravenous catheters or needle placement or have central venous access.
- The member must be capable of self-administering or have a nurse or a caregiver who can be adequately trained, capable and is willing to administer/monitor home infusion therapy safely and efficiently following appropriate teaching and adequate monitoring.

PRIOR AUTHORIZATION

All IHPT services require prior authorization. Requests must be made through the Rational Drug Therapy Program (RDTP).

See the BMS web site at www.dhhr.wv.gov/bms for the approved prior authorization form.

- **Pre-mixed Solutions or products requiring no compounding**

  Pre-mixed solutions or products include those injectable items that do not require compounding by the pharmacist because a) the items are marketed as pre-mixed, thus requiring no dilution and/or compounding, or b) compounding is performed by the patient, the nurse or the caregiver. Commercially prepared products are mandated to be dispensed if available. Compounded products and related professional services shall not be reimbursed when the commercially prepared product is available.

  The request for prior authorization must include the diagnosis, duration of therapy, prescribing physician information, and appropriate documentation. The prior approval will be effective from the date of physician's original order and continue for the specified length of therapy unless there is a change in prescription or level of care. Changes in therapy require new prior authorizations. Written requests for prior authorization must be submitted via fax or mail to the RDTP on form IV-1. This form can be found at the BMS website at www.dhhr.wv.gov/bms.

- **Products requiring compounding**

  Certain injectable products require compounding in order to meet the needs of the member, and are not available commercially.

  The request for prior authorization must include the diagnosis, duration of therapy, prescribing physician information, and appropriate documentation. The prior approval will be effective from the date of physician's original order and continue for the specified length of therapy unless there is a change in prescription or level of care. Changes in therapy require new prior authorizations. Written requests for prior authorization must be submitted via fax or mail to the RDTP on form IV-1. This form can be found at the BMS website at www.dhhr.wv.gov/bms. Signed physicians orders for compounded IHPT

medications must be provided to RDTP if reimbursement for compounding activities is requested.

Refer to *Chapter 506, DME/Medical Supplies Manual*, for the policy governing parenteral nutrition.

BILLING AND REIMBURSEMENT VIA POINT-OF-SALE

Billing for IHPT claims is accomplished through NCPDP Version D.0 electronic or 1.1 batch (paper claim) system. Instructions for the processing of claims are found in the general pharmacy manual information.

The active ingredient(s) for each prescription is/are to be billed using the National Drug Code (NDC) and its respective unit of use. The drug portion of IHPT will be reimbursed online according to the current reimbursement policy. The codes used for the reimbursement of compounding services are inclusive of but not limited to diluents for reconstitution, IV fluids, and other supplies used in the compounding process.

Billing shall correspond to those items and fees reflecting therapy for a duration of a maximum of 34 days as prior authorized by RDTP. If the order is discontinued, any therapy that has been billed but not delivered to the member, must be reversed.

- **Pre-mixed Solutions or products requiring no compounding**
  After receiving prior authorization, prescriptions for items which are dispensed with no compounding requirements shall be submitted for payment via Point-of-Sale or approved paper claim form using the NDC number of the product and the quantity dispensed. Reimbursement will be made using the established retail reimbursement policy. (Do not use the NCPDP compound indicator).

- **IV Drugs Requiring Compounding**
  Products for IHPT requiring compounding involve billing in multiple parts. Drug components shall be submitted online or on the approved paper claim form using the actual NDC's that were used and quantity of each drug component, as approved by the Rational Drug Therapy Program. Use the NCPDP compound indicator when the product includes multiple agents. Please note: reimbursement for the diluting agent is included in the compounding fee and shall not be billed as a component of the compounded IHPT product if reimbursement for a compounding fee is requested.

- **Compounding Fee**
  The compounding fee which includes all components of the prescription compounding, such as sterile water, alcohol swabs, IV fluids, needles/syringes, etc., and professional services shall be submitted online or on the approved paper claim form. The authorization for reimbursement of the compounding fee will be issued from RDTP upon receipt of a copy of the signed order from the prescribing physician. (Do not use the NCPDP compound indicator).

- **Units Dispensed**
  Units are defined by First Data Bank product classification. In general, if a drug requires reconstitution, the units submitted will be the number of vials. For example, a 2 gm vial of cephazolin is submitted as a quantity of "1" for each vial. If the drug or component is

available in solution, the units are submitted in milliliters. For example, a 2ml vial of gentamicin injection (80mg/vial) is submitted as "2" for each vial. The actual amount used in compounding shall be submitted. Wastage shall be kept to a minimum. The units dispensed must match the amount prior authorized by RDTP.

The RDTP Help Desk is available to assist providers with questions regarding proper unit billing. In all cases, the amount and duration of therapy for which BMS is billed must match those ordered by the physician and delivered to the member.

- **Brand Name Justification**

  If a drug being dispensed is a product for which a generic equivalent exists, the generic must be dispensed. The use of brand name products must be justified, as referenced in the general pharmacy instructions.

- **Supplies**

  Refer to *Chapter 506, DME/Medical Supplies Manual* for coverage policy and billing instructions for supplies associated with IHPT.

ASSIGNED NDC CODES FOR IHPT COMPOUNDING

CODES AND DESCRIPTIONS:

TABLE OF PROGRAM-ASSIGNED NDC NUMBERS FOR THE SUPPLY/COMPOUNDING PORTION OF THE ANTIBIOTIC/CHEMO/HYDRATION/PAIN MANAGEMENT HOME IV THERAPY CLAIM

ANTIBIOTIC THERAPY

	Every 24 hrs	Every 18 hrs	Every 12 hrs	Every 8 hrs	Every 6 hrs	Every 4 hrs	Every 3 hrs
Bag	$15.92 99999-2124-00	$14.04 99999-2118-00	$12.23 99999-2112-00	$11.02 99999-2108-00	$10.42 99999-2106-00	$9.81 99999-2104-00	$9.50 99999-2103-00
Syringe	$11.54 99999-2224-00	$9.73 99999-2218-00	$7.92 99999-2212-00	$6.71 99999-2208-00	$6.11 99999-2206-00	$5.50 99999-2204-00	$5.19 99999-2203-00
Cassettes	$33.60 99999-2424-00		$29.98 99999-2412-00				

CHEMOTHERAPY

	Every 24 hrs	Every 18 hrs	Every 12 hrs	Every 8 hrs	Every 6 hrs	Every 4 hrs	Every 3 hrs
Bag/Syr.	$17.02 99999-3424-00	$15.21 99999-3118-00	$32.71 99999-3412-00	$12.19 99999-3108-00	$11.59 99999-3106-00	$10.98 99999-3104-00	$10.67 99999-3103-00
Cassettes	$36.33 99999-3424-00		$32.71 99999-3412-00				

PAIN MANAGEMENT/CHEMOTHERAPY/ANTIBIOTICS

Cassette – reimbursement per cassette: $36.11

99999-4400-00

Intrathecal Pain Pump Refills – reimbursement per refill: $130.00

99999-5500-00

NOTE: THE ABOVE – REFERENCED COMPOUNDING FEES ARE CALCULATED PER UNIT. EACH BAG, CASSETTE, OR SYRINGE IS CONSIDERED ONE UNIT, REGARDLESS OF VOLUME.

Dispensing fees and co-payment requirements do not apply to the above referenced compounding fees.

CHAPTER–519 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRACTITIONER SERVICES – INCLUDING PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED REGISTERED NURSE PRACTITIONERS

CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment 18	Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners	01/16/12	01/16/12
Section 519.20.1	Prior Authorization for Outpatient Surgeries	01/10/06	02/15/06
Section 519.13.2.1	Immunization for Children	11/21/05	11/30/05
Section 519.19.1	Prior Authorization for Outpatient Surgeries	10/24/05	Postponed
Section 519.12.5	Medicaid Diabetes Disease State Management	10/4/05	10/15/05
Section 519.13.2.2	Immunizations for Adults	10/4/05	10/24/05
Section 519.13.2.1	Immunizations for Children	9/28/05	7/18/05
Section 519.19.1	Prior Authorization for Outpatient Surgeries	9/28/05	11/1/05
Section 519.14.3	Prior Authorization Requirements for Imaging Procedures	9/1/05	10/1/05
Section 519.7.6	Nursing Facility Visits	5/17/05	6/1/05
Section 519.11.3	Psychiatric Services	5/17/05	6/1/05
Section 519.12.1	Caloric Vestibular Testing	5/17/05	6/1/05

Section 519.12.4.1	Colorectal Cancer Screening	5/17/05	6/1/05
Attachment 15	Approved HCPCS J Codes	5/17/05	7/1/05
Attachment 16	Drugs Approved to be Billed with HCPCS Code J3490	5/17/05	7/1/05

January 16, 2012

Attachment 16

Introduction: This is an additional attachment

Change: Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners

Directions: Add attachment to manual.

February 15, 2006

Section 519.20.1

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of service 22 (Outpatient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment 17.

Change: First paragraph to read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listing in Attachment 17, along with the PA form that may be utilized.

Directions: Replace all affected pages of the current manual.

NOVEMBER 21, 2005

Section 519.13.2.1

Introduction: Coverage changes related to Vaccines for Children Program.

***Old Policy:** CPT 90645, 90646, 90656, and 90698 are provided by Vaccines for Children Program.

Change: Removing CPT 90645, 90646, 90656, and 90698 from the Vaccines for Children Program.

Directions: Replace all affected pages of the current manual.

OCTOBER 24, 2005

Section 519.19.1

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

OCTOBER 4, 2005

SECTION 519.12.5

Introduction: Clarification of Diabetes Disease Management Program. To enable providers easier access to the web based modules.

Change From: **(**Under System Process-second sentence)**.** Begin by accessing the course at www.healthywv.org. Under the column listed ~~–P~~revention", locate and click on ~~–D~~iabetes Education for Primary Care Providers". This will take you to the actually program.

Change To: Begin by accessing the course at ~~–w~~www.camcinstitute.org/professional/diabetes/camc.htm."

Change From: (Second to the last paragraph) The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate.

Change To: The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate.

Providers will receive a written notice from Unisys stating the provider file has been

updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

Change From: (Last Paragraph) In the near future, CD's of this program will be available for those who do not have broadband Internet access.

Change To: CD's of this program are available to those who do not have broadband Internet access.

Change From: (Under section Requirements for Becoming a Diabetes Management Provider: 5th paragraph –last sentence). Recertification is required annually.

Change To: Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification

SECTION 519.13.2.2

Introduction: Tetanus Toxoid, reduced Diptheria Toxoid & Acellular Pertussis vaccine (Adacel) becomes part of the VFC Program effective 10/24/05

Old Policy: CPT 90715 Tetanus Toxoid, reduced Diptheria Toxoid & Acellular Pertussis Vaccine (Adacel) has never been covered by the Vaccines for Children Program

Change: Adding CPT code 90715 for Adolescents ages 11 through 18 years to the Vaccines for Children Program. This will appear as a bullet in Section 519.13.2.1 children's vaccine.

Directions: Replace all affected pages of the current manual.

September 28, 2005

Section 519.13.2.1

Introduction: Meningococcal Conjugate Vaccine (Menactra) CPT 90734 becomes part of the VFC Program effective 7/18/2005

***Old Policy:** CPT 90734 has never been covered by the Vaccines for Children Program

Change: Adding CPT code 90734 Meningococcal Conjugate Vaccine (Menactra) for Adolescents to the Vaccines for Children Program. This will appear as a bullet in Section 519.13.2.1 children's vaccine.

Directions: Replace all affected pages of the current manual.

Section 519.19.1

Introduction: Added Prior Authorization for Outpatient Surgeries.

Change: All surgeries performed in place of service 22 (Out patient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

Directions: Replace pages.

September 1, 2005

Section 519.14.3

Introduction: Deleted all information in Section 519.14.3.

Change: Changed to **PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES**

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic

Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

Directions: Replace pages.

MAY 17, 2005

Section 519.7.6

Introduction: Changed 2nd paragraph to provide more clarity.

Change: Deleted 2nd sentence in the 2nd paragraph, ~~T~~treatment of an acute condition within the 30-day cycle is paid, based on an unlisted E&M code (CPT 99499) with a report attached outlining the reasons for the services." Replaced with the following, ~~E~~emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit".

Directions: Replace all affected pages of current manual.

Section 519.11.3

Introduction: Revision being made to include statement that Masters Level Social Worker and Counselors must be in the employ of the psychiatrist.

Change: Changed 1st paragraph from, ~~O~~utpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, Master's Level Social Worker, or Master's Level counselor must also be registered and assigned an authorization number by the contracted agent. Telephone numbers for this agent are located in the Behavioral Health Services section of Appendix M" to ~~O~~utpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Social Worker, or Master's Level counselor in their employ must also be registered and assigned an authorization

number by the contracted agent.

Directions: Replace all affected pages of current manual.

Section 519.12.1

Introduction: There was a typographical error in this section.

Change: In the 4th sentence in this section, changed code 92546-TC to 92543-TC.

Directions: Replace all affected pages of current manual.

Section 519.12.4.1

Introduction: Procedure code G0120 was omitted.

Change: Added procedure code G0120 as bullet 10 in this section.

Directions: Replace all affected pages of current manual.

Attachment 15

Introduction: This is an additional attachment

Change: Approved HCPCS J Codes.

Directions: Add attachment to manual.

Attachment 16

Introduction: This is an additional attachment

Change: Drugs approved to be billed with HCPCS Code J3490.

Directions: Add attachment to manual.

CHAPTER 519—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PRACTITIONERS SERVICES

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Attachment 11: Diabetes Managing Provider Care Tool

Attachment 12: Responsibilities for Licensed Practitioner to get Extended Office Visit Medicaid Reimbursement

Attachment 13: Diagnostic Codes Covered for Bone Density Scans

Attachment 14: Instructions for Completing the CMS 1500 Claim Form

Attachment 15: Approved HCPCS J Codes

Attachment 16: Drugs Approved to be Billed with HCPCS Code J3490

Attachment 17: Outpatient Surgery PA Requirements

Attachment 18: Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners

CHAPTER 519–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRACTITIONER SERVICES – INCLUDING PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED REGISTERED NURSE PRACTITIONERS

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers acting within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the Bureau for Medical Services (BMS).

WV Medicaid covers a broad scope of Practitioner Services subject to medical necessity, appropriateness, and prior authorization requirements. Covered Practitioner Services must be provided in settings appropriate for each specific type of practitioner. Medical records must substantiate that any Practitioner Service billed to WV Medicaid was actually provided to an eligible WV Medicaid member by an appropriately credentialed practitioner.

The policies and procedures herein are issued as regulations governing the provision of Practitioner Services in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the WV State Code. BMS is the single State agency responsible for administering the WV Medicaid Program.

519.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200.

519.2 MEDICAL NECESSITY

All services must be medically necessary and appropriate to the member‘s needs in order to be eligible for payment. The medical records of all members receiving Practitioner Services must contain documentation that establishes the medical necessity of the service.

Important: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider‘s responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are rendered.

519.3 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the WV Medicaid Program and receive payment from BMS, practitioners must meet all enrollment criteria as described in Chapter 300, as well as the specific requirements outlined below.

To participate as a practitioner, providers must submit a completed and signed application form to the

Provider Enrollment Unit of the BMS' fiscal agent. This application form can be obtained by calling provider services at the following telephone numbers:

- (888) 483-0793 - In-state and border providers
- (304) 348-3360 - Out-of-state and Charleston, WV providers

The address for Provider Enrollment is:

Unisys
Post Office Box 625
Charleston, WV 25322-0625

The address for Provider Services and Member Services is:

Unisys
Post Office Box 2002
Charleston, WV 25322-2002

Providers must meet all of the provider requirements of the WV Medicaid Program and their practices must be fully operational before they may enroll as Medicaid providers.

519.3.1 ENROLLMENT: PHYSICIAN

All physicians whether in a private practice, a member of a group practice, or an employee of a medical services entity, must enroll with WV Medicaid in order to receive reimbursement for services rendered to Medicaid members. BMS evaluates the following credentials and circumstances when reviewing applications submitted by physicians who wish to participate in the Program:

- Current license issued by the WV Board of Medicine, Board of Osteopathy, or by the regulatory entity in the state of the practice location
- In a medical specialty:
  - Current board or board eligible certification by a Member Board of the American Board of Medical Specialties
  - Certification of satisfactory completion of a residency program accredited either by the Liaison Committee of Graduate Medical Education or by the appropriate Residency Review Committee of the American Medical Association (AMA)
  - Current board certification or board eligibility by a Specialty Board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association
  - Documented qualifications and training to take examinations of the appropriate Member Board of the American Board of Medical Specialties, if the residency program was completed in a foreign country.

519.3.2 ENROLLMENT: PHYSICIAN ASSISTANT

Physician assistants cannot be enrolled as direct Medicaid providers. However, WV Medicaid allows enrolled physicians to bill for covered services rendered to Medicaid members by physician assistants in their employ and/or under their supervision. Supervising physicians must follow the regulations established in WV Code 30-3-1 et seq. Physicians are not required to be physically present on the premises in order to bill for physician assistant services performed under their supervision.

519.3.3 ENROLLMENT: ADVANCED REGISTERED NURSE PRACTITIONER

For purposes of this manual, an Advanced RN practitioner is an individual licensed and certified as an Advanced nurse practitioner by the WV Board of Registered Nurses, or the appropriate regulatory body in the state of the practice location, with certification in one of the following specialties: (See Chapter 30, Title 19, Series 7-8 of WV Code.)

- Certified nurse midwife
- Certified registered nurse anesthetist
- Family nurse practitioner
- Pediatric nurse practitioner
- Geriatric nurse practitioner
- Adult nurse practitioner
- Women's health nurse practitioner
- Psychiatric nurse practitioner

The Advanced RN practitioner must be enrolled as a provider in order to bill for the provision of WV Medicaid services. Prescriptive authority is not required to be enrolled as a provider.

An Advanced Nurse Practitioner must have a signed collaborative agreement for prescriptive authority with a physician who is enrolled with BMS. This collaborative agreement (which must be on file at the BMS) must document the professional relationship between the Advanced RN practitioner and the physician. The Advanced RN practitioner must notify BMS immediately, and if necessary submit a replacement document, if the collaborative agreement is cancelled, changed, or not renewed.

519.3.4 ENROLLMENT: GROUP/PAY-TO PRACTICES

Providers whose practice is incorporated under the same tax identification number or have an employer-employee relationship must enroll as a Medicaid group/pay-to provider. To receive Medicaid payments, each provider employed by or directing payment to the group/pay-to must be enrolled as an individual provider and designate that payment for rendered services is to be made to the group/pay-to entity. Individuals can participate in multiple groups and all such relationships must be documented with provider enrollment in order that payments may be appropriately made to the correct entity and reported to the correct tax identification number.

Termination of the corporation or the employer- employee relationship must be reported in writing, on office letterhead stationery, to the Provider Enrollment Unit. The notice must include the effective date of the termination. Failure to report these changes will result in incorrect routing of payments and invalid filings with the Internal Revenue Service.

519.3.5 ENROLLMENT: OTHER PRACTITIONERS

Enrollment requirements of other practitioners, e.g. chiropractors, podiatrists, and therapists, are discussed in the Chapters which corresponds to those specific providers.

519.3.6 ENROLLMENT: DOCUMENTATION

Documentation including required license, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, and any other materials substantiating an individual's eligibility to perform as a practitioner with the application for enrollment.

Renewals of license or certification must be maintained in a current status and the documentation must be submitted to Provider Enrollment for inclusion in the provider record.

In order to be paid for services related to skills attained after the initial enrollment, an individual must submit documentation of the new capabilities and request an addition of the specialty or service group to his/her provider profile.

519.4 PRACTITONER SERVICES: OVERVIEW

Practitioner Services are medical services rendered by one of the following:

- A doctor of medicine or osteopathy within the scope of a professional license issued under State law,
- A qualified non-physician practitioner who may provide care under the direction or supervision of a licensed doctor, e.g. a physician assistant or a nurse first assistant,
- An Advanced RN practitioner enrolled and practicing independently.
- Or a Masters Level Social Worker and Masters Level Counselor employed by a participating psychiatrist.

Practitioner Services furnished in federally qualified health centers or rural health centers are included in the facility's reimbursement and are therefore not separately billable.

519.4.1 PHYSICIAN SUPERVISION OF EMPLOYED NON-PHYSICIAN PRACTITIONERS

With certain specific exceptions, physicians must be onsite when WV Medicaid covered services are provided in order to bill for services furnished by physician assistants, clinical nurse specialists, employed nurse practitioners (other than those specialties listed in Section 519.3.3), or other qualified non-physician practitioners. The physician may not bill for services furnished by any employee who is enrolled, or eligible to be enrolled, as a Medicaid provider.

Exception to physician supervision of employees:

- Physician Assistants - The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
- Advanced Nurse Practitioners – The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
- Masters Level Social Worker or Masters Level Licensed Professional Counselors – The supervising physician must be available for consultation, but does not need to be on the premises.

Following are some of the provisions governing the activities of physician assistants in WV. They apply to all practice settings in which physician assistants are employed:

- Physician assistants must be supervised by a designated licensed, qualified physician. No physician may supervise more than three physician assistants.
- Physician assistants must have job descriptions approved by the WV Board of Medicine.
- Physician assistants are prohibited from billing directly for their professional services.
- Physician assistant's authority is limited by the following:
  - The supervisory physician's authority

- The physician assistant's license, national certification, and job description
- The employing facility's policies and procedures
- And all applicable statutes and regulations (See WV Code 30-3-1 et seq.)

The employing physician may also bill WV Medicaid for covered services furnished by a registered nurse first assistant acting as an assistant surgeon. See Section 519.4.5 for the requirements of this service.

519.4.2 PHYSICIAN SUPERVISION IN A TEACHING SETTING

Teaching physicians may bill for services provided by residents under their supervision. The teaching physician must be present when the service is rendered unless the individual is licensed to practice medicine and the service is within the scope of his/her license. The level of the service billed must reflect the complexity of the evaluation or treatment need; not the work effort required by the resident.

Residents in an approved graduate medical education program, who have received their license to practice, may be enrolled as Medicaid providers, but they may not bill Medicaid for physician services provided within the scope of the education program. Services related to that program are billed by the supervising physician with the following criteria:

- The teaching physician must be present for a key portion of the time during the performance of the service.
- The teaching physician must be present during the critical portion of a surgical, complex, or dangerous procedure, and be immediately available to furnish care during the entire service or procedure.

EXCEPTION: With regard to the requirement of the teaching physician's presence, there is a special exception to the physician presence requirement for mid-level evaluation and management services furnished through a family practice type of residency program that functions outside an inpatient hospital setting. The exception applies when Current Procedural Terminology (CPT) codes 99201-99203 or 99211-99213 are rendered within a specific residency program in an ambulatory care center. **This does not apply to preventive medicine codes.**

For this exception to apply, all of the following requirements must be met:

- Residents who provide services without a teaching physician present must have completed more than six months of an approved residency program.
- The teaching physician may not supervise more than four residents concurrently and must be immediately available to render care or answer questions.
- The members must be an identifiable group of individuals who use the outpatient setting for their usual and continuing source of care.
- Residents may, within the scope of their training, furnish acute care, chronic care, comprehensive care not limited by organ system or diagnosis, or coordination of care furnished by multiple providers
- The outpatient center must be located in a setting that includes the resident's time in the full-time equivalency count used for direct graduate medical education costs.

WV Medicaid does not apply this exception to preventive medicine. In other words, the teaching physician must be present to supervise the resident in order for Medicaid to pay the teaching physician for supervising the resident while the latter provided a covered preventive service.

519.4.3 RESIDENTS AND FELLOWS

Residents in an approved graduate medical education program may not bill Medicaid for physician services provided within the scope of the education program. Medicaid reimburses these services as hospital services rather than physician services. The reimbursement is in the direct graduate medical contracted education payments WV Medicaid makes to the hospital. (This is true for both teaching and non-teaching hospitals.)

Licensed/enrolled residents may bill WV Medicaid directly for physician services provided to members under the following circumstances:

- In non-approved teaching programs may bill Medicaid for covered services they provide in hospital settings and within the scope of their license
- They may also bill for physician services provided in freestanding skilled nursing facilities or home health agencies.
- They may bill for physician services provided in non-institutional settings, such as freestanding clinics not part of the hospital if the non-institutional setting is not part of the teaching program. **This does not apply to Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC). Services provided at a FQHC/RHC are not separately billable.**

Fellows may not bill separately for services when care is provided through a teaching program, even if a fellow supervises interns and residents. In other words, physician services furnished by fellows within an approved graduate medical education program are hospital services and are not therefore separately billable as physician services.

"Moonlighting" residents may receive separate Medicaid payments for physician services provided in the outpatient or emergency department of a teaching hospital. These are residents who are providing physician services separately identifiable from services required in their graduate medical education program. Separate payment may be made if a contractual arrangement between the resident and the hospital exists and all of the following conditions are met:

- The resident is fully licensed to practice medicine in the State where the services are provided.
- The services are identifiable physician services.
- ~~"~~Moonlighting" services can be differentiated from services provided as part of the approved graduate medical education program.

In these instances, a resident can be paid for covered physician services provided to the Medicaid member.

519.4.4 ADVANCED REGISTERED NURSE PRACTITIONER

WV Medicaid pays specified Advanced RN practitioners (See Section 519.3.3) separately for medically necessary and appropriate services rendered to Medicaid eligible individuals. The services must be rendered in accordance with the provisions of WV State Code, his/her State license, and within the scope of practice defined by that license. Advanced RN practitioners must meet all requirements of the WV Board of Nursing in order to obtain prescriptive authority.

Services provided by an Advanced RN practitioner may include incidental services and supplies that are included as part of another service or procedure. The cost of incidental services is not separately reimbursable.

Advanced RN practitioners cannot bill for nursing home visits, inpatient visits, or observation services.

519.4.5 REGISTERED NURSE FIRST ASSISTANT

WV Medicaid covers services provided by a registered nurse first assistant acting as the assistant surgeon for an employing physician. The employing physician may bill assistant at surgery provided by an employed RN if the following criteria are met:

- The RN first assistant has a current, active RN license
- The RN is certified in peri-operative nursing
- The RN has successfully completed and holds a degree or certificate from a program which consists of the following criteria:
  - The Association of Operating Room Nurses, Inc., Care Curriculum for the Registered Nurse First Assistant and
  - One year of post basic nursing study, which shall include at least 45 hours of didactic instruction and 120 hours of clinical internship or its equivalent of two college semesters, or
  - Was certified by the Certification Board of Perioperative Nursing prior to 1997

Procedures for which Medicaid will reimburse an RN first assistant at surgery are indicated in Appendix 1 of the Resource Based Relative Value Scale (RBRVS) Policy and Procedures Manual. Specific information is given in the discussion of Modifiers 80, 81, 82, and AS.

In billing for the RN first assistant services, the employing physician must repeat the appropriate surgical procedure used for billing his/her service with addition of the modifier ~~–~~AS." WV Medicaid covers only one assistant at surgery per surgical encounter. Also, an Assistant at Surgery is not reimbursable when co-surgeons or team surgery is billed.

519.4.6 OUT-OF-STATE PHYSICIAN SERVICES

WV Medicaid will reimburse **emergency** out-of-state physician services. The submitted claim must clearly indicate an emergency situation existed and the emergency room record must be submitted with the claim. Out-of-state physicians are subject to the same fee and payment regulations as in-state physicians and must enroll with WV Medicaid in order to receive reimbursement for services rendered.

Non-emergency outpatient services provided to WV Medicaid members by out-of-state physicians must be prior authorized by the BMS. (For information concerning provision of inpatient services, see Chapter 510 Hospital Services.) The exceptions to this rule are approved border providers and Medicaid-eligible children who have been placed in an out-of-state foster care home or out-of-state residential treatment center.

A physician who practices in WV and wishes to refer a member to an out-of-state physician must submit a request to the Out-of-State Unit in the BMS. The request must include the reason for the out-of-state referral, member's diagnosis, the expected treatment (including duration and plan for follow-up treatment by that provider), why the treatment cannot be provided in-state, and any other information deemed pertinent for the circumstances.

All claims submitted by out-of-state physicians for non-emergency medical services will be denied unless the physician is a border provider or the service is approved in advance.

519.4.7 WV MEDICAID MUST PAY PROVIDER OF SERVICE

The provider of a service to WV Medicaid-eligible members must bill directly to the WV Medicaid Program for the service. If certain criteria are met, payment may be made to the employer of the provider. (e.g., Payment may be made to the employer of the practitioner if the practitioner is required, as a condition of employment, to turn over his fees to the employer or to the facility in which the service is provided if the practitioner has a contract under which the facility submits the claim.) Information regarding group enrollment may be obtained from the Provider Enrollment Unit.

519.5 SERVICE DESCRIPTIONS IN OTHER MANUALS

Various medical services that may complement or augment the Practitioner Services described in this chapter may be rendered to WV Medicaid members by enrolled WV Medicaid providers. The policies and procedures covering the provision of those services may be found in the appropriate Chapters as listed below:

- Chapter 504: Chiropractic Services
- Chapter 505: Dental Services
- Chapter 506: Durable Medical Equipment
- Chapter 508: Home Health
- Chapter 510: Hospital Services
- Chapter 512: Laboratory & Radiology
- Chapter 515: Occupational/Physical Therapy
- Chapter 518: Pharmacy Services
- Chapter 520: Podiatry Services
- Chapter 524: Transportation
- Chapter 525: Vision Services

Policies and procedures regarding Organ Transplant Services are found in Chapter 510 of the Hospital Services Manual.

519.6 INDEX OF COVERED SERVICES

519.7 EVALUATION AND MANAGEMENT SERVICES

Evaluation and Management (E&M) Services involve face-to-face contacts between members and practitioners. Contacts may occur in a hospital setting, the member's home, the practitioner's office or other ambulatory setting, emergency room, or long-term care facility.

WV Medicaid coverage of E&M Services is outlined below:

- Only one E&M procedure code is covered on the same date of service per member per practitioner.
- Only one E&M procedure may be billed when more than one practitioner in the same specialty and same group provides a service to the same member on the same date of service, unless the E&M services are for unrelated problems.
- When multiple E&M visits occur on the same date of service, the practitioner must bill with the E&M procedure code that best represents the combined level of services.
- The E&M code must reflect the content of the service.
- The member's medical record must support the level of care provided and document, at a minimum, all of the following information:
  - The billed procedure code's components, based on CPT guidelines
  - The time the practitioner spent with the member for medical decision making
  - The coordination of care or counseling provided, including direct fact-to-face contact time when time is the key component for code selection.

WV Medicaid does not cover:

- Hospital visits related to a procedure that WV Medicaid does not cover
- Visits covered by a global surgical fee
- Visits by an RN practitioner in a hospital or nursing home.

In addition, WV Medicaid does not pay separately for manual or automated urine, hemoglobin, and hematocrit tests performed as part of the visit.

519.7.1 OFFICE VISITS AND OTHER OUTPATIENT SERVICES

WV Medicaid covers medical services rendered to the member for the prevention or diagnosis and treatment of illness, accident, and injury. Except for CPT 99211, face-to-face contact must occur. (e.g., the practitioner must examine the member and provide medical services in order to bill a visit.) CPT 99211 indicates an office or other outpatient visit for an established member that does not require the presence of a practitioner. The presenting problem is usually minimal and the practitioner typically spends five minutes performing or supervising this E&M service.

An office visit associated with a covered procedure or minor surgery performed in a practitioner‘s office is considered part of the procedure and is not payable by Medicaid. The visit may be billed separately, with the appropriate modifier, provided the visit is for a distinctly different reason.

A visit to a practitioner‘s office or outpatient department of a hospital solely for a diagnostic service does not qualify for coverage or payment as an E&M procedure. Medicaid payment will be made for the diagnostic service but not for the visit as it is bundled with the payment for the diagnostic service.

A preoperative office visit and uncomplicated follow-up care are bundled with the payment for the surgery and are not separately reimbursed.

Telephone contacts are not considered to be practitioner visits. Therefore, WV Medicaid does not reimburse for telephone contacts with the member or on the member‘s behalf.

519.7.2 PREVENTIVE CARE FOR MEMBERS

WV Medicaid covers well child, preventive medicine examinations for children based on the recommended frequency established by the American Pediatric Association and adopted by the WV Early and Periodic Screening, Diagnostic, and Treatment Program. For adult members, WV Medicaid covers one annual physical examination in a 12 month period. The annual examination must be reported with a preventive medicine code reflective of the member‘s age (CPT 99381-99387 or CPT 99391-99397).

- The annual physical examination is separate and distinct from treatment or diagnosis for a specific illness, symptom, complaint, or injury. If during the examination an abnormality is found or a preexisting condition requires significant additional work to perform the key components of a problem-oriented E&M service, that service may be billed with Modifier 25. Documentation in the medical record must support the provision of this service. Clinical laboratory services, radiology procedures, and other diagnostic services must be reported and billed separately.

WV Medicaid does not cover the following types of physical examinations:

- Sport physicals
- Camp physicals

- Physicals for inpatients in nursing facilities, hospitals, residential treatment facilities, and other such facilities
- Physicals required by third parties, such as insurance companies, Government agencies, and businesses as a condition of employment
- Daycare

Eligibility examinations requested by the county DHHR office are not annual physicals. See Section 519.7.10 for coverage information.

519.7.2.1 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

WV Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. (WV Medicaid EPSDT coverage is through the month in which the member turns 21 years of age.) These services target early detection of disease and illness and provide referral of members for necessary diagnostic and treatment services.

If the Medicaid member is a member of the Physician Assured Access System (PAAS) Program, a referral from the primary care physician (PCP) must be obtained prior to performing an EPSDT exam for reimbursement if the provider administering the exam is not the member's PAAS PCP. If the Medicaid member is a member of a Health Maintenance Organization (HMO), the HMO is responsible for reimbursement for the services when the HMO's requirements have been met.

Providers must make reasonable efforts for every member under 21 years of age to determine whether a visit to the provider's office stems from an EPSDT referral by asking the referring provider, clinic, or member. If the visit is the result of an EPSDT screening, the appropriate space on the claim must be marked "yes" to indicate a referral was the source of the visit. Likewise, the appropriate space on the claim must be marked ~~no~~" if the information cannot be obtained or is not the result of a screening.

519.7.3 HOSPITAL VISITS

All hospital admissions must be prior authorized based on the determination of medical necessity and appropriateness by BMS' contracted utilization management agent in order for WV Medicaid to reimburse for services rendered. Visits by physicians in conjunction with denied or non-covered inpatient services are non-reimbursable. Hospital admissions for diagnostic procedures may be reimbursed only when there is adequate documentation the procedure cannot be performed on an outpatient basis.

As with other E&M services, only one hospital visit per date of service is covered regardless of how many times the physician sees the member on that date. Payment for the hospital visit is included in the global fee paid for surgical/diagnostic procedures, depending on the global period for the procedure. Global periods for procedures are listed in the RBRVS table.

519.7.3.1 EMERGENCY DEPARTMENT SERVICES

WV Medicaid covers emergency department visits rendered by the onsite practitioner using CPT codes 99281-99285. If a practitioner is called in to the emergency department to treat a member, the services must be billed over the appropriate level office/outpatient procedure code. Additional billing of codes for after-hour visits or non-scheduled visits is not covered.

Surgical procedures performed in an emergency room are billable. However, the physician will not be

reimbursed for an emergency room visit in addition to the surgical procedure performed in the emergency room.

519.7.3.2 OBSERVATION SERVICES

Observation services are defined as the use of a bed and periodic monitoring by hospital nursing or other indicated staff at the level and frequency necessary to evaluate the member's condition to determine the need for inpatient admission. Medicaid limits the coverage of observation services to a maximum of 48 hours. Even if the 48 hours extends over three calendar days, only two observation visits are covered: the initial observation care and the observation care discharge services.

In addition to documentation in order to support the medical necessity of the service, the observation record must contain dated and timed physician's admitting orders specifying the care the member is to receive while in observation, admitting history and physical, nursing notes, dated and timed progress notes written by the physician, laboratory and other diagnostic test results, active treatment protocol, and documentation to justify the level of the observation code billed. **This record must be maintained in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.**

When a member is admitted to the hospital for observation, the admitting physician must be physically present on the hospital premises.

If a member is examined by a practitioner other than the admitting physician while in observation, that practitioner must bill the outpatient E&M code appropriate for the service provided.

519.7.4 REFERRALS

A referral involves the transfer of the total or a specific part of the care and treatment of a member from one physician to another physician. A referral does not qualify as a consultation. The care provided during the course of treatment subsequent to such a referral is therefore not considered a consultation for payment purposes and therefore should not bill the consultation E&M procedure codes.

519.7.5 CONSULTATIONS

A consultation is a service provided by a physician whose opinion or advice regarding the evaluation or management of a member's condition is requested by the attending physician or another appropriate provider. A consultant may initiate diagnostic or therapeutic services at the time of the consultation. The consultant must document in the member's record that the member was seen at the request of the referring provider and that the findings, recommendations, and treatment (if initiated) were communicated to the referring practitioner. If the consultant assumes responsibility for the member's continuing care, any subsequent service provided does not qualify as a consultation and should be billed with the appropriate CPT code. The physician must not bill a consultation if the member was self-referred for services, except in the case of a confirmatory consultation which may be requested by the member and/or family.

WV Medicaid applies a service limitation of one consultation per procedure code per consultant per six months to office or other outpatient consultations, initial inpatient consultations, and confirmatory consultations. This limitation applies to the following consultations performed by an individual physician: CPT 99241-99245, 99251-99255, and 99271-99275. In other words, a member may receive only one Medicaid–covered consultation of each specific level from the same physician over a

six month period. The member may receive consultations from different physicians within the same six month period, regardless of whether the physicians provide the same or different levels of service, unless the consultants are in the same group practice or partnership. WV Medicaid covers follow-up consultations (CPT 99261-99263) with no service limitation other than billing with other consultation codes or hospital/office visits.

Consultations are disallowed if and of the following criteria are met:

- They are provided in conjunction with other services furnished by the same physician on the same date to the same member, such as office visits, home visits, or hospital visits,
- They are provided by a surgeon immediately prior to the procedure and resulted in the initial decision to perform surgery with the use of modifier 57,
- When billed by a member of the same group and specialty as the physician performing the surgery.

Gathering of the member's medical history and/or performance of a physical examination prior to a member's admission for surgery is the responsibility of the admitting/operating surgeon under the global surgical package. This may not be billed as a consultation.

Pre-operative evaluations for anesthesia are not considered to be consultations and may not be billed as consultations. Payment for these evaluations is included in the fee for the administration of the anesthesia.

When the consultant assumes responsibility for the management of a portion or all of the member's care subsequent to the consultation, then consultation codes are no longer appropriate. There is a difference between consultations and referrals. See Section 519.7.4 for information on referrals.

519.7.5.1 SECOND OPINIONS FOR ELECTIVE SURGERY

Second opinions (Confirmatory consultations) are covered for elective/non-emergency surgery. The second opinion concept is to be a member oriented service that allows an individual member to make better informed decisions about a physician's recommendation on the need for surgery. However, a physician may also request a second opinion.

The consulting physician must document the type of surgery, the name of the member or physician requesting the second opinion, and must bill an appropriate confirmatory consultation procedure code.

519.7.5.2 TELEHEALTH SERVICES

A teleconsultation is an interactive member encounter that meets specific criteria. This service requires the use of ~~"i~~nteractive telecommunications systems" defined as multimedia communication equipment that involves at least audio and video equipment that permits two-way consultation among the member, consultant and referring provider. Telephones, facsimile machines, and electronic mail systems do not qualify as interactive telecommunication systems. WV Medicaid covers teleconsultations subject to the following criteria:

- The consultation must involve real time consultation as appropriate for the member's medical needs and as needed to provide information to and at the direction of the consulting physician.
- Medicaid coverage of teleconsultations is limited to members in non-metropolitan statistical professional shortage areas as defined by CMS. The referring provider must be located in the non-metropolitan area.

- The referring provider may bill for an office, outpatient, or inpatient E&M service that precedes the consultation and for other Medicaid-covered services the consultant orders, or for services unrelated to the medical problem for which the consultation was requested. However, the referring provider may not bill for a second visit for activities provided during the teleconsultation.
- The consultant must be in control of the member's medical examination, with the referring provider participating, as needed, to complete the examination. The member must be present in real time, and telecommunication technology must allow the consultant to conduct a medical examination of the member.
- The consultant's findings must be documented in a written report given to the referring physician.
- Payment for a teleconsultation does not include any separate reimbursement for telephone line charges or facility fees, and a member may not be billed any amount for these charges/fees.
- Separate payment is not made for the review and interpretation of medical records.
- Medicaid coverage is limited to professional consultations that meet the criteria specified for consultation service in the CPT Manual. Covered services include initial follow-up or confirming consultations in hospitals, outpatient facilities, or medical offices, that is: CPT 99241-99245, 99251-99255, 99261-99263, and 99271-99275. These are subject to the same service limits discussed in the consultation section of this chapter, Section 519.7.5.

Modifier GT must be used with the proper consultation code in order for a physician to bill for a teleconsultation.

519.7.6 NURSING FACILITY VISITS

WV Medicaid covers one nursing facility visit per 30 days when made by the member's primary care physician. The appropriate E&M code (CPT 99301-99313) must be used to bill for the visit. WV Medicaid does not reimburse a nursing facility visit if the same physician provides another E&M visit to the same member on the same date of service.

WV Medicaid does not cover daily, weekly, or routine nursing facility visits. Emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit.

Specialists called by an attending physician must bill the code appropriate for their services, such as a procedure code for a consultation or minor surgery. The service must be provided based on a specific request of the primary care physician. **Standing orders are not acceptable.**

Nursing discharge orders, CPT 99315 – 99316, are not covered by WV Medicaid.

There is no coverage for nurse practitioner visits.

519.7.7 CARE PLAN OVERSIGHT SERVICES

Care plan oversight (CPO) consists of physician supervision of members under either home health or hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement. WV Medicaid provides payment for only one CPO service per calendar month, per member, per provider. CPT 99375 and 99378 are the only procedure codes that may be used to bill CPO services. CPO coverage is subject to the following rules:

- The member must be receiving medically necessary home health services or hospice care.
- The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.

- A face-to-face encounter between the physician and member must occur at some time during the six months prior to the first month for which CPO services are billed, and every six months afterwards.
- Payment for CPO services may not be made to physicians having a significant ownership interest in or financial relationship with a home health agency or hospice.
- Only the attending physician may bill or receive payment for CPO services. **Exception:** The attending physician may not bill or receive payment for CPO services if he/she is the medical director or a physician employed by, or having a contractual relationship with, the home health agency or hospice.
- Physicians may not bill for CPO during the postoperative period of a global surgery period unless the service is unrelated to the procedure.
- CPT 99375 and 99378 are the only procedure codes that may be used to bill for CPO services.
- The physician must furnish at least 30 minutes of CPO services within the calendar month that is being billed. Medicaid allows multiple CPO encounters during the month on multiple days, but the total time must add up to 30 or more minutes, and can be billed only once.

CPO services for Medicaid members in nursing facilities are not covered. CPO services are not payable to physicians having a significant ownership interest in or financial relationship with a home health agency or hospice.

519.7.8 CRITICAL CARE VISITS

As circumstances warrant, physicians should bill for critical care, regardless of whether the associated visit was an initial or subsequent one, and regardless of the site if the level of care fulfills the criteria for critical care. However, physicians may not bill for procedures and services the CPT Manual defines as ~~-a~~ttendant to critical care management". These services are listed in the CPT Manual.

519.7.9 PROLONGED PHYSICIAN ATTENDANCE

WV Medicaid covers prolonged services only if the physician provides a prolonged direct, face-to-face service to the member that equals or exceeds the threshold time for the E&M service provided (typical time of the service plus 30 minutes). Time spent by office staff with the member or time the member was unaccompanied in the office is not counted toward the total time and may not be counted nor billed. For hospital-prolonged services, time spent waiting for certain events to occur, such as test results, changes in the member's condition, therapy to end, or use of facilities, may not be billed.

The member's medical record must document the duration and content of the billed E&M code and document that the physician personally furnished at least 30 minutes of direct service after the typical time of the E&M service had been exceeded by at least 30 minutes. (This time does not need to be continuous; however, it must be provided on the same date of service.)

Physicians may bill for prolonged services using CPT 99354-99357. These codes require billing of companion E&M codes when the same physician provides both types of services on the same date of service to the same member. CPT 99354 and 99356 are used for the first 30-60 minutes and 99355 and 99357 for each additional 30 minutes. The prolonged service codes are billed in addition to the appropriate visit code.

- The companion E&M codes for CPT 99354 are 99201-99205, 99212-99215, or 99241-99245.
- The companion E&M codes for CPT 99355 are 99354 and its related E&M code.
- The companion E&M codes for CPT 99356 are 99221-99223, 99231-99233, 99251-99255,

99261-99263, 99301-99303, or 99311-99313.

- The companion E&M codes for CPT 99357 are 99356 and its related E&M code.

All these procedure codes are subject to Medicaid coverage rules and CPT definitions.

519.7.10 ELIGIBILITY EXAMINATIONS

The local DHHR office requests physical examinations, consultations, and reports on pending applications for the purpose of determining Medicaid eligibility. These requests are made by letter, defining the service to be provided and the member identification number to be used in billing. These services must be billed on paper with a copy of the authorizing letter. (These services are not reimbursable by Managed Care Organizations.)

Based on Social Security disability regulations, eligibility examinations may only be performed by an MD or DO.

The specific codes that must be used when billing eligibility examinations are:

- 99450 General physical examinations,
- 99456 Specialist exams (including eye exams), and
- S9981 Medical records.

Only one of these procedure codes can be billed per provider and no other E&M code may be billed.

In addition to the procedure codes listed above, diagnostic services may also be ordered by the examining physician if medically necessary to complete the examination and/or consultation. Diagnostic procedures that may be covered for eligibility determination are:

- Diagnostic Eligibility
  - Diagnostic Colonoscopy 45378
  - Diagnostic Radiology 70010-76499
  - Diagnostic Ultrasound 76506-76886, 76977
  - Nuclear Medicine Diagnostic 78000-78999
  - Laboratory 80000-86804, 87001-87999, 88104-88299, 88342-88349, 88400-89060, 89160-89240
- Medicine Codes
  - Therapeutic or Diagnostic Infusions 90780-90781
  - Therapeutic, Prophylactic, or Diagnostic Injections 90782-90799
  - Gastroenterology 91000-91100, 91110, 91122, 91132-91133, 91299
  - Ophthalmology 92015-92060, 92081-92287
  - Otorhinolaryngology 92502-92506, 92511-92520
  - Vestibular Function 92541-92548, 92551-92589, 92610-92617
- Cardiovascular
  - Cardiography 93000-93278
  - Echocardiography 93303-93350
  - Electrophysiological 93660,93701-93722, 93875-93990

– Pulmonary	94010, 94060, 94200, 94375, 94720, 94760, 94761, 94772, 94799
– Neurology and Neuromuscular	95805-95811, 95812-95822, 95827, 95830, 95831-95904, 95920-95967
– Physical Medicine	97001,97003,97750
– A Codes	A9500-A9503, A9505, A9700
– G Codes	G0001, G0030-G0047, G0102-G0107, G0120, G0125, G0210-G0230, G0236, G0253-G0254
– P Codes	P7001,P9612

Documentation for medical necessity is required for all services. The documentation of the authorization, examination, medical necessity for diagnostic procedures, and diagnostic findings must be maintained in the member's record.

519.8 ANESTHESIA SERVICES

Anesthesia services covered by WV Medicaid include general, regional, and labor epidural. These services are primarily reimbursed using the American Society of Anesthesiologist's (ASA) ~~0~~" CPT codes. Supportive services rendered in order to afford the member the necessary anesthesia care are also covered.

Anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) are the only providers that may be reimbursed for general and monitored anesthesia services.

519.8.1 BASE AND TIME UNITS

Two distinct unit values apply to anesthesia services. Base units are defined by the ASA Uniform Relative Value Guide. These units are part of the procedure and may not be billed separately.

The other value is the time unit. WV Medicaid defines a time unit as 15 minutes which must be rounded to the nearest whole unit. (Eight minutes or more, round up. Seven minutes or less, round down.) Only time units may be billed.

Payment is determined by the sum of the ASA base units plus time units multiplied by the anesthesia conversion factor. There is a limit of 40 units (10 hours) on each anesthesia Zero ~~0~~" code, except for maternity-related anesthesia services. (See Section 519.8.3.) If anesthesia is provided longer than 10 hours, the claim must be billed on paper and submitted with documentation that would justify the additional anesthesia used.

519.8.2 COVERAGE POLICIES

WV Medicaid applies the following policies for coverage and reimbursement of anesthesia services:

- Payment for multiple anesthesia procedures is based on the procedure with the highest base unit value and the actual anesthesia time of the multiple procedures. Only one zero code may be billed (the highest value). Exception: Procedures performed at the same time as a delivery are included in the maternity service and must be billed with the maternity anesthesia CPT codes listed in Section 519.8.3.
- Anesthesia time begins when the CRNA or anesthesiologist begins to prepare the member for anesthesia care in the operating room or an equivalent area, and ends when the CRNA or the anesthesiologist is no longer in personal attendance.

- Preoperative evaluations for anesthesia are included in the fee for the administration of anesthesia and may not be billed as an E&M service.
- Regional IV anesthesia (e.g., 01995) is not based on time units; the base unit is covered. Therefore, only one unit of service may be billed. CPT 01995 is used only in situations involving the application of a tourniquet to a limb and injection of an agent for regional anesthesia.
- CPT surgical procedure codes (e.g., 62311 and 62319) are used for regional anesthesia. No base units or time units of anesthesia may be billed. Instead, one unit of service (an injection) is billed.
- Epidural for pain management other than the three stages of delivery (labor, delivery, and postpartum) must be billed with CPT 62311 and 62319. Time units may not be billed.
- CPT 01996 (Daily Management of Epidural or Subarachnoid Drug Administration) is not payable on the same day as the insertion of an epidural catheter or a general anesthesia service. The service unit for this procedure is one base unit.
- Epidural anesthesia for surgical procedures must be billed with the appropriate ~~"0~~" anesthesia code with time units.
- Medications for pain relief given during the time of the epidural anesthesia are inclusive and must not be billed as a separate procedure.
- Local anesthesia and IV (conscious) sedation are bundled into the procedure being provided and must not be billed as separate services.
- Anesthesia services rendered during a hysterectomy or sterilization require completion, submission, and acceptance of the appropriate acknowledge/consent forms.
- Occasionally a procedure which is usually requires no anesthesia or local anesthesia, because of unusual circumstances, must be rendered under general anesthesia. A written description of the reason for using modifier 23 is required, and the claim will be sent for review.
- Modifiers defining the CRNA or anesthesiologist participation are used in processing to allocate payments. (e.g., AD,QK,QX,QY, and QZ) The supervising/medical directing anesthesiologist/ CRNA must bill the same procedure code.
- Physical status modifiers are not used for processing by WV Medicaid. The billing of additional base units for physical status is prohibited.

519.8.3 MATERNITY-RELATED ANESTHESIA

The CPT codes listed below are for reporting maternity-related anesthesia services. WV Medicaid limits payment for maternity anesthesia to eight ~~T~~ime Units". (A maximum of two hours) Base units may not be billed separately.

- 01960 - Anesthesia for vaginal delivery only
- 01961 - Anesthesia for cesarean delivery only
- 01967 - Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or necessary replacement of an epidural catheter during labor)
- 01968 - Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Must be used with 01967.)
- 01969 - Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Must be used with 01967.)

If the Medicaid member is a recipient of a documented emergency cesarean section, the anesthesia

provider may receive reimbursement for up to two additional units of anesthesia. (See Section 519.8.4 for further details on billing emergency anesthesia.)

WV Medicaid's payment policy for labor epidural is as follows:

- Labor epidural provided by the surgeon must be billed with the appropriate delivery anesthesia code and modifier 97. Labor epidural provided by the anesthesiologist and/or CRNA must be billed with the appropriate ~~-0~~" anesthesia code
- CPT surgical codes 62311 and 62319 are not to be used to bill pain management for the three stages of delivery.
- Medications for pain relief given during the time of the epidural anesthesia are not covered as a separate procedure.
- Only one provider or team will be paid for epidural services.
- Emergency anesthesia is not allowed with the provision of epidural anesthesia or vaginal deliveries.
- The labor epidural procedures covered by WV Medicaid are inclusive of labor, delivery, and postpartum care. Additional procedure codes used for pain management are not covered.

519.8.4 EMERGENCY ANESTHESIA

Additional payment is allowed to anesthesiologists and non-medically directed certified registered nurse anesthetists for providing anesthesia for surgery on an emergency basis. The ASA recommended payment policy of two additional base units is followed. CPT code 99140 must be billed one unit in order to receive payment for this service.

519.8.5 MONITORED ANESTHESIA CARE

Monitored anesthesia care involves the intra-operative monitoring of the member's physiological signs in anticipation of the need for administration of general anesthesia or the development of adverse reactions to the procedure.

It must be performed at the request of the attending physician, made known to the member, and performed according to the facility's policies and procedures. If medically necessary, monitored anesthesia care is paid on the same basis as other anesthesia services.

WV Medicaid reimburses an anesthesiologist or CRNA for monitored anesthesia care only if they meet all of the following requirements:

- Performs a pre-anesthetic examination and evaluation of the member
- Prescribes the required anesthesia
- Participates personally in the entire plan of care
- Is continuously physically present when participating in the case
- Observes all facility regulations pertaining to anesthesia services
- Furnishes all the usual services an anesthetist usually performs.

The modifiers which are to be used for monitored anesthesia care are G8, G9, and QS.

519.8.6 OTHER ANESTHESIA SERVICES

Anesthesiologists and non-medically directed CRNAs (within the scope of their license) may bill for the following additional services: Swan-Ganz placement or any other central venous pressure line, critical care visits, emergency intubations, spinal puncture, and blood patch. Payment for these

specific services is based on the RBRVS payment system. Time units are not billable for these services.

They may also bill for cardiopulmonary resuscitation performed in conjunction with the anesthesia procedure or outside the operating suite.

519.8.7 ANESTHESIOLOGIST DIRECTED ANESTHESIA

Medical direction may apply to a single anesthesia service furnished by a CRNA or up to four concurrent anesthesia services. A physician who is directing the administration of anesthesia to four surgical members is not expected to be involved routinely in furnishing any additional services to other members. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic rather than continual monitoring of an obstetrical member would not substantially diminish the physician's capacity to direct the CRNA services.

The medical directing anesthesiologist must document in the member's medical record that all medical direction requirements have been met, including:

- Perform the pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Participate personally in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence
- Ensure a qualified individual performs any procedure in the anesthesia plan he/she does not perform personally
- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergency that may develop
- Provide indicated post-anesthesia care.

A physician may appropriately receive members entering the operating suite for the next surgery while directing concurrent anesthesia procedures. However, checking or discharging members in the recovery room and handling scheduling matters are not compatible with reimbursement to the physician for directing concurrent anesthesia procedures.

519.8.8 ANESTHESIA TEAMS

An anesthesia team is defined as one directing anesthesiologist and one CRNA providing services to a member. The payment split between the anesthesiologist and medically directed CRNA equals 100 percent of the payment level for an individually performing anesthesiologist with the anesthesiologist receiving 60 percent and the medically directed CRNA 40 percent.

Only one provider or anesthesia team will be paid for epidural anesthesia.

519.9 SURGICAL SERVICES

WV Medicaid covers medically necessary surgical procedures. No surgical procedure will be covered on an inpatient basis if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting, unless the procedure is performed secondarily to another necessary inpatient procedure.

If the Medicaid member is a participant in the PAAS Program, surgical services will require a referral

from the PCP prior to rendering the service.

Under Medicaid RBRVS payment rules, physicians are paid a single global fee for all necessary services. Payments are not made for individual components of a complete or bundled procedure.

In global billing, all expenses for surgical care must be dated the day the surgery occurred.

The following services are typically bundled into the global surgery period and are; therefore, covered by the global surgery fee and are not paid separately:

- Visits to/by the surgeon the day before or the day of the surgery (Neither hospital nor office visits)
- Visits to a member in intensive care or critical care unit
- Services normally a part of the surgery itself (e.g., use of an operating microscope)
- Services for any complications not requiring an additional trip to the operative room
- Preoperative and postoperative medical care. Only the surgical procedure code is necessary for billing purposes, using the date of the surgery as the date of service.
- Ninety days of postoperative care for major surgery and zero to 10 days for minor surgery.
- Biopsy procedures performed concurrently with a major surgical procedure

When multiple surgeries are performed during the same operative session, payment is based on the full amount for the primary procedure and 50 percent of the fee for all other necessary and appropriate procedures performed during the session. RBRVS coverage guidelines for bilateral surgery, assistant surgeon, co-surgeon, team surgery, and site of service differential also apply to all procedures.

519.9.1 RECONSTRUCTIVE SURGERY

The following types of reconstructive surgery must be medically necessary and require prior authorization prior to rendering the service:

- Eyelid surgery **(Attachment 1)**
- Breast reconstruction following cancer surgery **(Attachment 2)**
- Reduction mammoplasty **(Attachment 3)**
- Panniculectomy (request for panniculectomies must include written documentation demonstrating medical necessity) **(Attachment 4)**

The attachments listed above are copies of the forms that must be completed and submitted to request prior authorization for reconstructive surgery. Each form must be completed in full.

Photographs may be necessary when submitting documentation for medical necessity. However, HIPAA guidelines must be followed to ensure the privacy of Medicaid members.

Questions regarding reconstructive surgery and prior authorization requests must be addressed to BMS' Case Management Unit at (304) 558-1700 or fax number (304) 558-1776. Services must not be provided before any necessary prior authorization is received. The member must be informed he/she may be financially liable for services provided without the requisite authorization.

519.9.2 INTEGUMENTARY SERVICES

WV Medicaid applies multiple surgery rules to most dermatological procedures (e.g., CPT 11400, 11600, and 17260). Multiple surgery payment rules do not apply to selected dermatological services that are, by definition, multiple procedures.

WV Medicaid defines simple and intermediate repairs as follows:

- Simple repair procedure code must be used if the wound involves the skin and subcutaneous tissue.
- Intermediate repair must be used to close one or more of the deeper fascial layers in addition to the skin and subcutaneous tissue.

Services provided to PAAS Program members require a referral from the PCP for reimbursement prior to rendering services.

Procedures must be medically necessary and not for cosmetic purposes. (i.e., Scar revisions/excisions will only be covered for documented medically necessary reasons.)

519.9.3 BARIATRIC SURGICAL PROCEDURES

The West Virginia Medicaid Program covers bariatric surgery procedures subject to the following conditions.

519.9.3.1 MEDICAL NECESSITY REVIEW AND PRIOR AUTHORIZATION

The patient's primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request, along with all the required information, to the West Virginia Medical Institute (WVMI), 3001 Chesterfield Place, Charleston, West Virginia 25304. The West Virginia Medical Institute (WVMI) will perform medical necessity review and prior authorization based upon the following criteria:

- A Body Mass Index (BMI) greater than 40 must be present and documented for at least the past 5 years. Submitted documentation must include height and weight.

- The obesity has incapacitated the patient from normal activity, or rendered the individual disabled. Physician submitted documentation must substantiate inability to perform activities of daily living without considerable taxing effort, as evidenced by needing to use a walker or wheelchair to leave residence.

- Must be between the ages of 18 and 65. (Special considerations apply if the individual is not in this age group. If the individual is below the age of 18, submitted documentation must substantiate completion of bone growth.)

- The patient must have a documented diagnosis of diabetes that is being actively treated with oral agents, insulin, or diet modification. The rationale for this criteria is taken from the Swedish Obese Subjects (SOS) study, *International Journal of Obesity and Related Metabolic Disorders*, May, 2001

- Patient must have documented failure at two attempts of physician supervised weight loss, attempts each lasting six months or longer. These attempts at weight loss must be within the past two years, as documented in the patient medical record, including a description of why the attempts failed.

- Patient must have had a preoperative psychological and/or psychiatric evaluation within the six months prior to the surgery. This evaluation must be performed by a psychiatrist or psychologist, independent of any association with the bariatric surgery facility, and must be

specifically targeted to address issues relative to the proposed surgery. A diagnosis of active psychosis; hypochondriasis; obvious inability to comply with a post operative regimen; bulimia; and active alcoholism or chemical abuse will preclude approval.

- The patient must demonstrate ability to comply with dietary, behavioral and lifestyle changes necessary to facilitate successful weight loss and maintenance of weight loss. Evidence of adequate family participation to support the patient with the necessary lifelong lifestyle changes is required.

- Patient must be tobacco free for a minimum of six months prior to the request.

- Documentation of a current evaluation for medical clearance of this surgery performed by a cardiologist or pulmonologist, must be submitted to ensure the patient can withstand the stress of the surgery from a medical standpoint.

519.9.3.2 PHYSICIAN CREDENTIALING REQUIREMENTS

In order to be eligible for reimbursement for bariatric surgery procedures, physicians must: submit the following to the provider enrollment unit:

- Evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.

- Documentation that the physician is working within an integrated program for the care of the morbidly obese that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training and psychological/psychiatric assistance as needed.

- Assurances that surgeons performing these procedures will follow the guidelines established by the American Society for Bariatric Surgery including:

    - Credentials to perform open and laporoscopic bariatric surgery

    - Document at least 25 open and/or laporoscopic bariatric surgeries within the last three years

519.9.3.3 PHYSICIAN PROFESSIONAL SERVICES

Professional services which will be required of the physician performing bariatric surgery include the surgical procedure, the 90-day global post-operative follow-up, and a 12 month assessment period which includes the following: medical management of the patient‘s bariatric care, nutritional and personal lifestyle counseling, and a written report at the end of the 12 month period consisting of: an assessment of the patient‘s weight loss to date, current health status and prognosis, and recommendations for continuing treatment. That 12 month assessment report must be submitted to the patient‘s attending or primary care physician, as well as to the Bureau for Medical Services.

While the bariatric surgeon‘s association with the patient may end following the required 12 month

follow-up, the patient's continuing care should be managed by the primary care or attending physician throughout the patient's lifetime.

519.9.3.4 REIMBURSEMENT

The physician performing the bariatric surgery procedure will be reimbursed through the existing RBRVS payment methodology for the surgical procedure. Reimbursement includes a post-operative follow-up for the global period of 90 days. For the remainder of the required 12 month follow-up period and assessment, the bariatric surgeon may submit claims using the appropriate evaluation and management procedure code. After completion of the required 12 month evaluation period, the patient may be followed-up and medically managed either by the surgeon or primary care physician utilizing appropriate E & M procedure codes.

519.9.3.5 COVERED BARIATRIC PROCEDURES

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty.

43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty.

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy.

43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption.

43848 Revision of gastric restrictive procedure for morbid obesity (separate procedure). (This is only for correction of serious complications caused by the procedure within the first 6 months postoperatively, and is not meant to indicate that a patient can have a second procedure due to failure to lose weight from a prior procedure.)

Note: Only one procedure will be covered per lifetime. Those failing to lose weight from a prior procedure will not be approved for a second one.

519.3.6 NON-COVERED BARIATRIC PROCEDURES

The following procedures will not be covered by West Virginia Medicaid Program:

- Mini-gastric bypass surgery
- Gastric balloon for treatment of obesity
- Laparoscopic adjustable gastric banding

519.9.4 EXCLUDED SURGICAL PROCEDURES

Following the guidelines of the Correct Coding Initiative, procedures that would be billable when they are the only billed services become non-covered when billed in conjunction with other surgical procedures. Examples of these situations are:

- Surgical procedures incidental to the primary procedure. Examples of incidental surgeries are appendectomies, lyses of adhesions, and scar revisions. If incidental surgeries are billed and subsequently paid, the physician must return the payment to the BMS.
- Exploratory laparotomies performed at the same time as another surgical procedure in the same anatomical region. The exploratory laparotomy is included in the fee paid for the surgical procedure.
- Surgical destruction during a procedure. Payment for surgical destruction is included in the global fee for the surgery. Under special circumstances, where methods of destruction substantially alter

the standard management of the member's condition, consideration will be given for separate coverage. These special circumstances would require prior authorization.

WV Medicaid does not cover elective cosmetic surgery (surgery that has as its primary purpose the improvement of the member's appearance and is not medically necessary). Many of these procedures may be covered when provided for treatment of congenital anomalies, traumatic injury, or a disease process. Documentation supporting the medical necessity for the procedure must be maintained in the member's record. Examples of cosmetic surgery are otoplasty, rhinoplasty (except to correct internal nasal deformity and must be approved in advance), nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathia, malar augmentation, dermabrasion, certain skin grafts, lipectomy, mastopathy, liposuction, breast augmentation, replacement of breast implants used for purposes other than reconstruction due to cancer, and removal of tattoos.

WV Medicaid does not cover Stretta procedure, lung volume reduction surgery, pancreatic islet cell transplant, and living donor hepatic transplant.

WV Medicaid does not cover experimental, research, or investigational medical and surgical procedures, including those identified by the United States Department of Health and Human Services, nor transportation for any of these services. Minimally, the following criteria are considered in determining whether a procedure is experimental, research, or investigational:

- The current and historical judgment of the medical community as evidenced by medical research, studies, journals, or treaties
- The extent to which Medicare and private insurers recognize and cover the procedure
- The current judgment of experts and specialists in the medical specialty in which the procedure is applicable or performed
- The effectiveness of the procedure as predicated by the number of times the procedure has been performed, the mortality rate, the long-term prognosis, the reputation of the physicians and hospitals performing the procedure, among other factors.

519.10 OBSTETRICAL AND GYNECOLOGICAL SERVICES

A wide range of Obstetrical and gynecological services are covered under WV Medicaid including preventive, pregnancy related, and disease related services.

519.10.1 MATERNITY SERVICES

The practitioner may provide all or a portion of antepartum care, delivery, and/or postpartum care.

Antepartum care includes the initial and subsequent history, physical examinations, monitoring of weight, blood pressure, fetal growth and development, heart tones, and routine chemical urinalysis. During a normal pregnancy, prenatal visits are monthly up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Procedure code 99213TH must be billed for each individual pre-natal visit. Adjustments to the frequency may be made based on documentation of maternal and fetal risk factors.

Delivery services include admission to the hospital, admission history and physical examination, management of labor, vaginal delivery with or without episiotomy and with or without forceps, or cesarean delivery and postpartum care provided in the hospital. Postpartum care during the confinement for delivery is not separately billable.

Postpartum care is normally included in the payment for the delivery unless performed by a

practitioner other than the delivering practitioner. Postpartum care cannot be billed using 99213TH.

Visits or services for medical conditions unrelated to prenatal care may be billed using the appropriate procedure code along with the appropriate modifier: -25, -59, or -79. The diagnosis code reflecting the unrelated condition must appear on the claim and the description of the services must be related in the member's medical record.

WV Medicaid covers the following CPT codes for maternity services:

- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59410 - Vaginal delivery only, including postpartum care
- 59412 - External cephalic version, with or without tocolysis
- 59414 – Delivery of placenta (separate procedure)
- 59430 - Postpartum care only (separate procedure for six to eight weeks post-delivery)
- 59514 - Caesarean delivery only
- 59515 - Cesarean delivery only, including postpartum care
- 59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps) including postpartum care
- 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

WV Medicaid will not reimburse for the following global maternity-related procedure codes or the following bundled services codes:

- 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59425 - Antepartum care only; 4-6 visits
- 59426 - Antepartum care only; seven or more visits
- 59510 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

  The preceding bundled maternity codes are not reimbursed because Medicaid members often change physicians or managed care entities during maternity care, which greatly complicates or precludes the use of global codes to pay for maternity care.

59414 will only be reimbursed when an infant is delivered by someone other than the provider (i.e., nurse or paramedic) and the provider delivers the placenta and reviews the case. This code cannot be billed along with a vaginal or cesarean section delivery code.

The following multiple surgical rules govern the coding of, and reimbursement for, deliveries involving multiple babies:

- Both babies delivered vaginally: CPT 59409 (Twin A) and 59409-51 (Twin B)
- One twin delivered vaginally and one twin delivered by C-section: CPT 59409-51 (Twin A) and

59514 (Twin B)

- Multiple babies delivered by C-section (CPT 59514). This code must be used only once because only one caesarian procedure was performed.

CPT 99440 is used for newborns requiring life support following delivery; specifically, when providing positive pressure ventilation and/or chest compressions in the presence of inadequate ventilation and/or cardiac output.

Attendance at ―delivery" (when requested by the delivery physician) and initial stabilization of newborn (CPT 99436) is covered by WV Medicaid. The delivering physician must document the request in the member's medical record and explain the reasons for the request. The statement ―high risk delivery" is **not** sufficient to document the procedure's necessity.

Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output (CPT 99440) cannot be billed with 99436.

519.10.1.1 OBSTETRICAL ULTRASOUNDS/FETAL NON-STRESS TESTS

WV Medicaid covers obstetrical ultrasounds and fetal non-stress tests when medically necessary and in accordance with the criteria for high risk pregnancies established by the American College of Obstetrics and Gynecology (ACOG). Obstetrical ultrasounds on a routine basis or for determining the gender of the fetus are not covered.

Documentation of medical necessity for all ultrasounds and fetal non-stress tests is required. An office visit on the same date of service as an ultrasound or fetal non-stress test performed in the physician's office is billable only if a distinct, separately identifiable reason for the visit is documented in the member's medical record. The E&M procedure code must be billed with modifier 25.

If an ultrasound or fetal non-stress test in the physician's office, a separate interpretation of the results must be documented in the member's medical record in order to obtain reimbursement.

Any ultrasound performed before the 17th week of pregnancy must have documentation of medical necessity since there is a high false negative rate (Guidelines for Ultrasound as Part of Routine Prenatal Care, Journal of the Society of Obstetricians and Gynecologists of Canada, No. 28, 1999).

Medicaid follows ACOG Guidelines for fetal non-stress testing. Since testing prior to 28 weeks is not accurate, such testing will require documentation of medical necessity. Documentation of medical necessity must be retained in the member's medical record. ***These tests will be monitored for over utilization or inappropriate use.***

A referral from the PAAS PCP is not required for maternity services provided to PAAS members.

519.10.2 PREGNANCY TERMINATION

WV Medicaid covers pregnancy termination when the attending physician determines, in consultation with the member, that termination is medically advisable. Before making the determination, the physician must discuss the possible pregnancy termination with the member in light of her age, physical, emotional, psychological, and familial circumstances.

Certification by the physician is required for payment. A copy of the certification form to terminate a pregnancy can be accessed through the Unisys webpage which is located at www.wvmmis.com. The completed and signed form must accompany all claim forms for pregnancy terminations.

Attachment 5 lists the CPT codes physicians must use to report pregnancy termination procedures

and summarizes the services represented by these codes.

519.10.2.1 DRUG RU-486 (MIFEPREX)

WV Medicaid covers pregnancy termination using the drug RU-486 subject to the physician's compliance with all of the federal and manufacturer's requirements listed below. An appropriately executed physician certification for pregnancy termination form must be submitted for this service. The physician is required to maintain, on file at their practice location and available for review upon request, a copy of the order form/prescriber's agreement, certifying compliance with all manufacturer's prescribing requirements, including guidelines for use of this product, and an agreement, signed by the Medicaid member prior to the treatment, acquiescing to the procedure.

Reimbursement for pregnancy termination utilizing RU-486 includes:

- A visit for administration of three Mifepristone pills
- A second visit two days later for administration of Misprostol, if termination of the pregnancy cannot be confirmed
- A follow-up visit within two weeks to ensure and document that the abortion is complete.

Under federal law, Mifeprex must be provided by or under the supervision of a physician who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately
- Ability to diagnosis ectopic pregnancies
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and are able to assure member access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.

Following completion of the pregnancy termination service, the physician may bill using CPT codes S0190, S0191, and/or S0199.

Payment for S0199 includes laboratory services and ultrasounds. If these services are referred by a physician, the physician must pay the provider of the service and Medicaid cannot be billed.

If it is decided during the first visit that the member is not a candidate for this type of pregnancy termination, the physician may bill the appropriate E&M code.

519.10.3 STERILIZATION

Based on Federal Social Security Act requirements, WV Medicaid covers the sterilization of a male or female member if the following conditions are met:

- The member is at least 21 years of age at the time consent is given; i.e., when he/she signs and dates the consent form.
- At least 30 days, but not more than 180 days, have elapsed since the date of informed consent and the date of sterilization.
- The two exceptions to these conditions are:
  - Premature Delivery - A member may be sterilized at the time of premature delivery if informed consent was obtained at least 30 days before the expected date of delivery AND at least 72 hours have passed from the time the consent form was signed to the time of sterilization.
  - Emergency Abdominal Surgery - A member may be sterilized at the time of emergency abdominal surgery if at least 72 hours have passed since the informed consent was given (Cesarean sections are not emergency abdominal surgery for purposes of this exception).

In order to establish the 72-hour period, the specific time of the signing of the consent form is necessary. If premature delivery is indicated on the consent form, the member's expected delivery date must be indicated. If emergency abdominal surgery is indicated, the circumstances of the emergency must be explained. If both cases, the space for the condition that does not occur must be crossed out.

Informed consent is the voluntary assent from an individual that he/she has been informed orally of, and given the opportunity to, question and receive satisfactory answers concerning sterilization. Informed consent may not be obtained while the member is in any one of the following conditions:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substance that affects the individual's awareness
- Under anesthesia.

The consent form previously prescribed and distributed by the United States Department of Human Services (DHHS) should be used. The "State Agency Copy" of the consent form must be submitted to P.O. Box 2254, Charleston, WV 25328-2254. WV Medicaid uses the sterilization consent form deve1oped/approved by the Federal DHHS. A copy of the sterilization consent form can be accessed through the Unisys webpage which is located at www.wvmmis.com. It must be signed and dated by the:

- Member who wants to be sterilized
- Interpreter, if applicable
- Person who obtained the consent
- Physician who performed the sterilization procedure.

On the sterilization consent form:

- The interpreter's statement must be completed only if the member does not understand the language on the consent form or the language used by the person obtaining consent and needs an interpreter. If this section is used, the interpreter must sign and date the consent form, using the date informed consent was given.
- The physician must fully complete the ~~"P~~hysician's Statement" section.
- The ~~"D~~ate of Surgery" must list the specific date; "to be scheduled" and "after delivery" is not acceptable.
- The ~~"D~~ate of Physician's Signature" must occur within one day of the date of surgery.

The person who obtains the informed consent must answer any questions the member may have concerning the procedure and provide orally the following information to the member who is considering sterilization:

- Advise the member he/she may withhold or withdraw consent at any time prior to the procedure without affecting his/her right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which he/she may otherwise be entitled,
- Explain alternate methods of family planning with emphasis that sterilization is considered to be irreversible,
- Explain thoroughly all forms of sterilization procedures with special emphasis on the specific procedure being planned for this individual,
- Explain thoroughly the specific sterilization procedure to be performed and describe fully its advantages and disadvantages, including a thorough discussion of the discomforts and risks that

may accompany or follow the procedure. The explanation must include a description of the effects of the anesthetic to be used,
- Advise that the sterilization will not be performed for at least 30 days unless an exception (i.e., premature delivery or emergency abdominal surgery) applies,
- Make a copy of the consent form available to the individual,
- Make suitable arrangements to ensure the above information is effectively communicated to any individual not understanding the language on the consent form and to any individual who is handicapped in any way that would prevent a full understanding of the procedure (i.e., deaf or blind). If necessary, make arrangements for an interpreter prior to the consent form being signed. The individual must also be permitted to have a witness of his/ her choice present when consent is given,
- Follow any additional State or Local laws.

The sterilization consent may be sent with the claim or separately. Photocopies or faxes of the Sterilization Consent Form are acceptable. The photocopy or fax must be an exact copy of the actual form in the member's record. If the consent form is not attached or on file, all claims with a sterilization diagnosis and/or a sterilization procedure will ~~p~~end" for review. If a consent form is not received within 60 days, the claim will deny.

Procedures may have been done unilaterally, but did not render the member sterile because the other tube/ovary had not been previously removed. These must be billed on paper with the patient history, physical exam, pathology report and operative report attached to the claim and sent to P.O. Box 2254, Charleston, WV 25328-2254.

No Medicaid payments will be made unless the member has voluntarily given informed consent. WV Medicaid does not cover sterilizations under any of the following situations:

- Member is under 21 years of age at the time the consent form is signed
- Member is mentally incompetent
- Member is institutionalized
- Sterilization by court order
- Hysterectomy solely to achieve sterilization.

Attachment 6 lists the CPT codes physicians must use to report sterilization procedures and summarizes the services represented by these codes.

The requirements in this section also apply to Managed Care entities which provide services to Medicaid members.

519.10.4 HYSTERECTOMY

WV Medicaid covers hysterectomies performed for medical reasons regardless of the member's age. Federal regulations ensure that women can make informed and voluntary choices and emphasize a hysterectomy is not an appropriate or acceptable means of sterilization. A medically necessary hysterectomy is covered when:

- The person who performs the hysterectomy has informed the member and her representative, if any, orally and in writing the hysterectomy will render the member permanently incapable of reproduction
- The member or her representative has signed and dated the hysterectomy acknowledgment form.

The hysterectomy acknowledgment form will be accepted by WV Medicaid regardless of whether it

was signed by the member before or after the procedure. However, when the member signs the acknowledgment form after the surgery, the member's records must contain language which clearly states she was informed before surgery of the consequences of the surgery (i.e., it would render her sterile) and that the member was competent to sign.

WV Medicaid does not cover a hysterectomy that was performed solely to render a member incapable of reproduction; even when there are other indicators for a hysterectomy.

The physician who performs a medically necessary hysterectomy must complete and sign an acknowledgment form except under the two following conditions:

- The member was already sterile when the hysterectomy was to be performed
- The member requires a hysterectomy because of a life-threatening emergency (e.g., the member is in imminent danger of loss of life) for which the physician determines prior acknowledgment is not possible.

The physician who performs the hysterectomy must certify in writing on the Physician's Certification Form that the exception conditions are met. If the member was already sterile at the time of the hysterectomy the physician must indicate the cause of the sterility. If the hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgment was not possible, the nature of the emergency must be documented. An example of a life-threatening emergency that does not require an acknowledgment statement is a hysterectomy necessitated by a perforated uterus or an uteroplacental apoplexy.

WV Medicaid accepts photocopies or faxes of the Hysterectomy Acknowledgement Form as acceptable documentation. A photocopy or fax must be an exact copy of the actual signed form and contain all the required signatures. The provider must retain the original copy of the Hysterectomy Acknowledgement Form. This form, as well as the Physician's Certification Form to perform a hysterectomy, can be accessed through the Unisys webpage which is located at www.wvmmis.com.

The acknowledgment form or physician certification may be submitted with the claim or separately. If the appropriate form is not on file or submitted with the claim, it will suspend for review. No service related to the hysterectomy will be reimbursed unless appropriate documentation is received. If the documentation is not received within 60 days, the claim will deny.

If a physician performs a hysterectomy on an individual who later becomes eligible for Medicaid and Medicaid eligibility is retroactive to the date on or before the date which the hysterectomy was performed, the physician may bill Medicaid for the surgery if he/she certifies in writing:

- The member was informed before the operation the hysterectomy would make her permanently incapable of reproduction
- The member was already sterile and the cause of the sterility
- The hysterectomy was performed under a life-threatening emergency for which he/she determined prior acknowledgment was not possible. The physician must describe the nature of the emergency.

Attachment 7 lists the CPT codes physicians must use to report a hysterectomy and summarizes the services represented by these codes.

519.10.5 FAMILY PLANNING SERVICES

Family Planning services may be provided as part of the practitioner's routine care. If the practitioner does not wish to provide these services, the member must be informed they may go to any participating practitioner offering these services.

WV Medicaid does not make separate payment for obtaining a Pap smear. This is included in the E&M service. Laboratory services for Pap smears and other medically necessary tests are covered with payment to the performing pathologist and laboratory respectively.

Attachment 8 contains charts listing diagnostic and procedure codes covered for family planning services.

519.11 SPECIALTY SERVICES

Specialty Services refers to services provided to Medicaid members by specialists in a specific field of medicine.

519.11.1 PAIN MANAGEMENT

WV BMS covers a variety of pain management treatment modalities. Prior authorization is required if more than three months of treatment is necessary. Regardless of the treatment for pain management, the following information must be submitted with the physician‘s order and request for prior authorization:

- Number of additional visits and weeks of treatment requested, such as three visits a week for four weeks
- Progress the member has already made toward short-term and long-term goals since therapy began
- Reasons for short-term and long-term goals requiring extended services
- Treatment plan to reach goals
- Estimated number of visits to reach goals

WV Medicaid does not cover hypnosis, acupuncture, prolotherapy, any treatment not approved by the FDA or therapy not accepted as effective by the medical community for chronic pain managment.

DOCUMENTATION REQUIREMENTS

Documentation in the hospital‘s records and/or the therapist's records must contain the following information about the pain management a member received:

- Diagnosis – The diagnosis must document the member‘s need for pain management. A brief description of the member‘s medical condition may be necessary.
- Date of injury or onset of illness, if applicable.
- Name and Medicaid provider number of the physician prescribing the pain management and the physician's order itself.

Documentation of the service provided on the date billed must substantiate fully the amounts charged to WV Medicaid. The documentation must be clear, concise, demonstrate medical necessity and be made available upon request to the BMS or its representative.

519.11.1.1 OSTEOPATHIC MANIPULATIONS

WV Medicaid covers the following osteopathic manipulative services:

- 98925 Osteopathic manipulative treatment, one to two body regions involved
- 98926 Osteopathic manipulative treatment, three to four body regions involved
- 98927 Osteopathic manipulative treatment, five to six body regions involved
- 98928 Osteopathic manipulative treatment, seven to eight body regions involved
- 98929 Osteopathic manipulative treatment, nine to ten body regions involved.

Body regions include head, cervical, thoracic, lumbar, sacral, pelvic, lower and upper extremities, rib cage, abdomen, and viscera.

An E&M code cannot be billed with any manipulative service unless it is related to a distinctly separate service. However, if the manipulative service is distinctly a separate service, then modifier 25 must be used and the service documented in the patient's record.

Medicaid coverage is limited to a combined total of 40 manipulative treatments (not per procedure code) in a 12-month period.

519.11.1.2 PARAVERTEBRAL FACET JOINT BLOCK AND DENERVATION

Prior authorization is required if treatment is required more often than every three months. Treatment of more than three levels per side is considered excessive and will be denied. Use the LT and RT modifiers to indicate a unilateral procedure at any level. If both sides of any level are treated, use the -50 modifier. The fluoroscopy code, CPT 76005 may be used with these procedures. When more than one drug, i.e. anesthetic or steroid, is injected into the same site, only one injection codes is allowed.

The following chart lists the covered services in this pain management modality.

Procedure Code	Description	Coverage
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level	One unit per date of service
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	Two units per date of service
64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level	One unit per date of service
64476	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	Two units per date of service
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level MED:CIM 35-17	One unit per date of service

Procedure Code	Description	Coverage
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) MED:CIM 35-17	Two units per date of service
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level MED:CIM 35-17	One unit per date of service
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) MED:CIM 35-17	Two units per date of service
All of the above listed procedure codes are subject to the bilateral modifier (50).		

519.11.2 WOUND THERAPY

WV Medicaid covers a variety of modalities for wound care. Wound care encompasses local treatment such as topical medications, dressings, pressure relief, tissue healing therapies or debridement. This may also involve systemic treatment to improve underlying nutritional needs, infections, circulatory limitations or management of other contributory factors. Wounds are classified according to the following:

- Stage I Non-blanchable erythema or superficial redness with skin intact
- Stage II Partial thickness skin loss involving epidermis and/or dermis
- Stage III Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- Stage IV Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

Indications and Limitations of Coverage/Medical Necessity

The following criteria must be met for wound care to qualify for reimbursement by WV Medicaid:

- The services must be medically necessary in the treatment of the member‘s condition. Medical necessity is defined as:
  - The status of the dermal surface and/or wound is such that the treatment will make a significant improvement in the wound in a reasonable and generally predictable period of time.
  - There is an expectation that treatment will substantially effect tissue healing and viability, reduce or control tissue infection, remove necrotic tissue or prepare that tissue for surgical management.
  - The member‘s expected restoration potential must be significant in relation to the extent and duration of treatment required to achieve that potential. If wound closure is not a goal then the expectation is to optimize recovery and establish an appropriate non-skilled maintenance program.
- For criteria not otherwise listed, the BMS follows Medicare‘s criteria for the specified service.

Clinical Indicators

Some clinical indicators that may be used to determine medical necessity are:

- A history of slow-to –heal wounds
- Significant health factors that impair recovery
- Multiple, severe or extensive soft tissue injuries and/or wounds
- Increasing severity of tissue impairment, infection, or necrosis, undermining or an increase in size.

Documentation

Medical records should include the following information:

- Practitioner‘s order: Services may only be provided on the basis of a practitioner‘s written, signed and dated order
- Evaluation: The purpose of a wound care evaluation is to determine both the medical necessity and the appropriate type of skilled service. The evaluation should demonstrate the following:

- The type of tissue involvement; the severity of tissue destruction; undermining or tunneling, necrosis, infection, or evidence of reduced circulation. If infection has developed, the member's response to this infection should be described.
- The size and depth of tissue involvement and its location
- The medical and mental condition and all health factors that may influence the member's ability to heal tissue
- The prior response to other therapies
- A determination of the appropriate treatment plan and therapeutic goal(s) including specific objectives, goal-specific treatment plan and the expected frequency and duration of the skilled treatment
- If the wound therapy is being performed by other than a physician, (e.g., home health agency, physical therapist), an evaluation must be performed by a licensed practitioner who must see the member at least once every thirty days during treatment.

- Treatment Plan: This plan must include specific functional goals and a reasonable estimate of when they will be reached. The modalities/procedures, frequency, and duration of treatment must be defined in the plan. This plan must be reviewed and recertified by the ordering practitioner every 30 days. If this therapy is performed by other than the attending practitioner, the plan must be reviewed and recertified by the attending provider every 30 days and should be completed by licensed professional only.
- Treatment Notes: Documentation for each treatment should specify date and time, types of treatment, status of the member's contributory factors to the wound (i.e., status of infection or level of diabetic control), member and wound/or tissue status and the response to the treatment.
- Progress Reports: Weekly and monthly summaries should systematically describe the need for skilled service. Each progress report should describe changes in risk, severity or size of the wound with a comparison to the previous week or month. If the goals for that week or month are not met, or the wound status has worsened, then describe or detail any associated factors that may account for this condition. If the wound has worsened, there should also be documentation that the physician has been informed and any needed changes in the wound care protocol have been made. A photograph or wound drawing may be useful in reporting the status of the wound. There should be documentation that the provider has been informed if the therapy is administered by other than the attending provider.
- Discharge Summary: The final report that provides the measurement(s) and description of the dermal surface/wound at the time of admission or initiation of treatment and at the time of discharge, and the reason(s) skilled services are no longer required. The summary specifies all the discharge recommendations, the member's or caregiver's capability to care for the residual wound, and prevent further dermal lesions.

The following modalities for wound treatment are not covered by BMS:

- Procuren and other platelet releasate
- Topical Hyperbaric Oxygen Therapy
- Non-contact Normothermic Wound Therapy (NNWT). NNWT promotes wound healing by warming a wound to a predetermined temperature. (A6000, E0231, E0232)
- Maggot therapy
- Alloderm, Biobrane (considered a dressing), Celaderm (not FDA approved), Epicel, EZ Derm, Integra (non-human dermal template, Q0182), Laserskin (available in Europe only), Oasis collagen dressings (A6021-A6024)
- Electrical stimulation and electromagnetic therapy (G0281, G0282, G0283, G0295, G0329) for

wound care are not covered by BMS. (97014 and 97032 are not covered procedure codes for wound therapy.)

- Monochromatic Infrared Therapy (the Anodyne Therapy System) is not covered (E0221 and 97026).

Covered Services

- Wound repairs – local anesthesia is included in reimbursement of this service.
  - Wound closure using tissue adhesives only
  - Wound repair – The CPT procedure used to report the repair is dependent on the location of the wound, classification of the repair and length of the repair. WV Medicaid has not adopted CPT Manual definition of simple intermediate and complex repair, but follows those of CMS. WV Medicaid defines these as follows:
    - Simple repair procedure code should be used if the wound involves the skin and subcutaneous tissue
    - Intermediate repair should be used to close one or more of the deeper fascial layers in addition to the skin and subcutaneous tissue.
  - Wound closure with steri-strips or butterfly band aids is included in the E&M service and not separately billable.
  - Wound repairs of specific anatomic parts such as lips or eyelids have pertinent specific codes, as do repairs of internal structures.
- Debridement
  - Debridement performed by licensed physical therapists should be coded with 97597 and 97598 which represent non-surgical debridement, not requiring anesthesia. This service can also be provided by the attending provider.
    - CPT 97597- Removal of devitalized tissue from wound(s), selective debridement, without anesthesia, (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application (s), wound assessment, and instructions for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters.
    - CPT 97598- Removal of devitalized tissue from wound(s), selective debridement , without anesthesia,(e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application (s), wound assessment, and instructions for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters.
  - The status of the wound(s) including size should be adequately documented.
  - Debridement in this sense is covered only to promote wound therapy, and should not be reported in the same claim with the surgical debridement codes, 11040 – 11044.
  - Debridement during a repair procedure is bundled with the repair procedure.
  - Debridement of the wound is included in all repair codes. If in rare cases there is greater amounts of devitalized tissue removed, significant and extensive debridement performed in addition to the wound repair, modifier 59 could be added to the debridement code. Documentation in the member‘s record must substantiate the use of a debridement code with the 59 modifier in addition to the repair code.

- Codes 11010 – 11012 are used only for debridement associated with open fractures and open dislocations. These codes are not used for treatment of ulcers or wounds that are not associated with open fractures/open dislocations. Documentation must substantiate the medical necessity for the use of debridement codes in these situations.

- Negative pressure vacuum pump for wound healing – WV Medicaid follows Medicare criteria for the medical necessity of this modality.
- Regranex:
  - This agent is prescribed to the member when:
    - There is a diagnosis of a diabetic neuropathic ulcer, extending into the subcutaneous tissue, on the lower extremity
    - There is no evidence of infection in the wound and anti-infective therapy is being employed
    - The wound is full thickness (Stage III or IV)
    - The wound is free of necrotic debris
    - The member has adequate circulation in the area of the wound
    - Off-loading of pressure to the wound has been accomplished
    - Member and/or caregiver have been instructed on the appropriate application, storage and cost of Regranex
    - Regranex is prescribed appropriately (once-daily application, with no concomitant topical medications).
  - Prior authorization for quantities of Regranex that exceed 3 tubes in a 90-day period or therapy that extends beyond 12 weeks will be granted only if:
    - The above conditions have been met, and
    - The wound size requires additional quantities of gel to provide adequate coverage, as directed by the manufacturer. (Each square centimeter of ulcer surface requires 0.25 – centimeter length of gel)

      or

    - There is evidence of healing in the initial 90-day period and additional application is required for complete healing.
- Hyperbaric Oxygen Therapy (HBOT). Systemic HBOT is covered for the treatment of non-infected diabetic ulcers when the criteria are met. See Section 519.12.2 of this chapter for information on HBOT.
- Engineered skin – Apligraf and Dermigraft are covered for the treatment of diabetic ulcers. WV Medicaid follows CMS criteria for medical necessity and reimbursement of these agents. Orcel and Transcyte are analogues used for burns.
- Miscellaneous dressings are covered when listed as covered in the DME manual. Dressings and supplies for office procedures are part of the global fee for the procedure and not separately billable.

519.11.3 PSYCHIATRIC SERVICES

Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Social Worker, or Master's Level counselor in their employ must also be registered and assigned an authorization number by the contracted agent.

Psychiatric services are not the responsibility of the managed care organization, nor do they require PAAS approval prior to rendering services. Claims must be billed to Medicaid for reimbursement.

See **Attachment 9** for policies and regulations related to outpatient psychiatric services.

519.11.4 LABORATORY AND PATHOLOGY SERVICES

WV Medicaid covers various pathology services and offers a comprehensive scope of basic and extended clinical laboratory services to Medicaid members, subject to medical necessity and appropriateness criteria and prior authorization requirements.

519.11.4.1 LABORATORY SERVICES

A practitioner may bill for laboratory services if the practitioner owns a CLIA certified lab, or if the practitioner has CLIA certification to perform CLIA waived testing. CLIA waived tests (a list of which are available on the CMS CLIA website) are tests that can be performed within an office laboratory setting, but for which a CLIA certification is still necessary. Provider-performed Microscopy Services (PPM) also require certification. These tests include pin worms preps, koh scrapings etc. Physicians billing waived laboratory tests or PPM tests must have CLIA certification on file with the Medicaid Program.

Separate charges made by practitioners for drawing or collecting specimens are allowable whether or not the specimens are referred to outside laboratories. Payment is made only to those extracting the specimen. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. A specimen collection fee is allowed when drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

NONCOVERED LABORATORY RELATED SERVICES:

- Routine reflex testing is not covered. Reflex testing occurs when initial test results are positive or outside normal parameters and indicate that a second related test is medically appropriate. This is covered only when specifically ordered by the physician, that a second test would be performed only under conditions clearly indicated on the requisition.
- Separate payment will not be made for obtaining a blood sample through a finger, heel or ear stick.
- Separate charge for collecting a Pap smear or throat smear are not covered, as these services are included in the E&M visit.
- A practitioner may not bill an office visit if the sole purpose of the visit was to obtain laboratory work.
- A practitioner may not bill a laboratory fee for conveying or interpreting the laboratory results to the patient. This is considered part of the E&M visit for which the patient sought medical care.

519.11.4.2 PATHOLOGY SERVICES

A pathologist will only be paid for the professional component of physician pathology services. For those procedure codes that do not have a technical and professional component, do not bill modifier 26. The CPT code for the procedure with modifier 26 is paid according to the RBRVS fee schedule. Medicaid payment for the professional component of consultative anatomical and surgical pathology

services must be requested by an attending practitioner regarding an abnormal condition and results in a written report by the pathologist. Covered consultative services may be billed with CPT 80500 Clinical pathology consultation; limited, without review of the member's history and medical records and CPT 80502 Clinical pathology consultation; comprehensive, for a complex diagnostic problem with review of member's history and medical records.

NONCOVERED PATHOLOGY SERVICES

- Separate payment for reviews of laboratory services for quality assurance purposes.
- Autopsies - West Virginia Medicaid does not pay for autopsies and/or supervisory pathology services.
- Fertility services such as embryo/sperm collections and banking.

519.12 MEDICAL SERVICES

WV Medicaid covers the following medical services.

519.12.1 CALORIC VESTIBULAR TESTING

WV Medicaid covers up to four irrigations provided to a member on a single date of service. The procedure code for this service, 92543, is divided into technical and professional components. A physician must both perform and interpret the ear irrigation(s) in order to bill the total service. When performing only one component, the physician must bill 92543-TC for the irrigation or 92543-26 for the interpretation. **When providing both, this service must not be unbundled.**

519.12.2 HYPERBARIC OXYGEN THERAPY (HBOT)

WV Medicaid covers hyperbaric oxygen therapy provided in an inpatient or outpatient hospital setting for certain medical conditions identified below.

For WV Medicaid to reimburse hyperbaric oxygen therapy, the physician must be in constant attendance during the entire procedure and carefully monitor the member during therapy and be immediately available if a complication develops. (The physician must be on site during the entire treatment.) In general, hyperbaric oxygen does not require prior authorization, but a physician's order and documentation for the treatment's medical necessity must be kept in the member's medical record. Hyperbaric oxygen therapy must not be indefinite in duration. If HBOT is medically necessary beyond two months, prior authorization is required from BMS' contracted agent regardless of the member's condition. The physician's order and medical documentation that substantiates medical necessity must be faxed or mailed to BMS' contracted agent.

Coverage of hyperbaric oxygen therapy is limited to members with the following medical conditions and diagnosis codes:

- Acute carbon monoxide intoxication (ICD-9-CM diagnosis 986)
- Decompression illness (ICD-9-CM diagnosis 993.2, 993.3)
- Gas embolism (ICD-9-CM diagnosis 958.0, 999.1)
- Gas gangrene (ICD-9-CM diagnosis 040.0)
- Acute traumatic peripheral ischemia. Hyperbaric oxygen therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb or life is threatened. (ICD-9-CM diagnosis 902.53, 903.01, 903.1, 904.0, 904.41)
- Crush injuries and suturing of severed limbs. As in the previous condition, hyperbaric oxygen therapy would be an adjunctive treatment when loss of function, limb or life is threatened. (ICD-9-

CM diagnosis 927.00-927.03, 927.09-927.11, 927.20-927.21, 927.8-927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0-929.9, 996.90-996.99).

- Progressive necrotizing infections (necrotizing fasciitis) (ICD-9CM diagnosis 728.86). Meleney ulcers (necrotizing soft tissue infections that are a result of clostridium or synergistic aerobic-anaerobic infection).
- Acute peripheral arterial insufficiency (ICD-9-CM diagnosis codes 444.21, 444.22, and 444.81).
- Preparation and preservation of compromised skin grafts (not for primary management of wounds) (ICD-9-CM diagnosis 996.52; excludes artificial skin graft). Hyperbaric oxygen therapy use is limited to the loss of viability of full thickness, free vascular, or pedicle flap grafts. Hyperbaric oxygen therapy must be used after signs and/or symptoms indicate compromise of graft. It is not covered for split thickness grafts or the initial preparation of the body site for a graft.
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management (ICD-9-CM diagnosis 730.1).
- Osteoradionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis 526.89).
- Soft tissue radionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis 990).
- Cyanide poisoning (ICD-9-CM diagnosis 987.7, 989.0).
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment, (ICD-9-CM diagnosis 039.0-039.4, 039.8, 039.9).
- Lower extremity diabetic wound if the following criteria are met:
  - The member has type 1 or 2 diabetes and has a lower extremity wound that is due to diabetes. (ICD-9 diagnoses codes 250.70-250.73, 250.80-250.83, 707.0, 707.10, 707.12-707.14, and 707.19);
  - The member has a wound classified as Wagner grade III or higher; and
  - The member has failed an adequate course of standard wound therapy. The use of HBOT will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in members with diabetic wounds includes:
    - Assessments of a member's vascular status and correction of any vascular problems in the affected limb if possible,
    - Optimization of nutritional status,
    - Optimization of glucose control,
    - Debridement by any means to remove devitalized tissue,
    - Maintenance of clean, moist bed of granulation tissue with appropriate moist dressings,
    - Appropriate off-loading,
    - Necessary treatment to resolve any infection that might be present,

    Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBOT. Continued treatment with HBOT is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

The only WV Medicaid-covered indications for HBOT are those specified above. No program payment may be made for any conditions other than those listed above.

The provider must code to the highest level specified in the ICD-9-CM, (e.g., fourth or fifth digit). However, correct use of an ICD-9 code does not assure coverage of a service.

BILLING CODES

The following procedure codes are used to bill for hyperbaric oxygen therapy:

- Physician - 99183 Physician attendance and supervision of hyperbaric oxygen therapy, per session. (Physician billing is per session, not per minute.)
- Hospital - C1300 Hyperbaric oxygen under pressure, full body chamber, per 30-minute intervals. Separate payment for inpatient hyperbaric oxygen therapy is not made because payment is in the Diagnosis Related Group (DRG) payment rate.

The amount of time billed includes only the time the member spends in therapeutic pressure. Billed time must not include descent or ascent time or air-break time.

DOCUMENTATION REQUIREMENTS

Medical documentation to support the conditions for which hyperbaric oxygen therapy is provided must include:

- An initial assessment including a detailed medical history and physical exam
- Physician progress notes
- Any communication between physicians detailing past or proposed treatments
- Treatment records for hyperbaric oxygen therapy
- Culture reports to confirm the infection status of the member
- Definitive x-ray findings and positive culture to confirm the diagnosis of osteomyelitis
- Definitive x-ray findings to establish the diagnosis of osteoradionecrosis
- For soft tissue radionecrosis, clinical photographs of the necrotic site must be available in the medical record
- Documentation must support the continued efficacy and need for treatment.

The need for more than one service daily will be reviewed.

PHYSICIAN CREDENTIALS

A physician must be credentialed by the hospital in which the therapy is being performed, including hyperbaric medicine, management of acute cardiopulmonary emergencies, and placement of chest tubes.

Credentialing includes the following minimum requirements:

- Training, experience, and privileges within the institution to manage acute cardiopulmonary emergencies, including advanced cardiac life support and emergency myringotomy.
- Completion of a recognized hyperbaric medicine training program as established by either the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society with a minimum of 40 hours of training and documented by a certificate of completion
- Continuing medical education in hyperbaric medicine of a minimum of 16 hours every two years after initial credentialing.

The hospital must keep documentation of the physician‘s credentials on file.

Since hyperbaric therapy requires the physician be ACLS certified with adequate support staffing and equipment, reimbursement of this service will be restricted to the inpatient or outpatient hospital setting. **Exception: Free standing facilities must meet all credentialing requirements listed above.**

Team coverage for cardiopulmonary resuscitation must be immediately available during the operational hours of the hyperbaric chamber.

EXCLUSIONS

Hyperbaric oxygen therapy is not covered to treat the conditions listed below. No exceptions or prior authorizations are available for any of the listed conditions.

- Cutaneous, decubitus, and stasis ulcers
- Congenital conditions, such as cerebral palsy, autism, mental retardation. Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell anemia
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome (Pick‘s Disease, Alzheimer‘s Disease, Korsakoff‘s Disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic disease
- Acute cerebral edema
- Mental retardation
- Traumatic brain injury

Topical application of oxygen does not meet the definition of hyperbaric oxygen therapy. No Medicaid payment will be made for the topical application of oxygen.

519.12.3 HIGH FREQUENCY CHEST WALL OSCILLATION, AIRWAY CLEARANCE THERAPY: RESPIRATORY VEST SYSTEM

WV Medicaid covers respiratory vest systems for eligible members including Medicaid-eligible children in the Children‘s Specialty Care Program. This devise must be prior authorized before its use can commence.

All of the following criteria must be met before consideration will be given to coverage of the airway clearance therapy/respiratory vest system:

- The devise must be prescribed by a physician (MD/DO) specializing in pulmonary or critical care medicine
- The letter requesting prior authorization and the physician‘s prescription for the devise must be in the physician‘s own words and on his/her letterhead/prescription pad. No request from the

manufacturer's reimbursement specialist or patient advocate will be accepted. The original letter and prescription with the physician's original signature must be submitted to BMS' contracted agent.

- A diagnosis of cystic fibrosis, neuromuscular disease, or broncheictasis must be documented and associated with at least three of the following:
  - Peak flow <300 LPM
  - Sputum production of at least 30 ml per day
  - FEV1 <80% of predicted
  - FVC <50% of predicted
  - 25% decrease in small airway score (FEF 25-75%) over past year
  - For bronchiectasis, radiologic evidence of the diagnosis must be provided in addition to the three other measurements
- Failure with flutter valve and manual chest physiotherapy
- Pattern of at least yearly hospitalizations for respiratory illnesses.

Exclusions/contraindications – The respiratory vest system will not be covered if any of the following exist:

- Unstable head or neck injury
- Subcutaneous emphysema
- Bullous emphysema
- Recent skin grafts to chest
- Recent transvenous or subcutaneous pacemaker
- Chest wall pain
- Uncontrolled hypertension
- Intracranial pressure
- Pleural effusions or emphysema
- Active or gross hemoptysis
- Susceptibility to pneumothorax, pneumomediastinum, or cardiovascular instability
- Diagnosis of COPD
- Distended abdomen
- Suspected pulmonary tuberculosis
- Recent spinal injury or surgery (within the past year)
- Rib fractures
- Hemodynamic instability
- Pulmonary edema/congestive heart failure
- Bronchopleural fistula
- Bronchospasm
- Recent esophageal injury (within the past year)
- Recent epidural anesthesia (within the past year)
- Recent spinal infusion (within the past year)
- Surgical wounds
- Burns of chest wall
- Osteoporosis
- Lung contusion
- Osteomyelitis

- Coagulopathy
- Uncontrolled airway at risk for aspiration

Other provisions:

- Only one generator per family can be covered.
- No other respiratory therapy services will be approved after approval of the respiratory airway clearance system.
- Approval of the respiratory airway clearance system will transpire only if other methods of therapy have failed. Documentation of therapies tried and the reason for failure must be kept.
- This devise will not be covered for individuals who are less than two years of age.

Covered diagnoses- The following ICD-9 diagnosis codes will be covered if they are accompanied by documentation of medical necessity and documentation that manual techniques do not work. (Use of this devise will not be covered merely because there is no one available to perform manual techniques.)

- 277.0 Cystic fibrosis
- 335.20 Amyotrophic lateral sclerosis
- 358.0 Myasthenia gravis
- 359 Muscular dystrophies
- 494 Bronchiectasis
- 518.81 Respiratory failure
- 748.61 Congenital bronchiectasis

The diagnoses listed above are the only diagnoses covered. All other diagnoses are not covered for this service.

If approved, this devise will be rented for three months (payment to go towards the purchase price or lease purchase). If applicable, modifier RR will be used to bill the rental period. Continued coverage will be dependant on a follow-up report which must include:

- The outcome – What expected goals were met?
- The number of times used daily and the duration of each treatment
- An assessment of compliance

The only billable procedure code for this service is:

- E0483 High frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each.

Payment for this service will be according to WV Medicaid Program guidelines for Durable Medical Equipment.

Questions regarding this service should be directed to WV Medicaid's contracted agent for Durable Medical Equipment.

519.12.4 CANCER SCREENING

WV Medicaid covers various types of cancer screening.

519.12.4.1 COLORECTAL CANCER SCREENING

WV Medicaid covers colorectal cancer screening tests for high risk members and for members aged 50 and over. Characteristics of the High Risk Individual at high risk for developing colorectal cancer:

- Close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- Family history of familial adenomatous polyposis.
- Family history of hereditary nonpolyposis colorectal cancer.
- Personal history of adenomatous polyps.
- Personal history of colorectal cancer:
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

The following Healthcare Common Procedure Coding System (HCPCS) codes are used to report the service:

- G0104 - Colorectal cancer screening; flexible sigmoidoscopy (service limit: one in 48 months for members age 50 and over)
- G0105 - Colorectal cancer screening; colonoscopy for an individual at high risk (service limit: one in 24 months for members at high risk)
- G0106 - Colorectal cancer screening; (alternative to G0104, screening sigmoidoscopy) barium enema (service limit: one in 48 months for members age 50 and over)
- G0107 - Colorectal cancer screening; fecal-occult blood test, one to three simultaneous determinations (service limit: one in 12 months for members age 50 and over) Screening fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. Fecal occult testing can only be billed by providers who have certification to perform CLIA waived tests.
- G0120 – Colorectal cancer screening; (alternative to G0105, screening colonoscopy) barium enema (high risk). (1 in 24 months/high risk members).

G0106 and G0120 are covered as alternatives to (but not in addition to) G0104 and G0105. G0104 and G0106 cannot be billed for the same episode of care, nor can G0105 and G0120.

Additionally, the preceding ~~"G~~" codes cannot be billed with their equivalent CPT codes. For example:

- G0106 and G0120 may not be billed with CPT 74280
- G0107 may not be billed with CPT 82270
- G0104 may not be billed with CPT 45330
- G0105 may not be billed with CPT 45378.

If during the course of performing a screening procedure, a condition is discovered that warrants further service, the code for the diagnostic procedure must be billed rather than the screening code. Stool DNA analysis as a part of colorectal screening is not covered by WV Medicaid.

519.12.4.2 PROSTATE CANCER SCREENING

West Virginia Medicaid covers yearly digital rectal examination of the prostate for cancer screening, but makes no separate payment for this exam, as it is included as part of the E&M service. PSA (prostate specific antigen testing) is covered for susceptible populations when the appropriate counseling regarding the potential for over diagnosis has been discussed with the patient.

519.12.4.3 BREAST AND CERVICAL CANCER SCREENING

The Breast and Cervical Cancer Screening Program (BCCSP), administered by the West Virginia Department for Health and Human Resources' Bureau for Public Health, provides statewide screening services free of charge or at a minimal fee to low income and uninsured or underinsured women. Women at or below 200 percent of the Federal Poverty Level qualify for services. The BCCSP offers screening mammography and diagnostic services for breast abnormalities to women age 50 and older. Diagnostic services for breast abnormalities are available for women under the age of 50. Cervical cancer screening services are available for women 25 and older. Cervical cancer screening services are also available for women under age 25 with Pap test results of HGSIL.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) effective October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer, including pre-cancerous conditions. Qualifying patients are eligible for Medicaid benefits while the cancer condition is undergoing active treatment.

The West Virginia Medicaid program covers yearly pap smears for cervical cancer screening in susceptible populations. A separate reimbursement for obtaining the Pap smear is not allowed, as this is considered part of the E&M service and examination. Billing for a pap smear with a laboratory (8000) code is only paid to the pathology facility actually reading the smear. In addition, a separate specimen handling charge is also not covered.

519.12.4.4 MAMMOGRAPHY

West Virginia Medicaid covers yearly screening mammograms for any aged female (according to the guidelines established by the American Cancer Society.) The order must come from the treating provider. If the physician who is performing the test (ordered by a patient‘s doctor) decides the patient needs additional testing procedures based upon the findings of screenings, the testing physician may proceed with appropriate diagnostic testing. The testing provider should receive authorization from the ordering physician (either by phone or fax) for the additional tests believed to be necessary if possible. If this cannot be obtained while the patient is present for the mammography, the testing physician may order those tests necessary as a result of abnormal findings of the screening.

Mammography services are regulated by the Food and Drug Administration. Therefore, a physician who meets the qualification requirements for an interpreting physician may order a diagnostic mammogram based upon the findings.

519.12.5 DIABETES DISEASE STATE MANAGEMENT

The concept of the Medicaid Diabetes Disease State Management Program is based upon the premise that eligible Medicaid members will benefit from a patient-centered health care approach that is responsive to the unique needs and conditions of people living with diabetes.

The program provides for a coordinated approach to the treatment of Medicaid members who have been diagnosed with Type 1, Type 2, or gestational diabetes mellitus. The essential program components of Medicaid‘s disease management program have been developed from the American Diabetes Association Guidelines (ADA), which aim to prevent the development of serious complications from diabetes. Not only will the member‘s PCP or provider (doctor, nurse practitioner) agree to manage the member‘s medical treatment, but will also ensure that self-management skills and diabetes educational needs are met. Practitioners will provide diabetes education or refer

individuals with diabetes to a Certified Diabetes Educator who is enrolled in the Diabetes Disease Management Program. This policy does not change the requirement for PAAS primary care referral.

The components of Diabetes Disease State Management are:

- Evaluation and education, which includes a comprehensive assessment of the member's clinical status, including health care needs, risks, hygiene, and diet, etc.
- A drug therapy evaluation of the member's oral or injectable medication requirements and their ability to self-monitor blood glucose, to recognize emergency conditions, etc.
- Diet management/education including education on diet restrictions, eating patterns, diet and medication interactions, etc.
- Referral to other providers to meet identified health care needs, such as skin and/or wound care, eye or renal care, etc.
- Comprehensive diabetes assessment using a Diabetes Managing Provider Care Tool. (See **Attachments 10 &11**)

  Medicaid members with diabetes will benefit from a patient-centered health care approach that is responsive to their unique needs and conditions. Because the care is patient centered, the most effective treatment options can be implemented that will ultimately prove cost-effective with outcomes and results that are quantifiable and measurable. The evaluation form to be used for initial and ongoing screening for members is the Diabetes Managing Provider Care Tool, which is included with the instructions for this program, and provides for the ADA Guidelines for appropriate treatment of members with diabetes. This form, which is to be completed by the member's Managing Provider, will define the health care and health related support needs of the member.

Requirements for Becoming a Diabetes Management Provider:

Managing providers may be any of the following licensed practitioners:

- Physicians (MD, D.O.)
- Medicaid Enrolled Nurse Practitioners
- Certified Diabetic Educators

In order to be reimbursed for diabetes management extended visits and for comprehensive educational services, Medicaid providers are required to meet the following criteria:

- enroll as a Medicaid provider
- Certified Diabetes Educators may only enroll with West Virginia Medicaid for the provision of diabetes education and self-management skills. Along with the provider enrollment information found in Chapter 300, the CDE must submit a copy of credentials showing current, unrestricted certification as a Certified Diabetes Educator issued by the National Certification Board for Diabetes Educators.
- Demonstrate successful completion of the six hours of web-based training provided by the Bureau for Medical Services and the Diabetes Prevention and Control Program by submitting the provider's Medicaid number via the web upon completion of the training program. This will provide the documentation necessary for BMS to enroll the provider as a provider of diabetes disease management and will allow reimbursement for diabetes disease management service codes. Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification.

- Document care utilizing the tools provided
- Submit documents for outcome monitoring as required by BMS
- Demonstrate a capacity to provide all core elements of disease state management services, which includes:

    - Comprehensive client assessment and service plan development
    - Assisting the client to access needed services, i.e., assuring that services are appropriate for the client's needs and that they are not duplicative or overlapping.
    - Monitoring and periodically reassessing the client's status and needs.

System Process

The following are directions for completing the on-line course for ~~"~~Diabetes Education for Primary Care Providers":

Begin by accessing the course at www.camcinstitute.org/professional/diabetes/camc.htm. On the course ~~"o~~pening page", click the button labeled ~~"C~~*lick here to begin program*". Fill in your 10-digit Medicaid number, (Physician Assistants will use their employing physician's Medicaid number and personal 4-digit identifier). These number(s) will track your participation. When you access this course the first time, you will be asked to submit your personal demographic information. This information will be retained for you. If necessary, you may edit the information at a later time. Provide valid credit card information for a one-time Credit Processing fee of $30.00 for six hour of continuing education credit. Complete and submit the program pre-test. From the Program Menu Page, you will find a listing of the six module titles. Complete the modules in any sequence you choose.

When all modules have been completed, a link will become available at the bottom of the Program Menu Page for a post course evaluation form and Certificate of Completion processing. Complete Post Course Evaluation form and submit. At this point, a Certificate of Completion is displayed and an automated email is sent to WV Medicaid advising them that you have successfully completed the course. Another automated email is sent to the email address you provided in your demographic information. You may print the Certificate of Completion for your personal records. The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate. Providers will receive a written notice from Unisys stating the provider file has been updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

CD's of this program will be available for those who do not have broadband Internet access. However, to use CD version of the course, the computer you use must have dial-up access to the Internet. CDs will be provided upon request, at no charge by contacting CAMC Health Education and Research Institute at 304-388-9960 or email tera.kirk@camc.org.

Reimbursement

Medical care that is covered by Medicaid and provided will be reimbursed at the Medicaid fee schedule. Diabetes disease management service codes are only reimbursable if the requirements previously noted for becoming a diabetes disease management provider have been met. In addition, reimbursement for the managing provider's extended office visit is a billable service based on the completion of the Diabetes Managing Provider Care Tool. This service is reimbursable, separate

from, and in addition to, the evaluation and management services rendered on the same date of service. Modifier 25 must be used to indicate that a significant separately identifiable EM service was required by the same provider on the same day of a procedure or other service. Reimbursement for diabetes education and self-management training is a separate service from the extended office visit, and payable to either managing providers or Certified Diabetes Educators. Billing should be submitted on the HCFA-1500 claim form or through electronic transmission. Claims which exceed the service limits spelled out in this program instruction will not be reimbursed.

If a Diabetes Managing Provider determines that a patient may benefit from diabetes education beyond extended office visits, a referral may be made to a Certified Diabetes Educator or provided by the practitioner. Certified Diabetes Educators and Diabetes Managing Providers who choose to provide diabetes education must define the educational support needs and develop an educational plan of care. Certified Diabetes Educators must develop and implement a plan of care and supply a copy of this plan to the patient‘s Diabetes Managing Provider, as well as maintaining documentation for services rendered and billed to Medicaid for audit purposes. For your convenience, a Diabetes Educational Provider Care Tool is included with this manual. The provider of diabetes education and self-management training will monitor and re-assess the patient periodically. It is the responsibility of those submitting claims to inquire whether these services have been previously received from other entities, so that service limits are not exceeded. The member may not be held liable for payment of claims which are not reimbursed by Medicaid.

Disease State Management services are reimbursed on a fee-for-service basis with limitations as follows:

HIPAA Compliant Code 7/01/04	Explanation	Previous Code
S0315	Disease management program; Managing Provider Extended Office Visit Limits - 2 visits per year	**W1875**
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes replaces Certified Diabetes Educator Contact Visit and Certified Diabetes Educator Brief Visit (1 unit = 30 minutes) Combination of G0108 and G0109 Limits - 8.5 hours per year (17 units)	**W1870** **W1874**
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes replaces Certified Diabetes Educator Group Service. (1unit = 30 minutes) Combination of G0108 and GO109 Limits - 8.5 hours per year (17 units)	**W1871**
S0316	Follow-Up/reassessment replaces Certified Diabetes Educator Follow-Up Visit Limits - 2 visits per year	**W1873**

519.12.6 PULMONARY FUNCTION TESTS

WV Medicaid covers the following pulmonary function tests:

- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94060 Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94375 Respiratory flow volume loop
- 94642 Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
- 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- 94720 Carbon monoxide diffusing capacity (e.g., single breath, steady state)
- 94772 Carbon dioxide, expired gas determination by infrared analyzer
- 94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determination (e.g., during exercise)

Separate payment for 94760 and 94761 is made only when the services are medically necessary and there are no other covered services provided on the same date by the same physician.

No other pulmonary function tests are covered by WV Medicaid.

519.12.7 HEMOPHILIA SERVICES

Diagnostic, treatment and prophylactic blood factor therapy are covered for members with hemophilia and other hemorrhagic conditions.

Blood factor supplied to a member with a crisis episode is covered without restriction as needed to control the bleeding.

519.12.8 TOBACCO CESSATION PROGRAM

West Virginia Medicaid operates a tobacco cessation program in cooperation with the Public Employees Insurance Agency and the Bureau for Public Health. In order for members to have access to drugs and other tobacco cessation services, they are required to enroll in the program through the YNOTQUIT Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available through the quit line program. Additional information regarding the YNOTQUIT Line can be accessed through the Partners in Corporate Health website, www.ynotquit.com.

All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate. Drug products are limited to:

- Nicotine gum – 24 pieces per day
- Nicotine patches – 1 patch per day
- Nicotine lozenges – 20 lozenges per day
- Nicotine inhalers – 168 inhalers per 30 days

- Nicotine nasal spray – 4 spray bottles per 30 days (This therapy is reserved for those who have failed other forms of nicotine replacement therapy.)
- Buproprion – 2 tablets per day

519.13 MEDICATION SERVICES

Medication Services involve drugs and their administration to Medicaid members.

519.13.1 INJECTIONS

Therapeutic, prophylactic or diagnostic injection (CPT 90782) is not covered by WV Medicaid when billed in conjunction with an E&M code. Reimbursement for the drug is covered. If the injection is the primary purpose for the visit, an E&M service is not allowed.

Appropriate HCPCS ~~"J~~ Codes" are used to bill for the provision of the medication injected. If there is not a specific code for the medication, a non-specific ~~"J~~ Code" (J3490 or J9999) is used. These claims must be billed on a paper claim with the name, NDC, and quantity of the medication written on the claim on the line below the billed line or in ~~"F~~ield 19".

When an unlisted drug is billed using a J-code, the following information is required:

- The name of the drug
- National Drug Code (NDC)
- Exact dosage administered
- Strength of the drug administered
- Method of administration (i.e., subcutaneous, intramuscular, etc.)
- A cost invoice for the drug

When an HMO is the member's provider, the HMO is responsible for the cost of the drug and injection fees when the service is provided in the practitioner's office during the office visit. The requirements of the HMO must be followed for reimbursement.

The following injected substances have specific coverage and reporting requirements:

- Intra-articular and intra-bursal injections must be appropriate for the diagnosis; type, NDC, and quantity of steroid or other medication must be reported on the claim with the appropriate CPT code.
- Medications available in parenteral form, only; i.e., gold salts are covered for psoriasis or rheumatoid arthritis and cancer chemotherapy.

WV Medicaid covers Vitamin B-12 injections for particular illnesses and injuries. Following are the medical conditions covered for Vitamin B-12 injections:

- Anemia
  - Pernicious
  - Megaloblastic
  - Macrocytic
  - Fish tapeworm.
- Gastro-intestinal disorder
  - Gastrectomy
  - Malabsorption syndrome
  - Surgical and mechanical disorders resulting from resection of small intestine, strictures, anastomosis, and blind loop syndrome.
- Neuropathy
  - Neuropathy associated with pernicious anemic
  - Severe or acute neuropathy due to malnutrition
  - Severe or acute neuropathy due to alcoholism.

Importantly, diagnoses such as "vitamin deficiency," "secondary anemia," "neuritis," and "menopause" are not sufficient for Medicaid coverage.

WV Medicaid does not cover injections for uses other than those approved by the United States Food and Drug Administration.

519.13.1.1 PALIVIZUMAB/SYNAGIS

Palivizumab (Synagis®) is a humanized monoclonal antibody produced by recombinant DNA technology. It is used to help prevent serious lower respiratory tract disease caused by respiratory syncytial (RSV) in pediatric members at high risk of RSV disease. This antibody is usually administered intramuscularly on a monthly basis even though the RSV season usually spans October

through March in WV.

Prior authorization through the Rational Drug Therapy Program is required for all orders for Palivizumab (Synagis®). This program may be reached at 1-800-847-3859 or faxed at 1-800-531-7787. Its mailing address is:

Rational Drug Therapy Program
West Virginia University, School of Pharmacy
Robert C. Byrd Health Sciences Center
PO Box 9511
Morgantown, West Virginia 26506-9511

Medicaid coverage of Palivizumab (Synagis®) is limited to members who meet one of the following criteria:

- Member is under 24 months of age at the start of therapy and has chronic lung disease and needs oxygen chronically, or has been off oxygen use for less than 3 -6 months.
- Member is under one year of age at the start of therapy with a gestational age of under 28 weeks.
- Member is under 6 months at the start of therapy with a gestational age of 28-32 weeks or 32-36 week gestational age with concomitant medical problems/risk factors.
- Member is under 3 months of age at the start of therapy with gestational age of 32-36 weeks.

Requests must include the information needed to make a coverage determination, including medical documentation supporting the factors placing the child at high risk of RSV, past or present use of oxygen, current medication, or exposure to risk factors in the American Academy of Pediatric (AAP) guidelines. A diagnosis of bronchopulmonary dysplasia alone is insufficient.

Palivizumab (Synagis®) will not be approved for members currently exhibiting RSV infection or receiving immunoglobulin infusions.

Pharmacies may submit claims for Palivizumab (Synagis®) through the pharmacy point-of-sale (POS) system or appropriate manual form using the National Drug Code.

Physicians and outpatient hospitals may bill using CPT 90378 per 50mg, which equals 1 unit. No separate claim for inpatients must be submitted for Palivizumab (Synagis®) provided to hospital inpatients because payment for the drug is included in the DRG payment rate.

519.13.2 IMMUNIZATIONS

WV Medicaid covers medically necessary immunizations provided to members.

519.13.2.1 IMMUNIZATIONS FOR CHILDREN

Routine vaccines to Medicaid members less than 19 years of age are provided free-of-charge through the Vaccines for Children (VFC) Program, which the WV Department of Health administers. When these vaccines are provided, the practitioner is reimbursed only for the administration.

The following list of CPT codes and modifiers must be used for reimbursement of vaccinations using VFC supplies:

- 90647 Hemophilus influenza B vaccine (Hib)
- 90648 Hemophilus influenza B vaccine (Hib)
- 90655 Influenza virus vaccine 6-35 months
- 90657 Influenza virus vaccine 6-35 months
- 90658 Influenza virus vaccine three years and above (to age 19)

- 90669 Pneumococcal conjugate vaccine
- 90700 Diphtheria, tetanus toxoids, acellular pertussis vaccine (DtaP)
- 90702 Diphtheria and tetanus toxoids, (seven years old or less)
- 90707 Measles, mumps, and rubella vaccine (MMR)
- 90713 Poliovirus vaccine (IPV)
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
- 90716 Varicella virus vaccine
- 90718 Tetanus and diphtheria toxoids (Td), seven years or older (to age 19)
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine (DtaP - HepB - IPV)
- 90732 Pneumococcal polysaccharide vaccine
- 90734 Meningococcal Conjugate Vaccine (Menactra)
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage

90660 is not a covered service.

In order to assist Medicaid in the accurate identification of the vaccine administered, the appropriate CPT code must be billed. In addition to the specific CPT vaccine codes, an ‗SL' (state supplied) modifier must be placed on the claim to indicate the vaccine was provided by VFC. The appropriate administration CPT codes, 90471 or 90472, must be billed with the appropriate CPT code. Administration codes will not be reimbursed if the corresponding VFC code is not billed.

To bill a single vaccine, bill the CPT vaccine code with the ‗SL' modifier and CPT code 90471 for administration reimbursement.

To bill multiple VFC or subsequent vaccines itemize each CPT vaccine code using the ‗SL' modifier and bill 90472 with the number of additional administrations in the units block.

For vaccines administered to adults >19 years of age, or for vaccines not supplied by VFC, bill the appropriate CPT code. Do not bill the ‗SL' modifier or the administration codes 90471 or 90472. Reimbursement will include the serum and the associated administration.

Coverage of Influenza Vaccine

VFC has restricted coverage due to limited stocks of influenza virus vaccine. Medicaid members must meet one of the CDC's defined criteria for at-risk populations as follows:

- All children aged 6-23 months
- Adults aged 65 years and older
- Persons aged 2-64 years with underlying chronic medical conditions
- All women who will be pregnant during influenza season
- Residents of nursing homes and long-term care facilities
- Children 6 months-18 years of age on chronic aspirin therapy
- Health-care workers with direct patient care who are Medicaid eligible
- Out-of-home caregivers and household contacts of children aged <6 months.

Medicaid will reimburse for influenza vaccine if VFC's serum is depleted if BMS has been notified by VFC that serum supply has been depleted.

According to the National Immunization Program at the CDC, states' immunization programs should

have enough influenza vaccine to meet the demands. However, in the case that VFC's serum is depleted, WV Medicaid will reimburse providers for private stock of vaccine. WV Medicaid will review for inappropriate use and billing of vaccines. A member's high risk status and VFC depletion must be documented or reimbursement will be recouped.

If VFC depletion occurs, bill the appropriate CPT code without modifiers and without the administration code.

WV Medicaid will reimburse practitioners for the administration of vaccine through VFC using specific billing methodologies outlined in this chapter.

519.13.2.2 IMMUNIZATIONS FOR ADULTS

The provision of many immune globulins and vaccines/toxoids for adults is covered by WV Medicaid when prescribed and provided by their practitioner. When this occurs, the appropriate CPT code must be billed. Reimbursement for this service includes the serum and the associated administration. Do not bill 90471 or 90472 when providing immunizations to adults. The vaccine must be billed by the practitioner. WV Medicaid does not reimburse pharmacies for Medicaid members' vaccines.

The following CPT codes are covered for adult WV Medicaid members:

- 90281 Immune globulin (Ig), human, for intramuscular use
- 90283 Immune globulin (IgIV), human, for intravenous use
- 90288 Botulinum immune globulin, human, for intravenous use
- 90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
- 90296 Diphtheria antitoxin, equine, any route
- 90371 Hepatitis B immune globulin (HBIg), human, for intramuscular use
- 90375 Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use
- 90376 Rabies immune globulin, heat treated (RIg-HT), human, for intramuscular and/or subcutaneous use
- 90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
- 90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
- 90386 Rho(D) immune globulin (RhIg), human, for intravenous use
- 90389 Tetanus immune globulin (TIg), human, for intramuscular use
- 90393 Vaccinia immune globulin, human, for intramuscular use
- 90396 Varicella-zoster immune globulin, human, for intramuscular use
- 90399 Unlisted immune globulin
- 90581 Anthrax vaccine, for subcutaneous use
- 90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
- 90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, for intravesical use
- 90632 Hepatitis A vaccine, adult dosage, for intramuscular use
- 90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- 90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- 90665 Lyme disease vaccine, adult dosage, for intramuscular use
- 90675 Rabies vaccine, for intramuscular use
- 90676 Rabies vaccine, for intradermal use
- 90703 Tetanus toxoid absorbed, for intramuscular use
- 90704 Mumps virus vaccine, live, for subcutaneous use

- 90705 Measles virus vaccine, live, for subcutaneous use
- 90706 Rubella virus vaccine, live, for subcutaneous use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live , for subcutaneous use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live , for subcutaneous use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
- 90717 Yellow fever vaccine, live, for subcutaneous use
- 90718 Tetanus and diphtheria toxoids (Td), absorbed for use in individuals seven years or older, for intramuscular use
- 90720 Diptheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
- 90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza B vaccine (DtaP - Hib) , for intramuscular use
- 90725 Cholera vaccine for injectable use
- 90727 Plague vaccine, for intramuscular use
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
- 90733 Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
- 90735 Japanese encephalitis virus vaccine, for subcutaneous use
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
- 90749 Unlisted vaccine/toxoid

519.13.3 ANTIGEN/ALLERGY SERVICES

WV Medicaid covers diagnostic services, antigen desensitization, and allergen immunotherapy in accordance with Medicare‘s policies, as described below.

- A dose is defined as the total amount of antigen to be administered to the member during one encounter/treatment session whether mixed or in separate vials.
- Members selected for covered immunotherapy must have significant life-threatening symptomatology (e.g., anaphylaxis) or a chronic allergic state (e.g., allergic rhinitis, asthma), which has not responded to conservative measures, such as environmental control or judicious use of pharmacological agents. Immunotherapy has been shown to be effective in stinging insect hypersensitivity, inhalant allergies, and allergic asthma, but has not been shown to be effective for food allergies and non-allergic rhinitis.
- Desensitization, not immunotherapy, is the procedure of choice for drug allergies.
- The length of immunotherapy depends on the demonstrated clinical efficacy. A presumption of failure can be made when the member does not experience a noticeable decrease of symptoms after 12 months of therapy, there is no evident increase in tolerance to the offending allergen, and no reduction occurs in medication usage. Long-term treatment will not be reimbursed when it has no apparent clinical benefit.
- Whole body extract of biting insect or other arthropod is indicated for use for fire ant allergy only.

- Antigens prepared for sublingual administration are not covered as they have not been proven to be safe and effective. Antigens are covered only if they are administered by injection.
- Very low dose immunotherapy or continued submaximal dose immunotherapy has not been shown to be effective and will be denied as not medically necessary.
- Immunotherapy is not covered for food allergies as it has not been shown to be effective. Strict elimination of the offending allergen is the only proven effective treatment of food hypersensitivity.

- Oral desensitization therapy has not been shown to be effective and is not covered by Medicaid, as it is not considered reasonable and necessary.

WV Medicaid **does not** cover allergen immunotherapy for the following antigens: newsprint, tobacco smoke, dandelion, orris root, phenol formalin, alcohol, sugar, yeast, grain mill dust, goldenrod, pyrethrum, marigold, soybean dust, honeysuckle, wood, fiberglass, green tea, or chalk.

Only physicians who have training and experience in the specialty of allergy and clinical immunology are paid to perform allergy testing and for antigen extract or allergy serum. Follow-up immunotherapy can be referred to a practitioner other than an allergist.

There are no restrictions on the services for acute anaphylaxis whether related to the source of reaction (Allergen, venom, etc.) or the practitioner providing the care.

An E&M service is covered on the same day as allergy testing or immunotherapy if a significantly identifiable E&M service is performed (and billed with modifier 25); that is, the primary purpose of the visit was not the allergy service. Preparation and provision of the antigens for the therapy is separately billable. The global codes are not covered.

WV Medicaid's payment for antigen services is included in the corresponding RBRVS fee. No separate payment is made for antigen services. An allergist must bill two codes when preparing and administering an antigen. WV Medicaid does not allow allergists to bill for a global service (i.e., injection and extract/extract preparation). Injections must therefore be billed using the following codes:

- 95115 Professional services for allergen immunotherapy, not including provision of allergenic extracts; single injection
- 95117 Two or more injections.

The antigen extract and the physician's professional service for preparing the extract must be billed using one of the following codes:

- 95144 Professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens, single dose vials; specify number of vials
- 95145 Professional services for supervision and provision of antigens for allergen immunotherapy; (specify number of does); single stinging insect venom
    - 95146 Two single insect venoms
    - 95147 Three single stinging insect venoms
    - 95148 Four single stinging insect venoms
    - 95149 Five single stinging insect venoms
- 95165 Professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens; specify number of doses
- 95170 Whole body extract of biting insect or other arthropod; specify number of doses.

CPT codes 95120 through 95134 are not valid for payment purposes.

HMOs are responsible for reimbursing for allergy injections and the cost of serum when the service is provided in an office setting to an HMO member. Requirements of the HMO must be followed for reimbursement. PAAS PCP referrals are required prior to rendering the service if the servicing provider is not the PCP.

MULTIPLE DOSE VIALS

Allergists must produce multiple dose vials rather than the more expensive single dose vials, unless another physician will inject the antigen. Therefore, CPT 95144 (single dose vial) is not covered when injection code 95115 or 95117 is billed.

Payment is based on a maximum of 10 doses per multiple dose vial. Medicaid can only be billed for a maximum of 10 doses per vial, even if more than 10 doses are obtained from the vial (e.g., if the physician administered 0.5 cc doses, instead of one cc dose). If fewer than 10 doses are prepared from a vial, the smaller number must be billed.

Medicaid must not be billed any additional amount for diluted doses, for example, by taking a one cc aliquot from a multi-dose vial and mixing it with nine cc of diluent in a new multi-dose vial.

If the number of doses is subsequently adjusted (perhaps because of a member‘s reaction) and a different number of doses are provided than was originally anticipated, the physician may not change the number of doses billed. In other words, the number of doses anticipated when the antigen was prepared is the number that must be billed because the CPT codes require the number of prospectively planned doses. The physician will not be required to refund any payments if fewer doses are provided than were originally planned.

The practice of reducing the amount of antigen provided in a ~~“~~dose” in order to increase the number of doses from a multiple dose vial so that the payment would be increased for the same amount will be monitored.

When a provider bills allergen immunotherapy (CPT 95115, 95117, 95144-95180) and an E&M code on the same date of service, Modifier 25 must be used with the E&M code to indicate the member‘s condition required a significant, separately identifiable service above and beyond allergen immunotherapy. Supporting documentation is required in the member‘s medical record.

The member‘s medical record must confirm that allergen immunotherapy is clinically reasonable and necessary and show that indications for immunotherapy were determined by the appropriate diagnostic procedures coordinated with clinical judgment. The number of vials or doses and injection schedule must be maintained in the member‘s medical record. Documentation must be made available upon request to the BMS.

519.13.4 CHEMOTHERAPY ADMINISTRATION

WV Medicaid covers chemotherapy administration. This service includes refilling and maintenance of a portable or implantable pump, chemotherapy injection, and provision of the chemotherapy agent. The preparation of the chemotherapy agent is included in the payment for administration of the agent and; therefore, is not separately reimbursable. An office visit on the same date of service as the chemotherapy administration may be covered if it is for a separately identifiable service documented in the member‘s medical record.

Chemotherapy drugs administered in the office are reimbursed using the appropriate HCPCS code. If no code is available, CPT 96545 may be billed and the appropriate medical documentation and an invoice showing the drug‘s actual cost must be attached to the claim.

Separate payment will be made when different chemotherapeutic agents are furnished or administered on the same date of service by different routes. For example, if Adriamycin is administered by "push" on the same date as cisplatin is administered by "infusion," both administrations may be billed to Medicaid. Each chemotherapeutic agent must be billed with a separate code for each method of administration.

HMOs are responsible for reimbursing for chemotherapy administration to HMO members regardless of the setting. Requirements of the member's HMO must be followed in order to be reimbursed. A PAAS PCP referral is required if an oncologist or other specialist provides the chemotherapy services.

519.14 RADIOLOGY SERVICES

WV Medicaid covers diagnostic and therapeutic radiology and nuclear medicine services. Specific policies and procedures concerning coverage of radiology services are listed below or found in Chapter 512 of the Laboratory & Radiology Manual.
A signed provider's order listing the service and the appropriate diagnosis is required for Medicaid coverage. West Virginia Medicaid has adopted CMS's policy to cover diagnostic tests only if ordered by the physician or non-physician practitioner who is actively treating and managing the patient. Diagnostic tests ordered by a physician who is not the patient's attending/treating physician, e.g., medical director of a nursing home for a nursing home patient, or a physician in a mobile center, will NOT be covered except in the following situations:

- On call physician who has been given responsibility for a patient's care when the patient's physician is unavailable.
- Specialist who is managing an aspect of the patient's care.
- Non-physician practitioners can order diagnostic test within the scope of their practice. However, supervision of diagnostic testing, such as required by CMS in IDTFs, can only be performed by physicians.

Providers should bill modifier-26 for the professional component only, if only performing radiological supervision and interpretation, and TC only if the provider owns the equipment. Practitioners performing services that require radiological supervision and interpretation may bill for these services. However, oftentimes, the facility also has a radiologist providing another reading. At this time, WV BMS pays for only one reading of a procedure. The provider whose reading results in a decision making process is typically the one that is medically necessary and that is reimbursed. Payment for a second reading interpretation of x-rays for quality assurance/confirmation is NOT covered.

Medicaid will pay for portable x-rays and for low osmolar contrast media. When billing for low osmolar contrast media, use Procedure Code 78990 and attach a manufacturer's or cost invoice. For radiation oncology management services, West Virginia Medicaid requires physicians to bill for weekly treatment management instead of daily treatment management.

Comparison x-rays are not covered routinely. If performed, documentation must substantiate the necessity of the second x-ray. This must be in the patient's record for review.

519.14.1 EMERGENCY ROOM X-RAYS AND ELECTROCARDIOGRAMS

West Virginia Medicaid will only cover one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. The professional component of service must include an interpretation and written report for inclusion in the patient's medical record. Reviewing an x-ray or EKG without providing a written report does not meet the criterion that CMS and public payers have established for separate payment.

CMS' criterion is also used for determining which claim should pay in the event of multiple claims being submitted for the same emergency room visit:

- The interpretation and report that directly led to the diagnosis and treatment of the patient.
- Interpretation of the x-ray or EKG by a radiologist/cardiologist if the interpretation is performed at the same time as the diagnosis and treatment.

Note: When circumstances warrant and are well documented, Medicaid will cover two interpretations. However, in most instances only one interpretation will be covered. Payment for interpretation of x-rays and EKG's for quality assurance is NOT Covered.

519.14.2 BONE DENSITY TESTING

WV Medicaid covers bone density scans in order to prevent the morbidity associated with osteoporosis and osteoporotic fracture. The bone density test is not to be routinely performed for dialysis patients. Routine screening of individuals without symptoms or risk factors is not covered. Criterion for providing bone density testing is: The test must be ordered for the symptoms or disorder associated with the loss of bone density.

- The bone density test is limited to one every two years. More frequent requests will require prior authorization with documentation of the medical necessity. (An exception of the limit would occur if the member had an abnormal screen on a peripheral site and an actual test was necessary to confirm the abnormality.)
- Only axial testing is allowed for monitoring osteoporosis therapy. Photo-densitometry of a peripheral bone and ultrasound bone densitometry are not allowed as part of this monitoring.

Only one scan can be billed regardless of how many sites are tested during the session. For those providers who are also the treating physician, a separate written interpretation of the scan must be included in the ember's chart as the codes include interpretation and report.

A complete list of diagnostic codes covered for bone density scans is found in **Attachment 13.**

519.14.3 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES

Effective 10/01/05, prior authorization will be required on all outpatient Radiological/Nuclear Medicine services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic Services required during an emergency room episode will not require prior authorization.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

519.15 UNLISTED SERVICES, DRUGS, PROCEDURES, OR ITEMS

Unlisted services, drugs, procedures, or items (as defined by HCPCS) are used only when there is no code that describes the service, item, or procedure provided to a Medicaid member. Unlisted codes must always be billed on paper with a description of the service provided, e.g., an operative report or clinical notes.

When billing for other unlisted services, procedures, or items, the claim must be accompanied by all documentation necessary to justify reimbursement (i.e., operative reports, cost invoices, etc).

519.16 NON-COVERED ITEMS – MEDICAL SUPPLIES/DURABLE MEDICAL EQUIPMENT

Payment will not be authorized for non-covered items – medical supplies/durable medical equipment. Details of non-covered items – medical supplies/durable medical equipment are found in the Chapter 506 pertaining to durable medical equipment.

519.17 NON-COVERED SERVICES

Certain services and items are not covered by the Medicaid Program. Non-covered services include, but not limited to, the following:

- Acupressure
- Acupuncture
- Autopsy
- Cardiac rehabilitation programs, pulmonary rehabilitation programs, and other rehabilitation programs
- Chelation therapy
- Claims received more than 12 months after the date of service
- Completion of forms and reports, except for eligibility purposes as specifically requested by the Department of Human Services using ~~"E~~SRT" letters of request
- Cosmetic procedures, medical or surgical, the primary purpose of which is to improve the member's appearance. Such procedures include, but not limited to, otoplasty for protruding ears of lop ears, rhinoplasty (except to correct nasal deformity), nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathism or both, dermabrasion, certain skin grafts, malar augmentation, breast implants for other than breast cancer reconstruction, and lipectomy
- Courtesy Calls (visits in which no identifiable medical service was rendered)
- Dietary (food) supplements, except as provided in a hospital or nursing home
- Direct payments to members (payments are made to the provider of service)
- Domestic or housekeeping services, except to the extent they may be provided under a home health service plan
- Drugs and supplies dispensed by the physician which are acquired by the physician at no cost
- Educational services
- Experimental/Research/Investigational medical or surgical procedures
- Genetic testing
- Hypnosis
- Immunizations required for travel outside the Continental United States
- Incidental surgical Procedures (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, etc.) performed at the same time as a major surgical procedure
- Infertility services (i.e., artificial insemination, in vitro fertilization, etc.)
- Inhalation Therapy (chronic basis)

- Injections and visits solely for the administration of injections unless medically necessary and the member's inability to take appropriate oral medications are documented in the member's medical record and on the claim form
- Inpatient rehabilitation services for members over 18 years of age
- Items/Services not related to medical care that were provided for the convenience of the member, their custodian, or the provider
- Maintenance services if no progress is being made
- Mass screenings for any condition
- Massage therapy
- Meals-on-Wheels (or similar food service arrangements)
- Naturopathy
- Non-legend Drugs (over-the-counter drugs), except for the following:
  - Family planning supplies
  - Insulin
  - Diabetic syringes/Needles/Testing kits
  - End-Stage Renal Disease (ESRD) Vitamin/Vitamin mineral preparations and other medications related to ESRD services.

  NON-LEGEND DRUGS FOR MEMBERS RESIDING IN LONG-TERM CARE (LTC) FACILITIES (skilled and intermediate nursing homes) are to be furnished by the LTC and are not to be billed to the member or the Department of Health and Human Resources.
- Nutritional (dietary) counseling
- Operating surgeon may not bill for the administration of anesthesia, except epidural anesthesia
- Pain Clinics (Specific medical procedures ordered by the physician for treatment are covered)
- Payment to a physician for laboratory services as payment is made directly to the facility performing these services. (The physician may have a laboratory specifically approved for Medicaid purposes; the laboratory must have a Medicaid laboratory provider number)
- Personal comfort items (items which do not directly contribute to the treatment of an illness or injury or to the functioning of a malformed body part)
- Physician services denied by Medicare as not medically necessary, ineffective, unsafe, or without proven clinical value
- Physician services included as part of the cost of an inpatient facility or hospital outpatient department
- Pre-operative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them
- Procedures prohibited by State or Federal statute or regulations
- Pulmonary rehabilitation programs and other similar rehabilitation programs
- Referrals from one physician to another for treatment of specific member problems are not to be billed as consultations
- Reflexology
- Rehabilitation programs such as cardiac, pulmonary, dietary, weight control, etc.
- Respiratory therapy
- Routine Foot Care, except for those members having a metabolic disease such as diabetes and the metabolic disease must be documented
- Services and items under a Workers Compensation law or other payment services
- Services provided as inpatient hospital services if the service could appropriately and safely be

performed on an outpatient basis in an office or outpatient hospital setting unless the procedure is performed as a secondary necessary procedure

- Services provided by students
- Services provided for the purpose of relieving discomfort
- Services which are not medically justified
- Services which are provided at no charge to patients who are not Medicaid members (i.e., services provided free to the general public cannot be billed to Medicaid)
- Sex change surgery (transsexual surgery)
- Sex determination services
- Spectacle (glasses) cases
- Sterilizations when the member is under 21 years of age, institutionalized, or mentally incompetent
- Tai chi
- Telephone contacts with members or on their behalf
- Tempomandibular Joint Syndrome (TMJ) surgery or treatment
- Visits solely for one or more of the following:
  - Prescription pickup
  - Collection of specimens for laboratory procedures
  - Ascertaining members‘ weight.
- Weight reduction (obesity) clinics/programs.
- Yoga

519.18 BILLING AND REIMBURSEMENT

Practitioners must bill WV Medicaid directly for covered services provided to Medicaid members. However, payment may be made to a practitioner‘s employer when the practitioner is required as a condition of employment to turn over his/her fees to the employer or when the facility where a service is rendered has a signed contract with the practitioner that requires the facility to submit the claim. **Chapters 300 and 600** contain additional information.

As is consistent with Federal law prohibiting Medicaid providers from balance billing, (i.e., billing an amount in excess of the Medicaid fee), the practitioner may not bill the member any additional amount regardless of the setting in which a service is rendered.

519.18.1 HCPCS CODES

The Center for Medicare and Medicaid Services (CMS) of the Federal Government has mandated that all States implement the HCPCS codes to identify medical services provided to Medicaid members.

HCPCS is a coding system that uses the AMA‘s Current Procedural Terminology, fourth edition (CPT-4) as its base (Level I codes) and then nationalizes non-standard codes used by various states so all state and federal payers of medical claims use the same coding system (Level II codes).

In an effort to maintain uniformity with National Correct Coding Policies implemented by CMS, the BMS incorporates the National Correct Coding Initiative methodologies for the analysis of standard medical and surgical practice. These policies were developed based on coding conventions defined in the AMA‘s CPT-4 Manual, in national and local policies, in edits and in coding guidelines developed by national societies. They are consistent with federally and state mandated program policies. Incorporating these edits into the review process does not represent new policy or monitoring procedures by the BMS and should not be interpreted as such. These edits represent generally accepted standards of medical and surgical practice. Adherence to these policies will be monitored

through post payment reviews conducted by BMS or its contracted agent.

On a case-by-case basis, WV Medicaid determines whether to cover and pay for unlisted physician services, i.e., procedure codes with the last two digits typically ending in 99. These clinical codes require the physician to submit a detailed report with the claim for payment. These codes cannot be billed electronically because they must be reviewed manually.

519.18.2 CLINICAL CODE MODIFIERS

At times, a physician may have to attach a 2-digit modifier to the end of a CPT code in order to report accurately and completely the services provided to a Medicaid member. WV Medicaid has adopted the definitions of modifiers consistent with the AMA's CPT-4.

519.18.3 PAYMENT FOR ANESTHESIA SERVICES

Medicaid fees for anesthesiology services are calculated somewhat differently from the fees paid for all other physician services. The fee equals the conversion factor for anesthesia services multiplied by the sum of the base units and time units for a service. (There are no relative value units for these services.)

The base units for a given anesthesia service are the same every time the service is provided and have been established by the American Society of Anesthesiologists (ASA). The time units depend on the length of time to provide the service. The time units are expressed in 15-minute blocks and are expressed in whole units. Thus, a service that takes 75 minutes would be assigned five time units.

An example follows:

If an anesthesia service has three base units and five time units and the anesthesia conversion factor is $15.25 per unit, the fee would be $122.00.

Fee = Conversion Factor x Total Units

$122.00 = $15.25 x 8

Base units are in the system and are not billed by the provider.

Time units do not apply to certain anesthesia services. These services are paid using the RBRVS fee schedule. The BMS establishes relative value units for these services so the fee equals the number of units multiplied by the anesthesia conversion factor.

519.18.4 CMS 1500 CLAIM FORM

A physician must submit a completed claim (CMS-1500) in order to be paid for covered services furnished to Medicaid members. **Attachment 14** lists a brief description of the spaces or fields the physician must complete to bill the WV Medicaid Program.

519.19 SOLICITATIONS

It is unlawful for a physician to knowingly solicit, offer, pay, or receive any remuneration including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for furnishing or arranging to furnish any item or service for which payment may be made under the WV Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging or recommending the provision of a service.

519.20 MEDICAL NECESSITY CERTIFICATION AND PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In

addition, the following limitations also apply to the requirements for payment of Practitioner Services described in this chapter:

- Requests for medical necessity certification and prior authorization must be submitted to the Bureau for Medical Service's contracted agent.
- Prior authorization requests for Practitioner Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.
- Prior authorization numbers will not be issued over the telephone. Practitioners must not render services until an authorization number is received.
- Prior authorization does not guarantee payment. Services must be rendered by approved provider to eligible individual within service limitations in effect on date of service. All provider/member eligibility requirements and service limitations apply.

519.20.1 PRIOR AUTHORIZATION FOR OUTPATIENT SURGERIES

Certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listing in Attachment 17, along with the PA form that may be utilized.

519.21 MANAGED CARE

Unless noted otherwise, services detailed in this manual are the responsibility of the HMO if the Medicaid member is a member of an HMO. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met for those members.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 1
PRIOR AUTHORIZATION FORM FOR
BLEPHAROPLASTY, UPPER EYELIDS
PAGE 1 OF 3

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Upper Eyelid Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

West Virginia Medicaid covers eyelid surgery with documentation of medical necessity according to the following criteria.

ICD-9-CM Code(s): _____ CPT Code(s): _____

Blepharoplasty and repair of blepharoptosis are considered for payment by WV Medicaid when medically necessary.

Symptoms documented by member complaints which may justify functional surgery and are commonly found in patients with: (Check as appropriate and attach required documentation)

_____ Visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis
_____ Sensation of looking through lashes
_____ Symptomatic redundant skin weighing down on upper lashes
_____ Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin; prosthesis difficulties in an anophthalmia socket

History:

Myasthenia Gravis
Thyroid Disease
Diabetes
Partial blindness or unilateral blindness

Physical Examination: (Must include a full visual examination to rule out other potential causes of visual disturbance. The presence of any of the following should be documented.)

_____ Ptosis
_____ Dermatochalasis
_____ Pseudoptosis
_____ Chronic blepharitis
_____ Upper eyelid margin approaches to within 2.0 mm of the corneal light reflex
_____ Upper eyelid skin rests on the eyelashes
_____ Upper eyelid indicates the presence of dermatitis
_____ Upper eyelid position contributes to difficulty tolerating prosthesis in an anophthalmia socket
_____ Any significant retinopathy

Documentation: (Attach to Request)

_____ Current photographs: The photographs must be taken with the head perpendicular to the plane of the ground, pointing straight ahead, canthus to canthus. Photos should also be taken from the side to show the excess skin resting on the eyelid.
For requests for blepharoptosis repair, another set of photos with the skin lifted off the lid to show persistent drooping is necessary.

_____ Copies of current visual fields, both taped and untaped, recorded to demonstrate:

_____ Minimum twelve (12) degree or thirty percent (30%) loss of upper field of vision with upper lid skin and/or upper lid margin in natural position and elevated (by taping of the lid) to demonstrate

potential correction by the proposed procedure or procedures. Visual field examination by tangent screen testing is not acceptable.

_____ Visual field testing by either Goldman perimetry or automated perimetry will be accepted. The test object must be indicated with Goldman testing, and the fixation monitor with fixation losses must be listed with the automated testing. The test must show a superior (vertical) extent 50-60 degrees above fixation with targets present at a minimum of 4 degrees vertical separation starting at 24 degrees above fixation while using no wider than a 10 degree horizontal separation.

_____ Demonstration of an improvement of visual field examination with lid (in the case of blepharoptosis) or excess lid skin (for blepharoplasty) elevated is necessary to show that the procedure is medically necessary. The improvement must be at least 30%.

Per National Correct Coding Edits, requests for a blepharoplasty, CPT 15283 with a blepharoptosis repair 67904, will be bundled into the latter.

For the most part, lower eyelid surgery is cosmetic, and medical necessity for entroprion repair must be documented with photos and slit lamp examination.

This procedure must be performed on an outpatient basis by a Board Certified/Eligible plastic surgeon or Board Certified Ophthalmologist with experience with this procedure.

_____ _____

Physician Signature Date

WVDHHR/BMS/PARequest01/10/05

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 2
PRIOR AUTHORIZATION FORM FOR
BREAST RECONSTRUCTION
PAGE 1 OF 3

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Open Periprosthetic Capsulectomy, Periprosthetic Capsulectomy, or Revision of Reconstructed Breast Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

ICD-9-CM Code(s): _____ CPT Code(s): _____

Reconstruction after cancer:

West Virginia Medicaid covers reconstructive breast surgery for those patients who have had surgical procedures for cancer. A pathology report and operative report is necessary for documentation of breast cancer surgery.

If the patient has elected to undergo reconstruction at the time of breast cancer surgery, a separate prior authorization for the reconstructive process is necessary over and above the authorization for the hospital stay. If any part of staged procedures is performed on an outpatient basis, prior authorization is also necessary.

The reconstructive surgeon must list the proposed procedure(s), and any subsequent procedures if the reconstruction is performed in stages. Reconstructive surgery on the opposite breast, if necessary for symmetry, will also be approved when documentation of medical necessity is submitted.

The following procedures are covered:

Reconstruction with tissue expanders and implants
Latissimus flap reconstruction
Nipple areola reconstruction

Nipple tattooing is not covered as this is not considered medically necessary.

Implants:

If placed for reconstruction after cancer surgery is covered. Replacement of breast implants originally placed for reconstruction after cancer is covered with documentation of medical necessity. (i.e., Baker Class III contracture or implant ruptures.)

Removal of ruptured implants and/or Baker Class III placed for any other reason is also covered. **(Removal due to patient anxiety is not covered.)**

Replacement of implants placed for reasons other than post-cancer reconstruction is not covered.

The following should be documented for revision of a reconstructed breast:

Photos are required only in cases when a revision of a reconstructed breast, or the contralateral breast is requested.

Medical condition that necessitates the surgery:

_____ Pain
_____ Asymmetry
_____ Deformity
_____ Ruptured implant
_____ Infection
_____ Malignancy/tumor

Documentation: (Attach to request)

_____ Current original photographs (Only for revision requests and for requests for surgery on contralateral breast)

_____ Preoperative studies
_____ Preoperative diagnosis
_____ Postoperative studies
_____ Postoperative diagnosis
_____ Operative report
_____ Pathology report
_____ History/physical report

Requests for reconstruction for congenital defects are reviewed on a case-by-case basis, and require photos as part of the documentation process.

These procedures must be performed by Board Eligible/Certified Plastic Surgeons. The procedures may be inpatient or outpatient depending on whether other cancer surgery is performed during the same hospitalization. Prior approval for these procedures is necessary over and above the approval for the hospital admission.

_____ _____

Physician Signature Date

WVDHHR/BMS/PA Request01/10/05

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PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 3

PRIOR AUTHORIZATION FORM FOR BREAST REDUCTION

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Breast Reduction Mammoplasty Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

ICD-9-CM Code(s): _____ CPT Code(s): _____

History:

Documentation showing the patient has sought medical attention for any of these conditions must be submitted in support of medical necessity for reduction mammoplasty. (Mark all that apply)

_____ Health problems and/or discomfort related to breast hypertrophy
_____ Postural problems related to breast size (Must be depicted in photo)
_____ Respiratory symptoms related to breast size (Must be documented by need for medications and/or physician/ER visits)
_____ Neurological symptoms related to breast size (e.g., ulnar nerve parasthesia) (Must be documented by EMG and/or neurologic consultation
_____ Refractory skin infections in the inframammary creases (Must be documented by need for medications and/or practitioner visits)

Physical Examination:

_____ Weight _____ Height _____ Bra Size
_____ Right low nipple position (distance of nipple from level of suprasternal notch >21cm)
_____ Left low nipple position (distance of nipple from level of suprasternal notch >21cm)
_____ Right span of distance from inframammary crease to nipple >6.5cm
_____ Left span of distance from inframammary crease to nipple >6.5cm
_____ Right areolar diameter
_____ Left areolar diameter
_____ Refractory candidal rashes beneath breasts
_____ Secondary skeletal effects
_____ Dorsal kyphosis of spine
_____ Supraclavicular bra strap grooves **(Must be shown in photographs. If shoulders are cut off in photographs, the appeal will be returned for lack of documentation of medical necessity.)**
_____ Ulnar nerve compression secondary to descent of coracoid process (Requires documentation by EMG)
_____ Additional information (please attach documentation, if applicable)

Documentation: (Attach to Request)

_____ Copy(ies) of recent mammogram
_____ Current original photographs
_____ Copy(ies) of previous breast operation and pathology reports, if applicable

Other information needed:

(These services can only be performed by Board Certified or Board Eligible Plastic Surgeons.)

_____ Right estimate excess breast tissue weight to be removed
_____ Left estimate excess breast tissue weight to be removed

Will this procedure be performed in an outpatient or inpatient setting? (Circle either inpatient or outpatient)

_____ _____

Physician Signature Date

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PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 4
PRIOR AUTHORIZATION FORM FOR PANNICULECTOMY

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Panniculectomy Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

ICD-9-CM Code(s): _____ CPT Code(s): _____

Documentation must show that the patient has significant dermatologic and musculoskeletal problems as a result of large pannus. Panniculectomy solely to improve appearance is not covered by West Virginia Medicaid.

History:

_____ Ulcers and/or intertrigo under surface of panniculus refractory to treatment for at least six months
_____ Antibiotics/antifungals (type used, length of use, and outcome of use)
_____ Hospitalization for infections
Treatments for back pain (List):
Medications: _____
Therapy: _____
Chiropractic: _____
Functional limitations (List): _____
Other medical conditions (List): _____
_____
_____ Previous abdominal surgery (e.g., gastric by-pass/gastroplasty)

Documentation of the above conditions must be attached to this prior authorization request.

Physical Examination:

_____ Weight _____ Height
_____ Approximate weight of panniculus to be removed
_____ Back exam as affected by pannus
_____ Examination of abdomen

Documentation:

_____ Current photographs taken from the front and side which show the full extent of the pannus, hanging to, at least, the pubic bone

Liposuction is not covered.

Abdominoplasty to cover a rectus diastasis is not covered, as this does not represent a true hernia.

This procedure must be performed by a Board certified/Eligible plastic surgeon or a Board Certified general surgeon with experience performing this procedure. This procedure must be performed as an inpatient procedure; therefore, the patient's admission requires a separate authorization from the procedure's prior approval.

_____ _____

Physician Signature Date

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PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 5
CPT CODES TO REPORT PREGNANCY TERMINATION PROCEDURES
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ICD-9-CM Diagnosis	Description
635.10	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Unspecified
635.11	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Incomplete
635.12	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Complete
635.20	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Unspecified
635.21	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Incomplete
635.22	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Complete
635.30	Legally induced abortion - Complicated by renal failure - Unspecified
635.31	Legally induced abortion - Complicated by renal failure - Incomplete
635.32	Legally induced abortion - Complicated by renal failure - Complete
635.40	Legally induced abortion - Complicated by metabolic disorder - Unspecified
635.41	Legally induced abortion - Complicated by metabolic disorder - Incomplete
635.42	Legally induced abortion - Complicated by metabolic disorder - Complete
635.50	Legally induced abortion - Complicated by shock - Unspecified
635.51	Legally induced abortion - Complicated by shock - Incomplete
635.52	Legally induced abortion - Complicated by shock - Complete
635.60	Legally induced abortion - Complicated by embolism - Unspecified
635.61	Legally induced abortion - Complicated by embolism - Incomplete
635.62	Legally induced abortion - Complicated by embolism - Complete
635.80	Legally induced abortion - With unspecified complication - Unspecified
635.81	Legally induced abortion - With unspecified complication - Incomplete
635.82	Legally induced abortion - With unspecified complication - Complete
635.90	Legally induced abortion - Without mention of complication - Unspecified
635.91	Legally induced abortion - Without mention of complication - Incomplete
635.92	Legally induced abortion - Without mention of complication - Complete

CPT or HCPCS Code	Description
	(Anesthesia)
01964	Anesthesia for abortion procedures
	(Surgery)
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis – injections), including hospital admission and visits, delivery of fetus and secundines;
59851	with dilation and curettage and/or evacuation
59852	with hysterotomy (failed intra-amniotic injection)
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856	with dilation and curettage and/or evacuation
59857	with hysterotomy (failed medical evacuation)
S0190	Mitepristone, oral, 200 mg (Mifoprex 200 mg oral)
S0191	Misoprostol, oral, 200 mcg
S0199	Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drug

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ATTACHMENT 6
CPT CODES TO REPORT STERILIZATION PROCEDURES

ICD-9-CM Diagnosis	Description
V25.2	Sterilization – Admission for interruption of fallopian tubes or vas deferens

CPT Code	Description
	(Anesthesia)
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral/bilateral
	(Surgery)
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during the same hospitalization (separate procedure)
58611	Ligation or transaction of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

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ATTACHMENT 7
CPT CODES TO REPORT HYSTERECTOMIES

ICD-9-CM

Diagnosis

NA

CPT Code	Description
	(Anesthesia)
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy
01962	Anesthesia for urgent hysterectomy following delivery
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
	(Surgery)
51925	Closure of vesicouterine fistula; with hysterectomy
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152	with colpo-urethrocystopexy (e.g., Marshall-Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling with or without removal of tube(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260	Vaginal hysterectomy, for uterus 250 grams or less;
58262	with removal of tube(s) and/or ovary(s)
58263	with removal of tube(s) and/or ovary(s), with repair of enterocele
58267	with colpo-urethrocystoplexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58280	with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)

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ATTACHMENT 8
DIAGNOSTIC & PROCEDURE CODES FOR COVERED FAMILY PLANNING SERVICES

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FAMILY PLANNING
DIAGNOSTIC CODES

ICD 9	DESCRIPTION
V15.7	Hx of Contraception
V25.01	Prescription of Oral Contraceptives
V25.02	Initiate Contraceptive Measure NEC
V25.03	Emergency Contraceptive Counsel/Rx
V25.09	Contraceptive Management NEC
V25.1	Insertion of IUD
V25.2	Sterilization
V25.3	Menstrual Extraction
V25.4	Contraceptive Surveillance
V25.40	Contraceptive Surveillance NOS
V25.41	Contraceptive Surveillance
V25.42	IUD Surveillance
V25.43	Subderm Contraceptive Surveillance
V25.49	Contraceptive Surveillance NEC
V25.5	Subderm Contraceptive Insertion
V25.8	Contraceptive Management NEC
V25.9	Contractive Management NOS
V26.4	Procreative Management Counseling
V26.8	Procreative Management NEC
V26.9	Procreative Management NOS

FAMILY PLANNING
PROCEDURE CODES

CODE	DESCRIPTION
J1051	Medroxyprogesterone Injection
J1055	Medrxyprogester Acetate, 150 mg, Injection
J1056	MA/EC Contraceptive Injection
J7302	Levonorgestrel IU Contracept
11975	Insert Contraceptive Capsules
11976	Remove Contraceptive Capsules
11980	Subcutaneous Hormone Pellet Implant
57170	Fitting of Diaphragm/Cervical Cap
58300	Insert Intrauterine Device (IUD)
58301	Remove Intrauterine Device (IUD)
58615	Occlude Oviduct(s)

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PRACTITIONER SERVICES

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ATTACHMENT 9

APS UTILIZATION MANAGEMENT GUIDELINES (FOR PSYCHIATRIC SERVICES)

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APS UTILIZATION MANAGEMENT GUIDELINES

WEST VIRGINIA

PSYCHIATRIC SERVICES - CPT CODES

VERSION 1.0

APS HEALTHCARE, INC.- WEST VIRGINIA

Service Utilization Management Guidelines

Psychiatric Services – CPT Codes

Table of Contents

Psychiatric Services – CPT Codes

APS Healthcare, Inc.
West Virginia Medicaid ASO

The right consumer

receives the right service

at the right time

from the right provider

at the right intensity

for the right duration

with the right outcome

The purpose of the utilization management system is to assure that the "rights" as listed above are in place for every consumer and to assure consistency in level and duration of treatment and support among service providers and throughout regions.

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services psychiatrists and eligible staff in their practices may provide Medicaid beneficiaries and invoice the WV Bureau for Medical Services for reimbursement. Notice that each service listing provides:

- a definition,
- level of benefit,
- initial authorization limits,
- increments of re-authorization, and
- service exclusions.

In addition, the service listing provides:

- consumer-specific criteria, which discusses the conditions for
  - admission,
  - continuing stay,
  - discharge,
- clinical exclusions, and
- basic documentation requirements.

The elements of these service listings will be the basis for utilization reviews and management by APS Healthcare, Inc. (APS). Additional detail regarding service definitions and documentation requirements can be found in the American Medical Association Current Procedural Terminology (CPT) Manual.

REQUEST FOR PRIOR AUTHORIZATION

APS has developed a tiered system for initial and continuing-stay service authorizations. While most services require the provider submit only minimal information for the initial authorization; others require the provision of more clinical information to establish medical necessity. Continued-stay authorizations most frequently require the additional clinical information be submitted. Admission and continued stay criteria for these services were developed based upon the intensity of the service in question, as consumers are best served when services are tailored to individual needs and are provided in the least restrictive setting.

Status of Request for Prior Authorization

When a prior authorization for service is required, the service provider submits the required information to APS. The provider will be notified if the request is authorized, pended (additional information is needed to make the decision), closed or denied and/or what alternative services may be recommended.

Provider requests for service authorizations failing to meet the medical necessity guidelines are subject to negotiations between the provider and APS. APS strives to assist the provider in developing an appropriate plan of care for each consumer. Typically, the vast majority of discrepancies between the request for service and final status are resolved through discussion and mutual agreement. In the event that a consumer truly does not have a demonstrated behavioral health, or MR/DD diagnosis and/or need that meets the guidelines for care, the request will be denied. In this event, it is the provider's responsibility to share the denial with the consumer and their support system so that alternative arrangements may be made. Please see the APS Provider Manual for additional information regarding the denial process.

MULTIPLE SERVICE PROVIDERS

Each provider is responsible for obtaining authorization for the service(s) they provide an individual. In cases where one provider has already registered or received prior authorization to perform a service and an additional provider(s) attempts to register or request prior authorization that would exceed the client benefit, APS Care Managers will make every effort to determine which provider the consumer chooses to render the service. We are hopeful that providers will continue to coordinate services for consumers to avoid duplication and maximize the therapeutic benefit of interventions.

Note: It is the provider's responsibility to coordinate care and establish internal utilization management processes to ensure consumers meet all medical necessity/service utilization guidelines and to obtain authorization prior to the onset of service when required. In instances where another provider is performing the service requested or the consumer benefit is exhausted, requests will not be authorized.

Medical Necessity

Prior authorization does not guarantee payment for services. Prior authorization is an initial determination that medical necessity requirements are met for the requested service. In the Managed Care position paper, published in 1999, the state of West Virginia introduced the following definition of medical necessity:

"services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided."

The CPT code services rendered by psychiatrists more clearly define the services and criteria utilized to meet parts (1) and (2) of the definition above. In determining the appropriateness and necessity of services for the treatment of specific individuals the

- diagnosis,
- level of functioning,
- clinical symptoms and
- stability and available support system are evaluated.

The current role of the ASO is to devise clinical rules and review processes that evaluate these characteristics of individuals, and ensure that psychiatric services requested are medically necessary and to enforce the policies of the Bureau for Medical Services.

The Utilization Management Guidelines published by APS serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the specific services.

Part (4) of the definition, in the context of CPT code services rendered by psychiatrists, relates to services requested by the consumer that may be helpful but are not medically necessary, as well as to alternative and complementary services not provided by the psychiatrist but to which the consumer may be referred. This portion of the definition prohibits the utilization of treatment codes to provide service that meets a consumer need but does not meet the medical necessity criteria. Prior authorization review will utilize these guidelines as well as specific clinical requirements for the specific service(s) requested.

Part (5) of the definition which refers to the "most appropriate level of care that can be safely provided", in the context of CPT codes used by psychiatrists, relates to the least restrictive type and intensity of service acceptable to meet the consumer's needs while ensuring that the consumer does not represent a direct danger to himself or others in the community.

PRIOR AUTHORIZATION REQUEST TIERED SYSTEM

The information submitted at the ***"Registration"*** tier is brief and is primarily used to track utilization of various services. Significant clinical review of medical necessity and/or clinical appropriateness is not conducted at the registration level. A registration is allowed as long as the consumer has not exhausted the Medicaid benefit for the service requested.

The information submitted at the second tier (Tier 2) through the West Virginia Behavioral Health Care Connection® provides a clinically relevant summary but it alone is not always sufficient documentation of a consumer's medical necessity. For this reason, APS Care Managers may request additional information to make prior authorization decisions for consumers who do not clearly meet the UM guidelines for the service or do not clearly meet medical necessity requirements. The assessment, plan of care and proposed discharge criteria all serve to document the appropriateness and medical necessity of services provided to a consumer.

RETROSPECTIVE REVIEWS

Retrospective reviews may determine that services as planned and documented do not meet the criteria requirements in the Medicaid manual. Through internal utilization management processes, providers need to ensure that medical necessity documentation is complete and consistent throughout the clinical record.

90801 Psychiatric Diagnostic Interview Examination

Definition: Psychiatric diagnostic interview examination by a psychiatrist includes a history, mental status, and a disposition, and may include communication with family or other sources.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration required for 2 sessions/per consumer/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Registration required for additional units after one year by any provider previously utilizing the benefit for the same consumer. 2 sessions/per consumer/ per year Unit= Session/Event 2. Tier 2 data submission required to exceed limit of two (2) units per consumer/per year (consumer benefit is two (2) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Consumer has, or is suspected of having, a behavioral health condition, **-or-** 2. Consumer is entering or reentering the service system, **-or-** 3. Consumer has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Codes 90862 Pharmacologic Management, 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, and 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes, may not be billed *on the same day as* 90801 Psychiatric Diagnostic Interview Examination.
Clinical Exclusions	None
Documentation Requirement	Documentation must include a written record of findings and recommendations from the interview examination. Documentation must be signed (in practices of five (5) practitioners or less, where

	initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

H0031 AJ Mental Health assessment by a non-physician

Definition: Initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual. Specialty evaluations such as occupational therapy, nutritional, and functional skills assessments are included. The administration and scoring of functional skills assessments are included. This code is to be utilized by Master's Level Licensed Social workers or Licensed Professional Counselors working in a psychiatric practice.

Level of Service	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child & Adult (C&A)
Medicaid Option	Psychiatric Services-CPT Codes
Initial Authorization	Registration required for 1 session/per consumer/per year/per provider from start date of initial service Unit= Session/Event
Re-Authorization	1. Registration required for additional units after one year by any provider previously utilizing the benefit for the same consumer. 1 session/per consumer/ per year/per provider Unit= Session/Event 2. Tier 2 data submission required to exceed the limit of four (4) units per consumer/per year (consumer benefit is four (4) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Consumer has, or is suspected of having, a behavioral health condition, **-or-** 2. Consumer is entering or reentering the service system, **-or-** 3. Consumer has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for the consumer's treatment have been substantially met.
Service Exclusions	None

Clinical Exclusions	None
Documentation	Documentation must include a written record of findings and recommendations from the interview examination. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. The assessments are evaluative services and standardized testing instruments.

2. The assessments are administered by qualified staff and are necessary to make determinations concerning the mental, physical and functional status of the consumer.

90862 Pharmacologic Management

Definition: Pharmacologic Management by a psychiatrist including prescription, use and review of medication with no more than minimal medical psychotherapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration required for 12 sessions/per consumer/per 184 days/per provider 12 sessions for 184 days from start date of initial service Unit = Session/Event
Re-Authorization	1. Registration required for additional units after 184 days by any provider previously utilizing the benefit for the same consumer. 12 sessions for 184 days Unit = Session/Event *2.* Tier 2 data submission required to exceed the limit of twelve (12) sessions per consumer/per provider/per 184 days. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units/sessions being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit/session will be granted.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. A psychiatrist has determined the need for and prescribed psychotropic medication.
Continuing Stay Criteria	Consumer continues to meet admission criteria.
Discharge Criteria	Consumer no longer needs medication or refuses this service.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, and 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes may not be billed *on the same day as* 90862 Pharmacologic Management.
Clinical Exclusions	Service excludes intensive medical psychotherapy.
Documentation Requirement	Psychiatrist must complete a note describing the service provided. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

90804 Individual Psychotherapy 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized, depending

	on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90804 AJ Individual Psychotherapy 20-30 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts

	and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90807 Individual Psychotherapy with Medical Evaluation and Management

	Services 45-50 minutes, may not be billed *on the same day as* 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes. This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90806 Individual Psychotherapy 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/ per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g. 15, 20 etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in

	the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment needs. 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

2.

1. Physician Assistant may also perform this service.

Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90806 AJ Individual Psychotherapy 45-50 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes

Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis (other than a V-code) which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90805 Individual

	Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, may not be billed *on the same day as* 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes. This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90846 Family Psychotherapy (without patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed limit of ten additional units/per consumer/per year. This level of data is required to exceed authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*90846 Family Psychotherapy (without patient present) has a combined service limit with 90847 Family Psychotherapy (with patient present) of 10 units/per consumer/per year.*
Clinical Exclusions	1. There is no outlook for improvement with this level of service.

	2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.

2. ***Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.***

90847 Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*90847 FAMILY PSYCHOTHERAPY (WITH PATIENT PRESENT) HAS A COMBINED SERVICE LIMIT WITH 90846 FAMILY PSYCHOTHERAPY (WITHOUT PATIENT PRESENT) OF 10 UNITS/PER CONSUMER/PER YEAR.*

Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not “stand-alone” interventions.

90847 AJ Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*NONE.*
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.

Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 Group Psychotherapy 75-80 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual consumers. This code may not be utilized for multiple family group therapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 75-80 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/ per year Unit = 75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
ADMISSION CRITERIA	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.

Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 AJ Group Psychotherapy 75-80 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual consumers. This code may not be utilized for multiple family group therapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = session/75-80 minutes
Re-Authorization	2. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/ per year Unit = session/75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. Additionally, the need for additional units must be described in the free-text field.

ADMISSION CRITERIA	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90875 Individual Psychotherapy Biofeedback 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes

	NOTE: Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Psychiatrist, Physician Assistant or other qualified professional billing this code must have specific training in biofeedback techniques.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90876 Individual Psychotherapy Biofeedback 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must

	be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Psychiatrist, Physician Assistant or other qualified professional billing this code must have specific training in biofeedback techniques.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90899 Special Evaluation Services

Definition: Provision of special evaluation services especially those ordered by the court. Services must relate to a consumer's known or suspected behavioral health condition, symptoms or functional impairments and must be either court ordered or specifically requested by Child Protective Services, Adult Protective Services, or Youth Services for purposes related to treatment planning, permanency planning, possible court action and/or removal from the current living situation **and** to make recommendations related to interventions or services that will ameliorate the client's symptoms and/or improve current functioning. Special Evaluation Services include substance abuse evaluation, forensic and/or competency evaluation, sexual victim or perpetrator evaluation or domestic violence/child abuse evaluation (other than sexual abuse). The evaluator must have specific training and expertise in the area of specialty evaluation and evaluation activities must include two (2) or more of the following activities to be considered a special evaluation service: specialized testing or screening relevant to the specialty area (including interpretation of findings), ancillary or collateral interviews, extensive record review or review of court testimony/police reports, special interviewing techniques or videotape review. Documentation must include interpretation and scoring of any testing and a written report of findings and recommendations.

Service Tier	Tier 2 Prior Authorization
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Tier 2 Prior Authorization required 1 evaluation/per consumer/per year Unit = 1 hour The number of units requested should be included in the free text field. Units will be approved based on reasonable and customary times and rates for comparable evaluations. Unique circumstances that justify units above reasonable and customary should be noted in the free text field.
Re-Authorization	Tier 2 data submission is required for additional units within one-year of the start date of the authorized Special Evaluation by any provider for the same consumer. 1 evaluation/per consumer/per year Unit = 1 hour The number of units requested should be included in the free text field. Units will be approved based on reasonable and customary times and rates for comparable evaluations. Unique circumstances that justify units above reasonable and customary should be noted in the free text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services or a suspected behavioral health condition that requires special evaluation, **- and-**

	2. Consumer requires evaluation for a specific purpose (which is identified and documented), **-and/or-** 3. Evaluation is required to make specific recommendations regarding specialized treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the consumer's progress to the court.
Discharge Criteria	Consumer has withdrawn or been discharged from service.
Service Exclusions	90801 Psychiatric Diagnostic Interview by a Psychologist may not be billed on the same day as 90899. 96100 Comprehensive Evaluation by a Psychologist; 96110 Developmental Testing: Limited; 96111 Developmental Testing: Extended; 96115 Neurobehavioral Status Exam; and 96117 Neuropsychological Testing Battery may not be billed by the psychiatrist during the period 90899 is authorized but referrals may be made to psychologists to provide testing. Requests for authorizations by psychologists for these services will pend if a psychiatrist has authorization for 90899 and will be authorized on a case-by-case basis.
Clinical Exclusions	None.
Documentation Requirement	Documentation must include scoring and/or interpretation of testing, assessments and screenings administered and a written report of findings and recommendations. Documentation must be signed (including the credentials of the individual performing the service) and dated (date of service).

Additional Service Criteria:

1. Service must be provided by a Psychiatrist with specific training and expertise in the type of special evaluation requested;

2. The number of units requested should be based on reasonable and customary evaluations of a similar type **and** the activities required to complete the special evaluation for the specific client.

3. The designated start date will be the service start date and the end date of the request will be negotiated between the provider and the APS Care Manager but will be no more than 45 days from the designated start date.

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ATTACHMENT 10

DIABETES EDUCATION PROVIDER TOOL
PAGE 1 OF 2

Diabetes Education Provider Tool

This tool is based on the "National Standards for Diabetes Self-Management Education" and indicates minimum services to be provided in the continuing care of people with diabetes. It is not intended to replace or preclude clinical judgment or more intensive management where medically indicated. Use it as a reminder to simplify record keeping and as a way to continually improve care to all patients with diabetes.

DEMOGRAPHIC INFORMATION		
Patient Name:		
DOB:	Type of Diabetes: 1 2 GDM (circle one)	Year of Diagnosis:

DIABETES EDUCATION NEEDS	DATE OF VISIT					
Diabetes Disease Process						
Medical Nutrition Therapy						
Physical Activity						
Medication Therapy						
Monitoring						
Acute Complications						
Risk Reduction						
Goal Setting/Problem Solving						
Psychosocial Issues						
Preconception/Pregnancy						
Other Education Needs						

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PRACTITIONER SERVICES
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ATTACHMENT 11
DIABETES MANAGING PROVIDER CARE TOOL
PAGE 1 OF 2

Diabetes Managing Provider Care Tool
(MDs, DOs, FMPs, PNPs)

This tool is based on the 2004 American Diabetes Associations "Clinical Practice Recommendations 2004" and indicates minimum services to be provided in the continuing (initial visits have additional components) care of adults with diabetes. It is not intended to replace or preclude clinical judgment or more intensive management where medically indicated. Use it as a reminder for exams or important tests to simplify record keeping and as a way to continually improve care to all patients with diabetes.

DEMOGRAPHIC INFORMATION		
Patient Name:		
DOB:	Type of Diabetes: 1 2 GDM (circle one)	Year of Diagnosis:
Height	Smoker: YES NO (circle one)	Pneumococcal Vaccine Date (s):

CLINICAL INFORMATION	DATE OF VISIT					
Every Visit						
Weight						
B/P **Goal <130/80**						
A1c (every 3-6 mo.) **Goal: <7%**						
Foot Exam (Visual)						
Annually						
Foot Exam: Sensation, foot structure/biomechanics, vascular, and skin integrity						
Fasting Lipid Profile: • Total Cholesterol **Goal <200**						
• LDL **Goal <100**						
• HDL **Goal: Men >40 Women >50**						
• Triglycerides **Goal <150**						
Microalbumin **Goal: <30**						
Dilated Eye Exam **Referral Date**						
Flu Vaccine						
Counseling						
Self-Management Education **Referral Date**						
Exercise/Physical Activity						
Medical Nutrition Therapy **Referral Date**						
Nephrology **Referral Date**						
Behavioral Health **Referral Date**						
Tobacco Cessation						
Preconception Counseling (women of childbearing age)						
Other						
Review Self-Monitoring Glucose Log						
Assess Need for Aspirin Therapy						
Assess Need for Statin Therapy						

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PRACTITIONER SERVICES

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ATTACHMENT 12
RESPONSIBILITIES FOR LICENSED PRACTITIONER TO GET EXTENDED OFFICE VISIT MEDICAID REIMBURSEMENT
PAGE 1 OF 2

Responsibilities for Licensed Practitioner to get Extended Office Visit Medicaid Reimbursement

A. The provider or a member of the staff (RN, NP, PA, or LPN) must attend a Medicaid/Public Health Session **or receive equivalent training.**

B. Document that a diabetes instructional session of the provider's staff has taken place in the provider's office. (i.e. held a meeting in the practice and reviewed the DSM/Preventive Service manual with the staff, or used the CD ROM [Quick Tips] in the packet to educate the staff to the new diabetes information.)

C. Institute and complete the Flow sheet for each Medicaid patient with diabetes. The sheet includes:

1. Blood Pressure
2. HbA1c
3. Lipid Profile
4. Fasting/random blood glucose
5. EKG
6. Urinalysis
7. 24 hour urine or Microalbuminuria
8. Lytes, H&H, WBC, BUN, Creatinine
9. Aspirin as prevention
10. Immunizations (flu/pneumococcal)
11. Weight
12. Foot Exam
13. Eye referral
14. Nutrition Counseling

D. Complete a Diabetes Assessment (including exercise) and Plan for each **patient (A copy of this assessment is sent with a written referral to the Certified Diabetes Educator)**.

E. Provide written referral for nutrition counseling to **a certified diabetes educator (CDE)**.

F. **A written referral is sent by the provider to a diabetes educator indicating the material to be taught. The provider is responsible for survival skill information for diabetes:**

1. Medication administration with signs and symptoms of adverse effects
2. Monitoring: Glucose & Urine testing for ketones. Ketone testing for type 1 and illness in type
3. What to do in the event of Hypo/Hyperglycemia & sick day management
4. Foot care
5. Exercise Plan
6. Advanced level education: **Acute and chronic complications include** impotence, cardiovascular, nephropathy, neuropathy, pre-pregnancy counseling, pregnancy counseling , gestational diabetes

G. A written individualized diabetes plan of care is given to each patient b**y** the provider. The plan includes meal plan, exercise, medication, monitoring and goal for blood glucose.

H. The Certified Diabetes Educator will send a written report of the items taught and recommendations back to the Provider for review.

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ATTACHMENT 13
DIAGNOSTIC CODES COVERED FOR BONE DENSITY SCANS

Diagnostic Code	Description
242.90-91	Thyrotoxicosis
252.0	Hyperparathyroidism
255.0	Cushing's Syndrome
256.2, 627.2, 627.8	Estrogen deficient states
256.31-256.39	Other ovarian failure
259.3	Ectopic hyperparathyroidism
259.9	Other endocrine disorder, estrogen/testosterone deficiency
268.0-268.9	Osteomalacia, rickets, vitamin D deficiency
275.41	Hypocalcemia
626.0	Absence of menstruation
627.0-627.9	Menopausal disorders
733.00-733.09	Osteoporosis
733.11-733.16	Pathologic fractures
733.90	Disorder of bone and cartilage, unspecified
733.13	Pathologic fracture of vertebrae
756.51	Osteogenesis imperfecta
756.83	Ehlers-Danlos Syndrome
758.6	Gonadal dysgenesis, Turner's Syndrome
759.82	Marfan's Syndrome
805.00-805.9	Fracture of vertebral column, without spinal cord injury
806.00-806.9	Fracture of vertebral column with spinal cord injury
962.0, 995.2	Long-term use of glucocorticoid drugs
E932.0	Drugs causing adverse effects in therapeutic use
V49.81	Post menopausal status
V58.69	Long-term use (current) of other medications
V67.51	Following treatment with high-risk meds, monitoring for response to osteoporosis therapy
V67.59	Following other treatment, for monitoring ongoing therapy for osteoporosis

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ATTACHMENT 14

INSTRUCTIONS FOR COMPLETING THE CMS 1500 CLAIM FORM
PAGE 1 OF 7

Item 1a. Insured's ID Number

Enter the member's 11 digit identification number (no letters) assigned by the WV DHHR for Medicaid members. The Medical Card may indicate an "M" for Medicare or "P" for private insurance. This is NOT part of the Member I.D. Number.

Item 2. Member's Name

Enter the patent's last name, first name and middle initial.

Item 3. Member's Birth Date and Gender

Indicate the member's date of birth and whether male or female.

Item 4. Insured's Name

Enter the insured's name as listed on the Medicaid (Medical) Card.

Item 5. Member's Address

Enter the member's address in full.

Item 6. Member's Relationship to the Insured

Check "self."

Item 7. Insured's Address

Enter the current address of the member.

Item 8. Member's Status

Not required for Medicaid.

Item 9. Other Insured's Name

Enter policyholder's name if insurance other than Medicaid is covering this member. If no insurance, go to Block 10.

Medicaid is the payer of last resort program. Medicare and all other payers must be billed before Medicaid is billed.

Item 9a. Other Insured's Policy or Group Number

Enter policy or group number of the insurance policy.

Item 9b. Other Insured's Date of Birth

Enter the policyholder's date of birth and gender.

Item 9c. Employer's Name or School Name

Enter the name of the employer through which the policy is held.

Item 9d. Insurance Plan Name or Program Name

Enter the name of the insurance plan or program other than Medicaid.

Item 10. Member's Condition Related to Employment, Auto Accident or Other Accident

If treatment was due to accidental injury, auto accident or was employment-related, enter an "X" in the proper block.

Item 11. Insured's Group Number or FECA Number

Item 11a-11d. Enter insurance information other than listed in Block 9a - 9d.

Item 12. Member's Signature

Not required for Medicaid.

Item 13. Insured's Signature

Not required for Medicaid.

Item 14. Date of Current Illness, Injury and/or Pregnancy

Indicate the date of onset of current illness, injury, or pregnancy.

Item 15. Previous Date of Same or Similar Illness

Indicate the date of initial treatment for the same or similar condition, if known.

Item 16. Dates Member Unable to Work

Desired, but not required.

Item 17. Name of Referring Physician or Other Source

Enter the referring physician's name.

Item 17a. I.D. Number of Referring Physician

Enter the referring physician's UPIN, NPI or Medicaid Provider Number. Leave blank if the member was not referred for treatment.

Item 18. Hospitalization Dates

Admission and discharge dates, if known.

Item 19. Reserved for Local Use

Enter the 10 digit PAAS approval number, if applicable.

Item 20. Outside Lab

Not required for Medicaid.

Item 21. Diagnosis Code

Enter up to four ICD-9-CM diagnosis codes in priority order (primary, secondary, etc.).

The claim will be denied if there is no diagnosis code.

Diagnosis and procedure codes must be consistent.

Item 22. Medicaid Resubmission Code/Original Reference Number

If this is an adjustment for a previous claim, enter the TCN of the original claim.

Item 23. Prior Authorization Number

Enter the 10 digit prior authorization number if applicable for the claim. The claim must be split if more than one prior authorization applies.

Item 24A. Service Period

Enter the date(s) of service in the block (MM, DD, YY).

Item 24B. Place of Service

Enter the appropriate place of service code from the codes listed below.

CODE	Place of Service
11	Office
12	Member’s Home
21	Hospital - Inpatient
22	Hospital - Outpatient
23	Hospital - Emergency Department
24	Ambulatory Surgical Center (ASC)
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility

33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air-Water)
51	Psychiatric Facility - Inpatient
52	Psychiatric Facility - Outpatient
53	Community Mental Health Center (CMHC)
54	Intermediate Care Facility
55	Residential Substance Abuse Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic (RHC)
81	Independent Lab
99	Other Unlisted Facility

Item 24C. Type of Service - Defaults to 1 for CMS Services

Item 24D. Procedure Codes

Enter the five-digit code that describes the procedure performed on the date of service. The code will be a CPT-4 (Level I), HCPCS (Level II) or State-Specific (Level III) code.

If service provided requires a modifier, enter up to three modifiers in the spaces provided after the procedure code. If more than three modifiers apply, enter Modifier 99 first.

Two lines on the CMS-1500 cannot be billed with same information. One line will deny as a duplicate.

Procedure code and diagnosis code must match.

Item 24E. Diagnosis Code

Enter the diagnosis code reference numbers from locator 21 (maximum 4). Only specific reference numbers (1, 2, 3, 4) will be accepted.

Item 24F. Charges

Enter the <u>total</u> charges for the procedure code billed on each line.

Item 24G. Days or Units

Enter the number of times the procedure for which you are billing was performed.

For general anesthesia, show the elapsed time in units in Item 24G. Each 15 minutes equals one unit. <u>Base units are programmed in the system and are not to be entered on the claim form</u>. Do NOT bill in minutes.

Item 24H. EPSDT/Family Planning for Providers Participating in EPSDT and Family Planning Programs Only

Valid values include:
Spaces = not applicable
1 = Full screen, with referral
2 = Full screen, no referral
3 = Partial screen, with referral
4 = Partial screen, no referral

5 = Family planning, physician
6 = Family planning, mid-level
7 = Family planning, nurse

Item 24J. Coordination of Benefits (COB)

Indicate whether or not the member has other health coverage. Enter "1" if no other insurance; enter “2" if Medicare; enter "3" if there is any other health insurance.

Item 24K. Reserve for Local Use

Indicate any amounts paid toward these charges by other insurance, or member. If other insurance, attach “Explanation of Benefits” if (1) insurance denied the claim or (2) the insurance company billed is not listed on the medical card or is not the same as the one listed.

Item 25. Federal Tax I.D. Number

Enter Federal Tax I.D. Number.

Item 26. Member’s Account Number

Enter your member account number. Alpha and numeric characters may be used (maximum of 20). It is especially useful in locating files if the case number is incorrect, not on file, all zero numbers, etc. This information will appear on the remittance voucher. If using member's name: Last name first.

Item 27. Accept Assignment

Billing Medicaid indicates acceptance of assignment. (In order for Medicaid to pay the co-insurance and/or deductible owed, assignment must be accepted for Medicare members.)

Item 28. Total Charge

Enter total charge for the claim.

Item 29. Amount Paid

Enter total amount paid by other insurance.

Item 30. Balance Due

Not required for Medicaid.

Item 31. Signature of Physician or Supplier

Signature of person authorized to certify this claim. By signing the BMS Provider Enrollment Agreement (included in the Enrollment/Re-enrollment Packet) you have certified all information listed on a claim for reimbursement from Medicaid is true, accurate, and complete. Therefore, you may endorse your claim with a computer-generated, manual, or stamped signature.

Item 32. Name and Address of Facility Where Services Were Rendered

Enter the name and address of the facility, if a member was in an institutional setting (i.e., hospital, nursing home, etc.).

Item 33. Physician or Supplier Name, Address, Zip Code, Provider Number and Phone Number

Enter name, address, and Medicaid 10 digit provider number.

GRP # (Group Number)

Enter the 10 digit Medicaid group pay to provider number, if applicable.

STATUS CODES

A Active code: These are covered services for which payment is made using Medicaid's

physician fee schedule. Services with “relative value units” covered by Medicaid have an "A" status.

B Bundled code: Payment for covered services is bundled into payment for other unspecified services. Separate payment for the provision of these services is never made.

C Carrier-priced procedure code: Medicaid will establish the “relative value units” services considered unlisted CPT procedure codes, CPT codes that end in "99", and for services for which CMS has not established “relative value units”, typically low-volume services. The "C" is also used to indicate services typically covered by Medicaid, but for which there are no “relative value units” in Medicaid's database.

P Bundled and non-incident services: there are two instances in which no fee schedule payment is made for a covered service, but instead payment for the particular service is bundled into the payment for another covered service. The first instance occurs when a service is considered as incident to a physician service and is furnished on the same date of service, such as the provision of an elastic bandage. Payment for the service is considered bundled into the second service’s payment. The second instance occurs when a service is not considered “incident” to a physician service, such as the provision of colostomy supplies. In this latter case, payment for the service is made under other provisions.

T Injections and other minor services: There services are only paid if there are no other services payable and billed on the same date by the same provider. Services the same provider bills on the same date are bundled into the service for which separate payment is made.

Global Surgery Indicators

The WV Medicaid Program adopted Medicare's pre-operative and post-operative global surgical package windows for surgeries. During these global surgery periods, payment for office visits associated with the surgical procedure will not be made. The Global Indicator Variable indicates the post-operative period.

CODE	EXPLANATION
MMM	Global surgery period does not apply; maternity code
XXX	Global surgery period concept does not apply
YYY	Global surgery period determined by carrier
ZZZ	Code falls within global surgery period for another service
90	Global surgery period includes day before, day of, and 90 days after surgical procedure.
10	Global surgery period includes day of and 10 days after surgery
0	Global surgery period includes day of procedure only.

Payment Policy Indicators

Multiple Surgeries

A "Y" indicates these services may be billed as multiple procedures.

Bilateral Surgery

A "Y" indicates these services may be billed as bilateral procedures. When billing Modifier 50, use "1" in "Days or Units", Block 24G.

Assistant at Surgery

A "Y" indicates payment may be made for assistants at surgery, if medically necessary.

A “D” indicates payment may be made for assistant at surgery if documentation supports medical necessity.

Co-surgeons

A "Y" indicates physicians may bill as co-surgeons for the service, with or without supporting documentation depending on the procedure.

A “D” indicates physicians may bill as co-surgeons with supporting documentation to be reviewed for medical necessity.

Team Surgery

A "Y" indicates physicians may bill as team surgeons for this service, with supporting documentation depending on the procedure.

A “D” indicates physicians may bill as team surgeons for this service with supporting documentation to substantiate medical necessity.

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ATTACHMENT 15
APPROVED HCPCS J CODES
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West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0120	Injection tetracycline up to 250mg	Achromycin Sumycin Panmycin	Antibiotic	None	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0128	Injection abarelix 10mg	Plenaxis	Gonado-tropin	68158-0149-51	None	X	X												New code 1/1/05. Maximum dosage 100 mg on days 1, 15 & 29, then maximum 100 mg every 4 weeks thereafter. ICD-9-CM 185 required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0130	Injection abciximab 10mg	ReoPro	Antiplatelet	00002-7140-01															Not Covered
J0135	Injection adalimumab 20mg	Humira	Antirheu-matic	00074-3799-02															Not Covered
J0150	Injection adenosine 6mg	Adenocard	Antiarrhy-thmic	54569-3745-00															Not covered
J0152	Injection adenosine for diag. use 30mg	Adenocard	Diagnostic agent	00469-0871-20 00469-0871-30	None	X	X									X			Replaces J0151. **Use only for stress testing**. Separate billing when test provided in physician's office or IDTF. Adults only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0170	Injection adrenalin epi-nephprine up to 1ml	Adrenalin Chloride, SusPhrine	Respiratory	54868-1363-00' 54868-2065-00' 54868-2065-01 61570-0418-81	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0180	Injection agalsidase beta 1mg	Fabrazyme	Enzyme	58468-0040-01 58468-0041-01	None	X	X											X	New code 1/1/05. **Requires Prior Authorization for children 16<years of age.** Submit copies of physician's medical records, specialist's medical records (as appropriate), member's weight, signs and symptoms and diagnostic test results to confirm diagnosis of ICD-9-CM code 272.7 to BMS Medical Director. Children 16> years of age, do not require prior authorization. ICD-9-CM Code 272.7 must be documented on the CMS 1500 claim form when submitting to Unisys for payment consideration.. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0190	Injection biperiden lactate 5mg	Akineton		None	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0200	Injection alatroflaxacin mesylate 100mg	Trovan Trova-floxacin	Antibiotic	'00049-3890-28 '00049-3900-28															Not Covered
J0205	Injection alglucerase 10U	Ceredase	Enzyme	58468-1060-01	None	X	X												ICD-9-CM code 272.7 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.

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Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0207	Injection amifostine 500mg	Ethyol	Antineo-plastic	'58178-0017-01 '58178-0017-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0210	Injection methyldopate HCl up to 250mg	Aldomet Aldoril	Antihyper-tensive	00517-8905-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0215	Injection alefacept 0.5mg	Amevive	Monoclonal Antibody	59627-0020-01 59627-0021-03	see Special Instruc-tions	X	X												30 units per week X 12 weeks in a 6 month period per lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0256	Injection alpha 1 protein-ase inhibitor human 10mg	Prolastin	Alpha anti-tripsin I deficiency	00026-0601-30 '00026-0601-35 '49669-5800-01 '49669-5800-02	8 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J0270	Injection alprostadil 1.25mcg	Prostin VR Pediatric	Prostaglan-din	00009-3169-06 '00703-1501-02 '55390-0503-10 '55390-0506-05 '55390-0506-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0275	Alprostadil urethral suppository	Muse	Prostaglan-din	62541-0110-01 '62541-0110-06															Not Covered
J0280	Injection aminophyllin up to 250mg	Phyllocontin	Broncho-dilator	00074-7385-01 '00223-7128-02 '00223-7128-10 '00223-7130-00 '00223-7130-10 '54868-0004-00	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0282	Injection amiodarone HCl 30 mg	Cordarone	Antiarrhy-thmic	00008-0814-01 '10019-0131-01 '55390-0057-01 '55390-0058-10 '60505-0722-00 '61703-0241-03 '63323-0616-03 '63323-0616-13															Not Covered
J0285	Injection amphotericinB 50mg		Antibiotic	00003-0437-30 '00013-1405-44 '00703-9785-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0287	Injection amphotericinB lipid complex 10mg		Antibiotic	61799-0101-31 '61799-0101-41	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0288	Injection amphotericinB cholesteryl sulfate com-plex 10mg	Amphotec	Antibiotic	61471-0110-12 '61471-0115-12	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0289	Injection amphotericinB liposome 10mg.	Ambisome	Antibiotic	00469-3051-30	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0290	Injection ampicillin sodi-um 500mg.	Totacillin-N Omnipen-N	Antibiotic	00015-7403-20 '00015-7403-99 '54868-4047-00 '55045-1204-03 '55045-1204-09 '63323-0388-10	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0295	Injection ampicilllin sodi-um sulbactam sodium 1.5g	Unasyn	Antibiotic	00049-0013-83 '59911-5901-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0300	Injection amobarbital up to 125mg.	Amytal	Anticonvul-ant	63304-0303-10 '63304-0303-25	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0330	Injection succinylcholine chloride up to 20mg.	Anectine Quelicin Sucostrin	Neuromus-cular blocker	00052-0445-10 54868-4380-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0350	Injection anistreplase 30U	Eminase		None															Not Covered
J0360	Injection hydralazine HCl up to 20mg	Apresoline	Antihyper-tensive	00517-0901-25 '63323-0614-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0380	Injection metaraminol bitartrate 10mg	Aramine	Adrenergic agonist	00006-3222-10 '54868-3692-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0390	Injection chloroquine HCl up to 250mg	Aralen	Antiinfec-tive	00024-0074-01															Not Covered
J0395	Injection arbutamine HCl 1 mg	GenESA		00703-1105-01	None	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J0456	Injection azithromycin 500 mg.	Zithromax	Antibiotic	00069-3150-14 '00069-3150-83 '54868-4527-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0460	Injection atropine sulfate up to 0.3mg	AtroPen	Antichole-nergic	00074-7897-15 '00517-0805-25	3 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0470	Injection dimercaprol 100 mg.	BAL in oil	Antidote	11098-0526-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0475	Injection baclofen 10mg	Lioresal	Skeletal muscle relaxant	58281-0560-01 58281-0561-02 '58281-0561-04	4 per day	X	X										X		A4220 bundled into refill/maintenance services. ICD-9-CM 342.1, 343.0 - 344.9, 345.60 - 345.61, 434.91, or 781.0 must be documented on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0476	Injection baclofen 50mg	Lioresal for intrathecal trial	Skeletal muscle relaxant	58281-0562-01	1 per year	X	X										X		For intrathecal trial only. Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0500	Injection dicyclomine HCl up to 20mg	Bentyl Antispas Dilomine Dibent DiSpaz Neoquess	Anticholenergic	00068-0809-23	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0515	Injection benztropine mesylate 1mg	Cogentin	Anticholenergic	00006-3275-16 '00006-3275-38 '54868-2429-01	None	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J0520	Injection bethanechol chloride up to 5mg	Urecholine Mytonachol	Cholenergic	00006-7786-29	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0530	Injection penicillinG benzathine & penicillinG procaine up to 600K U	Bicillin CR	Antibiotic	61570-0139-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0540	Injection penicillinG benzathine & penicillinG procaine up to 1.2m U	Bicillin CR	Antibiotic	61570-0140-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0550	Injection penicillinG benzathine & penicillinG procaine up to 2.4m U	Bicillin CR	Antibiotic	61570-0142-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0560	Injection penicillinG benzathine up to 600K U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0570	Injection penicillinG benzathine up to 1.2m U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0580	Injection pennicillinG benzathine up to 2.4m U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0583	Injection bivalirudin 1mg	Angiomax	Anticoagulant	65293-0001-01	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0585	Botulinum toxin type A per unit.	Botox	Neuromus-cular blocker	00023-1145-01 '54868-4123-00	None	X	X											X	**Requires Prior Authorization.** Submit documentation of diagnostic treatment plan, failed therapies, adjunctive/concurrent therapies to BMS Medical Director for review prior to providing services. **Not covered for headache or cosmesis**. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0587	Botulinum toxin type B per 100 U	Myobloc	Neuromus-cular blocker	59075-0710-10 59075-0711-10 '59075-0712-10	None	X	X											X	**Requires Prior Authorization** Submit documentation of diagnostic treatment plan, failed therapies, adjunctive/concurrent therapies to BMS Medical Director for review prior to providing services. **Not covered for headache or cosmesis.** Medical necessity documentation of services provided must be maintained in the member's individual file.
J0592	Injection buprenorphine HCl 0.1mg	Buprenix	Analgesic narcotic	12496-0757-01	6 per day														Close code effective 7/1/05.
J0595	Injection butorphanol tartrate 1mg	Stadol	Analgesic narcotic	00015-5645-15 00015-5645-20 10019-0461-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0600	Injection edetate calcium disodium up to 1000mg.	Calcium Disodium Versenate, Calcium EDTA	Antidote	00089-0510-06	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J0610	Injection calcium gluco-nate 10ml	Kaleinate	Electrolyte Supplement	00223-7280-00 '00223-7280-10	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0620	Injection calcium glycer-ophosphate & calcium lactate 10ml	Calphosan	Electrolyte Supplement	00516-0060-60	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0630	Injection calcitonin sal-mon up to 400 U	Miacalcin Caalcimar	Antidote	00078-0149-23	1 per day	X	X												Not covered effective 7/1/05
J0636	Injection calcitrol 0.1mcg	Calcijex	Vitamin fat soluble	00074-8110-31 63323-0731-01 '66591-0315-12	30 per day	X	X												Not covered effective 7/1/05
J0637	Injection caspofungin acetate 5mg	Cancidas	Antifungal	00006-3822-10 '00006-3823-10	14 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0640	Injection Leucovorin calcium 50mg	Wellcovorin	Antidote	55390-0051-10	25 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0670	Injection mepivacine HCL 10ml.	Carbocaine Polocaine Isocaine HCL	Local Anesthetic	00074-1038-50' 00074-2047-50 '00186-0410-01 '00186-0420-01 '54569-4782-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0690	Injection cefazolin sodium 500mg.	Ancef Kefzol Zolicef	Antibiotic	00015-7338-99 '54569-4431-00	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0692	Injection cefepime HCL 500mg	Maxipime	Antibiotic	00003-7731-99 '51479-0053-01 '51479-0053-10	8 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0694	Injection cefoxitin sodium 1g	Mefoxin	Antibiotic	00006-3356-45 '59911-5963-02	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0696	Injection ceftriaxone sodium 250mg	Rocephin	Antibiotic	00004-1962-01 '00004-1962-01 '00004-1962-02 '00004-1962-02 '54868-0934-00 '54868-0934-00 '58016-9453-01 '58016-9453-01	8 per day	X	X	X	X								X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0697	Injection sterile cefurox-ime sodium 750mg	Kefurox Zinacef	Antibiotic	00002-5357-25 '00002-7271-01 '00002-7271-25 '00002-8994-25 '00173-0352-31 '00781-3918-96	2 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0698	Cefotaxime sodium per g	Claforan	Antibiotic	00039-0018-10 '00039-0018-25 '00039-0018-50 '54868-3429-00 54868-3429-01 '63323-0331-15	1 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0702	Injection betamethasone acetate & betametha-sone sodium phosphate 3mg	Celestone	Antiinflam-matory	00085-0566-05 '54868-0206-00 '58016-9191-01	9 per day	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J0704	Injection bemethasone sodium phosphate 4mg.	Celestone Phosphate Betameth Cel-U-Jec Selestoject	Antiinflam-matory	00223-7265-05	2 per day	X	X	X	X			X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J0706	Injection caffeine citrate 5 mg	Cafcit		00597-0060-11 '00597-0061-11	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0710	Injection cephapirin sodium up to 1g	Cefadyl		None	1 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0713	Injection ceftazidime 500 mg	Fortaz Tazidime	Antibiotic	00173-0377-31 '00173-0377-31															Not Covered
J0715	Injection ceftizoxime sodium 500 mg	Ceflzox	Antibiotic	00469-7251-01 '00469-7253-02 '00469-7255-10	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0720	Injection chloramphenicol sodium succinate up to 1 g	Chloromycetin Sodium Succinate	Antibiotic	61570-0405-71	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0725	Injection, chorionic gonadotropin per 1000 USP units	Novarel Profasi Pregnyl	Gonado-tropin	00052-0315-10 '00223-7760-10 '00223-7770-10 44087-8010-03 '52637-0126-10 '54569-1986-00 '54868-3910-00 '55566-1501-01 '63323-0025-10	5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0735	Injection clonidine HCl 1mg	Catapres	Alpha Adrenergic Agonist	00054-8233-01 '00054-8234-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0740	Injection cidofovir 375mg	Vistide	Antiviral	61958-0101-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0743	Injection cilastatin sodium imipenem 250 mg.	Primaxin	Antiinfec-tive	00006-3514-58	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0744	Injection ciprofloxacin for IV infusion 200mg	Cipro Ciloxan	Antibiotic	00026-8527-36 '00026-8552-36 '00026-8562-20	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0745	Injection codeine phos-phate 30mg		Analgesic-narcotic	00074-1102-02 '00074-1102-32	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0760	Injection colchicine 1mg		Antigout	55390-0605-02	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0770	Injection colistimethate sodium up to 150mg.	Coly-Mycin M	Antibiotic	39822-0615-01 '61570-0414-51	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0780	Injection prochlorperazine up to 10mg	Compazine Compa-Z Contrazine	Antiemetic	00641-0491-25 '54868-0261-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0800	Injection cotricotropin up to 40U	Cortrosyn ACTH Acthar	Diagnostic agent	63004-7731-01	None		X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0835	Injection cosyntropin 0.25mg	Cortosyn	Diagnostic agent	00548-5900-00	3 per day		X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0850	Injection cytomegalovirus immune globulin IV (human) per vial	CytoGam	Immune globulin	60574-3101-01															Not covered. Refer to CPT 90291
J0878	Injection daptomycin 1mg.	Cubicin	Antibiotic	67919-0011-01	4 per day X 14 days	X	X												New code 1/1/05. Maximum dose 4mg per day X 14 days. Adults only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0880	Injection darbepoetin alfa 5mcg	Aranesp	Anti-anemic	55513-0010-01 '55513-0011-01 '55513-0011-04 '55513-0012-01 '55513-0012-04 '55513-0013-01 '55513-0013-04 '55513-0014-01 '55513-0014-04 "55513-0015-01 '55513-0054-01 55513-0054-04	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0895	Injection deferoxamine mesylate 500mg	Desferal	Antidote	00083-3801-04	12 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0900	Injection testosterone enanthate & estradiol valerate up to 1cc	Andro-Estro 90-4 Androgyn LA	Androgen	00314-0786-70	1 every 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0945	Injection brompherina-mine maleate10mg	ND Stat		52637-0926-10	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0970	Injection estradiol valerate up to 40mg	Delestrogen Estradiol LA Valergen Estra-L	Contracep-tive	00223-7607-10 '00314-0784-70 '54569-1394-00 '55553-0244-10 '61570-0182-01	1 every 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1000	Injection depoestradiol cyplonate up to 5mg	Estradiol Cypionate Estra-D Estra-Cyp Estro-LA	Hormonal Replace-ment	00009-0271-01 '52637-0332-10 '54569-2580-00 '54868-1729-00	1 per 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1020	Injection methylpredniso-lone acetate 20mg	DepoMedrol	Antiinflam-matory	00009-0274-01	None	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1030	Injection methylpredniso-lone acetate 40mg	DepoMedrol MPrednisol Rep-Pred	Antiinflam-matory	00009-0280-02 '00009-0280-03 '00009-0280-51 '00009-0280-52 '00009-3073-01 '00009-3073-03 '54868-3896-00	None	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J1040	Injection methylpredniso-lone acetate 80mg	DepoMedrol Medralone Prednisol RedPred	Antiinflam-matory	00009-0306-02 '00009-0306-12 '00009-3475-01 '00009-3475-03 '54868-1185-00 '54868-1994-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1051	Injection medroxyproges-terone acetate 50mg	Depo-Provera	Contracep-tive	00009-0626-01 '00009-0746-30 '00009-0746-35 '54868-3348-01	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1055	Injection medroxyproges-terone acetate 150 mg	Depo-Provera	Contracep-tive	None	1 per day	X	X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1056	Injection medrosyproges-terone acetate/estradiol cypionate 5mg/25mg	Lunelle	Contracep-tive	00009-3484-04 00009-3484-05 '54569-5272-00 '54868-4660-00	1 per day	X	X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1060	Injection testosterone cypionate & estradiol cypionate up to 1ml	Depo-Testadiol Andro/Fem	Androgen	00009-0253-02 '54569-4199-00	1 per 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1070	Injection testosterone cypionate up to 100mg.	Depo-Testoster-one Depotest	Androgen	00009-0347-02	1 per 3 weeks	X	X	X											Male only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1080	Injection testosterone cypionate 1cc 200mg.	Depo-Tester-one Depotest Andro-Cyp 200	Androgen	00009-0417-01 '00009-0417-02	1 per week	X	X	X											Male only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1094	Injection dexamethasone acetate 1mg	Dalalone LA	Antiinflam-matory	00223-7390-05 '25332-0011-05 '54868-3977-00	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1100	Injection dexamethosone sodium phosphate 1mg	Cortastat Dalalone	Antiinflam-matory	Too numerous to list	10 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1110	Injection dihydroergota-mine mesylate 1mg	DHE 45	Anti-migraine	66490-0041-01	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1120	Injection acetazolamide sodium up to 500mg	Diamox	Glaucoma	55390-0460-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1160	Injection digoxin up to 0.5 mg	Lanoxin	Antiarrhy-thmic	00173-0260-10 '00173-0260-35 '00641-1410-35 54569-1523-00 '54569-1523-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1165	Injection phenytoin sodi-um 50mg	Dilantin	Anticonvul-ant	00074-1317-01 '00074-1317-02 '00641-0493-25 '00641-2555-45	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1170	Injection hydromorphone up to 4mg	Dilaudid	Analgesic narcotic	00074-2332-11 '00074-2333-11 '00074-2333-26 00074-2334-11 00641-0121-25	12 units per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1180	Injection dyphylline up to 500mg	Lufyllin Diler		00281-1112-31	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1190	Injection dexrazoxane HCl per 250mg	Zinecard	Cardio-protective agent	00013-8715-62	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1200	Injection diphenhydra-mine HCl up to 50mg.	Benadryl	Anti-histamine	00071-4259-03 '54868-0554-00 '54868-2048-00 '54868-2048-01 '54868-3644-00 63323-0664-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1205	Injection chlorothiazide sodium 500mg	Diuril Sodium	Antihyper-tensive	00006-3619-32	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1212	Injection DMSO di-methylsulfoxide 50%, 50 ml	Rimso		00433-0433-05 '49072-0433-05	1 per day	X	X												ICD-9-CM code 595.1 (intersitial cystitis) required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1230	Injection methadone HCl up to 10mg	Dolphine HCL	Analgesic narcotic	00054-1218-42	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1240	Injection dimenhydrinate up to 50mg	Dramamine	Antiemetic	00223-7475-10															Not Covered
J1245	Injection dipyridamole 10 mg	Persantine	Antiplatelet	00703-1652-02 '55390-0555-10 '63323-0613-02	8 per day	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1250	Injection dobutamine HCl 250mg.	Dobutrex	Adrenergic agonist	00074-2025-20	None	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J1260	Injection dolasetron mesylate 10mg	Anzemet	Antiemetic	00088-1206-32	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1270	Injection doxercalciferol 1mcg.	Hectorol	Vitamin D analog	64894-0840-50	20 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1320	Injection amitriptyline HCl up to 20mg	Elavil Enovil	Anti-depressant	00310-0049-10	1 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1325	Injection epoprostenol 0.5mg.	Flolan	Prostaglan-din	00173-0517-00	None	X	X												Requires ICD-99-CM code 416.XX on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1327	Injection eptifibatide 5mg	Integrillin	Antiplatelet	00085-1136-01 '00085-1177-01 '00085-1177-02	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J1330	Injection ergonovine maleate up to 0.2mg	Ergotrate Maleate	Anti-migraine	None	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1335	Injection ertapenem sodium 500mg	Invanz	Antibiotic	00006-3843-71	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1364	Injection erythromycin lactobionate 500 mg		Antibiotic	00074-6365-02 '00074-6482-01	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1380	Injection estradiol valerate up to 10mg	Delestrogen Estradiol Gynogen	Contracep-tive	00223-7606-10 '00223-7607-10 '25332-0117-10 '54569-1394-00 '55553-0244-10 61570-0180-01 '61570-0181-01 '61570-0182-01															Not Covered
J1390	Inection estradiol valerate up to 20mg	Delestrogen Dioval Estradiol Gynogen Valergan Estra L	Contracep-tive	00223-7606-10 00223-7607-10 '00314-0784-70 '25332-0117-10 '54569-1394-00 55553-0244-10 '61570-0180-01 '61570-0181-01 '61570-0182-01	None		X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1410	Injection estrogen conju-gated 25mg	Premarin IV	Estrogen Derivative	00046-0749-05	1 per day	X	X												Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1435	Injection estrone 1mg	Theelin Aqueous Estone 5 Kestrone 5		00223-7660-10 00223-7670-10 '25332-0019-10 '52637-0313-10															Not Covered
J1436	Injection etidronate disod ium 300mg	Didronel	Bone Res-tortive agent	58063-0457-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1438	Injection etanercept 25mg	Enbrel	Antirheu-matic	58406-0425-34 '58406-0425-41	2 per day	X	X												Not covered effective 7/1/05
J1440	Injection filgrastim (G-CSF) 300mcg	Neupogen	Colony stimulating factor	54868-2522-00 '55513-0530-01 '55513-0530-10	5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1441	Injection filgrastim (G-CSF) 480mcg	Neupogen	Colony stimulating factor	'55513-0546-01 55513-0546-10	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1450	Injection fluconazone 200mg	Diflucan	Antifungal	00049-3371-26 '00049-3435-26 '00049-3437-26	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1452	Injection omivirsen sodi-um intraocculur 1.65mg.	Vitavene		58768-0902-35															Not Covered
J1455	Injection foscarnet sodi-um 1000mg	Foscavir	Antiviral	00186-1905-01 00186-1906-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1457	Injection gallium nitrate 1 mg	Ganite		66657-0301-01 66657-0301-05															Not Covered
J1460	Injection gamma globulin IM 1cc	Gammar Gamastan	Immune globulin	00026-0635-04 00026-0635-12 54569-5275-00 54569-5275-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1470	Injection gamma globulin IM 2cc	Gammar Gamastan	Immune globulin	00026-0635-04 '00026-0635-12 '54569-5275-00 54868-4193-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1480	Injection gamma globulin IM 3cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1490	Injection gamma globulin IM 4cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1500	Injection gamma globulin IM 5cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1510	Injection gamma globulin IM 6cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1520	Injection gamma globulin IM 7cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1530	Injection gamma globulin IM 8cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1540	Injection gamma globulin IM 9cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1550	Injection gamma globulin IM 10cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1560	Injection gamma globulin IM over 10cc	Gammar Gamastan	Immune globulin	54868-4193-00 54569-5275-00 14362-0115-02 00026-0635-12 00026-0635-04	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1563	Injection immune globulin IV 1g		Immune globulin	00026-0648-20 '00026-0648-71 '00053-7486-05 00053-7486-10 00944-2620-03 '00944-2620-04 '44206-0507-56 52769-0268-66 '52769-0471-75 '52769-0471-80 '64193-0250-50	50 per day	X	X												Close code effective 7/1/05 - Replaced with Q9941 and Q9943
J1564	Injection immune globulin IV 10mg		Immune globulin	00026-0635-12 '00026-0646-12 '00026-0646-20 '00026-0646-24 '00026-0646-25 '00026-0646-71 '00026-0648-12 '00026-0648-15 '00026-0648-20 00026-0648-24 '00026-0648-71 49669-1612-01 '49669-1623-01 '49669-1624-01	None	X	X												Close code effective 7/1/05 - replaced with Q9942 and Q9944
J1565	Injection RSV immune globulin IV 50mg	RespiGam	Immune globulin	60574-2101-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1570	Injection ganciclovir sodium 500mg	Cytovene	Antiviral	00004-6940-03 '54569-4738-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1580	Injection Garamycin gentamicin up to 80mg	Gentamine Sulfate Jenamicin	Antibiotic	00085-0069-04 '00223-7719-02 '00223-7719-25 00223-7721-02 00641-0395-25 '00641-2331-43 '63323-0010-02 '63323-0010-20	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1590	Injection gatifloxacin 10 mg	Tequin Zymar	Antibiotic	00015-1179-80	40 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1595	Injection glatiramer acetate 20mg	Copaxone	Biological Misc	00088-1153-30	1 per day	X	X												Not covered effective 7/1/05
J1600	Injection gold sodium thiomalate up to 50mg	Aurolate Myochrysine	Antirheu-matic	11098-0533-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1610	Injection glucagon HCl 1mg.	Glucagon GlucaGen	Antidote	54569-2239-00 '54569-4734-00 '55390-0004-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1620	Injection gonadorelin HCl 100mcg	Factrel Lutrepulse	Gonado-tropin	00046-0507-05	1 per day	X	X												Not for fertility treatment and diagnosis. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1626	Injection granisetron HCl 100mcg	Kytril	Antiemetic	00004-0239-09 '00004-0240-09	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1630	Injection haloperidol up to 5mg	Haldol	Anti-psychotic	00045-0255-01 '00703-7041-03 '54868-3459-00 '55390-0147-10 55390-0447-10 '63323-0474-01 '63323-0474-91	2 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1631	Injection haloperidol decanoate 50mg	Haldol Decanoate 50	Anti-psychotic	00045-0254-14 '00144-0544-51 '00703-7021-03 '55390-0413-01 55390-0423-01 '63323-0471-01	1 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1642	Injection heparin sodium (heparin lock flush) 10U.	HepLock HepLock U/P	Anticoagu-lant	00223-7861-01 '00223-7863-02 '00641-0392-25 00641-0393-25 '00641-2438-45 '00641-2442-45 '63323-0544-11 '63323-0544-31	None									X	X				Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1644	Injection heparin sodium 1000U	Heparin Sodium Liqusemin Sodium	Anticoagu-lant	00223-7801-01 '00223-7810-10 00223-7843-10 '00223-7844-30 '00641-0391-25 '00641-2436-45 '00641-2440-45 '00641-2450-45 '11743-0210-02 '49072-0291-30 63323-0540-11 63323-0540-31	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1645	Injection dalteparin sodi-um 2500IU	Fragmin	Anticoagu-lant	00013-2406-91	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1650	Injection enoxaparin sodium 10mg	Lovenox	Anticoagu-lant	00075-0626-03	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1652	Injection fondaparinux sodium 0.5 mg	Atrixtra	Anticoagu-lant	66203-2300-01	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1655	Injection tinzaparin sodium 1000 IU.	Innohep	Anticoagu-lant	00056-0342-08 '00056-0342-53	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1670	Injection tetanus immune globulin human up to 250U	BayTet	Immune globulin	00026-0634-02	1 per 10 years	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1700	Injection hydrocortisone acetate up to 25mg	Hydrocortone Acetate	Antiinflam-matory	00463-1036-10	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1710	Injection hydrocortisone sodium phosphate up to 50mg	Hydrocortone Phosphate	Antiinflam-matory	00006-7633-04	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1720	Injection hydrocortisone sodium succinate up to 100mg	Solu-Cortef A-Hydrocort	Antiinflam-matory	00009-0825-01 '00009-0825-01 00074-5671-02 '00223-7893-02 '54868-0605-00 '54868-0605-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1730	Injection diazoxide up to 300mg	Hyperstat IV	Antihyper-tensive	00085-0201-05	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1742	Injection ibutilide fumarate 1mg	Corvert	Antiarrhy-thmic	00009-3794-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1745	Injection infliximab 10mg	Remicade	Antirheu-matic	57894-0030-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1750	Injection iron dextran 50 mg	Infed Dexferrum	Iron salt	00517-0134-10	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1756	Injection iron sucrose 1mg IV	Venofer	Iron supple-ment	00517-2340-10	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1785	Injection imiglucerase per unit	Cerezyme	Enzyme	58468-1983-01 58468-4663-01	None	X	X												ICD-9-CM code 172.7 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.
J1790	Injection droperidol up to 5mg	Inapsine	Antiemetic	00074-1187-01 00517-9702-25 11098-0010-02	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1800	Injection propranolol HCl up to 1mg.	Inderal	Antianginal	00046-3265-10 '54569-2232-01 '55390-0003-10 '63323-0604-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1810	Injection droperidol & fentanyl cit-rate up to 2ml ampule	Innovar	Antiemetic	00186-1230-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1815	Injection insulin 5U	Humalog Humulin Lispo	Antidiabetic	00002-8501-01	20 per day	X	X	X											ICD-9-CM code 250.00 - 250.9X required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1817	Insulin for administration thru insulin pump per 50 U.	Humalog	Antidiabetic	Too numerous to list															Not Covered
J1825	Injection interferon beta 1a 33mcg	Avonex	Biological Response Modulator	None	None	X	X												Not covered effective 7/1/05
J1830	Injection interforon beta 1b 0.25mg	Betaseron	Biological Response Modulator	50419-0523-15	2 per day	X	X												Not covered effective 7/1/05
J1835	Injection itraconazole 50 mg.	Sporonox	Antifungal	50458-0298-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1840	Injection kanamycin sul-fate up to 55mg	Kantrex Klebcil	Antibiotic	00015-3503-20 00015-3503-99 '63323-0359-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1850	Injection kanamycin sul-fate up to 75mg	Kantrex Klebcil	Antibiotic	00015-3503-20 63323-0359-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1885	Injection ketoralac tro-methamine 15mg	Toradol	Analgesic	00004-6925-06 '55390-0480-01 '60505-0705-00 '63323-0161-01	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1890	Injection cephalothin sodium up to to 1g	Cephalothin Sodium Keflin	Antibiotic	00338-0525-41	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1931	Injection laronidase 0.1 mg	Aldurazyme	Enzyme	58468-0070-01	None	X	X												ICD-9-CM code 277.5 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.
J1940	Injection furosemide up to 20mg.	Lasix Furomide	Antihyper-tensive Diuretic	00074-6101-02 '00223-7700-02 00223-7701-02 52637-0010-10 '63323-0280-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1950	Injection leuprolide ace-tate 3.75mg.	Lupron Depot	Antineo-plastic	00300-3641-01 54868-2825-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1955	Injection levocarnitine1g.	Carnitor	Nutritional Supplement	00517-1045-25 '00703-0404-02 54482-0146-09 '54482-0147-01 '55390-0136-05 '55390-0436-05			X												Not Covered
J1956	Injection levoflaxacin 250 mg	Levaquin	Antibiotic	00045-0067-01	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1960	Injection levorphanol tartrate up to 2mg	Levo Dromoran	Analgesic narcotic	00004-1911-06 '00187-3072-10	1.5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1980	Injection hyoscyamine sulfate up to 0.25mg.	Levsin	Anticholе-nergic	00091-1536-05	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1990	Injection chlordiazepoxide HCL up to 100mg.	Librium	Benzodiaze-pine	00187-3755-74 '54868-2362-01															Not Covered
J2001	Injection lidocaine HCl IV infusion 10mg		Antiarrhy-thmic	00548-1192-00	None	X													Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2010	Injection lincomycin HCl up to 300mg	Lincocin	Antibiotic	00009-0555-01 '00009-0555-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2020	Injection linezolid 200 mg	Zyvox	Antibiotic	00009-5137-01	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2060	Injection lorazepam 2mg	Ativan	Antianxiety	00008-0581-15 '00074-1985-01 '10019-0102-01 '54868-3566-01	2 per day	X	X	X		X							X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2150	Injection mannitol in 25% in 50ml	Osmitrol	Diuretic	00074-4031-01 '00517-4050-25 '63323-0024-25	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2175	Injection meperidine HCl per 100mg	Demerol	Analgesic narcotic	00074-1180-69 '00074-1201-20 '00074-1256-01 00074-2046-01 '00641-1150-35 '10019-0158-68 '54868-3610-00	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2180	Injection meperidine & promethazine HCl up to 50mg	Mepergan	Analgesic combo narcotic	54868-4136-00	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2185	Injection meropenem 100 mg	Merrem	Antibiotic	00310-0321-30 00310-0325-20	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2210	Injection methylergonovine maleate up to 0.2mg.	Methergine	Ergot alkaloid & derivative	00078-0053-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2250	Injection midazolam HCl per 1mg	Versed	Benzodiaze-pine	10019-0028-05 '10019-0028-10 '59911-5912-02 59911-5913-02 '60505-0711-01 '60505-0711-02 '60505-0711-03 '63323-0411-05 '63323-0411-10 '63323-0411-12															Not Covered
J2260	Injection milrinone lactate 5mg	Primacor	Enzyme	00024-1200-05 '00024-1200-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2270	Injection morphine sulfate up to 10mg	Roxanol	Analgesic narcotic	00641-0180-25 '00641-1180-35 '00641-2343-41 '10019-0178-44 '10019-0178-62 '10019-0178-68 '54868-4189-00	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2271	Injection morphine sulfate 100mg.	Roxanol	Analgesic narcotic	00641-2343-41 '10019-0178-62	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2275	Injection,morphine sulfate (preservative-free sterile solution)10mg	Astramorph PF Duramorph	Analgesic narcotic	00074-1135-03 '00641-1132-31 '61703-0224-72	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2280	Injection moxifloxacin 100 mg	Avelox	Antibiotic	00026-8582-31	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2300	Injection nalbuphine HCl per 10mg	Nubain	Analgesic narcotic	00074-1463-01 '54868-3471-00 '54868-3608-00 '54868-3686-00 '54868-3686-01 '58016-9384-01 '63481-0432-10 '63481-0508-05	6 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2310	Injection naloxone HCl per 1mg	Narcan	Antidote	63481-0368-05 '63481-0377-10	None	X	X	X											Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2320	Injection nandrolone decanoate up to 50mg.	Decaduraboli n	Anabolic steroid	00052-0697-02 '00052-0698-01 '00364-6717-47	1 per week	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2321	Injection nandrolone decanoate up to 100mg.	Decaduraboli n Hybolin Decanoate	Anabolic steroid	00052-0697-02	1 per week	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2322	Injection nandrolone decanoate up to 200mg	Decaduraboli n Neo-burabolic	Anabolic steroid	00052-0697-02 '00052-0698-01 00364-2186-46 '00364-6717-47	1 per week	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2324	Injection nesiritid 0.5mg	Natrecor	Vasodilator	65847-0205-25	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J2352	Injection octreotide acetate 1mg																		Code deleted 12/31/03
J2353	Injection octreotide depot form for IM 1mg	Sandostatin	Anti-diarrheal	00078-0342-84	None	X	X												Replaced J2352. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2354	Injection onctreotide non-depot form for SQ or IV 25 mcg	Sandostatin	Anti-diarrheal	00078-0180-01 00078-0181-01 00078-0182-01 00078-0183-25 00078-0184-25	7 conse-cutive days	X	X												Replaced J2352. For IV route only. Physician reimbursement for administration is limited to 7 consecutive days per Medicaid member per lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file..
J2355	Injection oprelvekin 5 mg	Neumega	Platelet growth factor	58394-0004-01 '58394-0004-02	2 per day	X	X												ICD-9-CM code 287.4 must be documented on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file..

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J2357	Injection omalizumab 5 mg.	Xolair	Anti-asthmatic	50242-0040-62	None	X	X												New code 1/1/05. Requires ICD-9-CM code 493.XX on CMS 1500 claim form for payment consideration.. Age limit 12> years. For children: the first dose may be split into 2 doses the first week. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2360	Injection orphenadrine citrate up to 60 mg.	Norflex	Muscle relaxant	00089-0540-06 '11584-1016-02 '11584-1016-05 '52959-0179-06	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2370	Injection phenylephrine HCl up to 1ml	Neo-Synephrine	Adrenergic agonist	00074-1800-01 '00517-0299-25 '00703-1631-04 '10019-0163-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2400	Injection chloroprocaine HCl 30ml	Nesacaine Nesacaine MPF	Local Anesthetic	00074-4169-01 '00074-4170-01 '00186-0971-66 '00186-0972-66	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2405	Injection ondansetron HCl 1mg	Zofran	Antiemetic	00173-0442-00 '00173-0442-02 '54868-4509-00	32 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2410	Injection oxymorphone HCl up to 1 mg	Numorphan	Analgesic-narcotic	63481-0444-10	9 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2430	Injection amidronate disodium 30 mg	Aredia	Antidote	00083-2601-04 '00703-4075-19 '55390-0127-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2440	Injection papaverine HCL up to 60 mg.	Para-Time SR	Vasodilator	00517-4002-05 '00517-4010-01 '55390-0107-10 '60793-0015-02 '60793-0015-10	1 per day	X	X												Not covered effective 7/1/05
J2460	Injection oxytetracycline HCl up to 50 mg	Terramycin	Antibiotic	00049-0750-77	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2469	Injection palonesetron HCl 25mcg	Aloxi	Antiemetic	58063-0797-25	10 units per week	X	X												New code 1/1/05. Requires ICD-9- CM code V58.0, V58.1, 140.0 - 208.91, 230.0, OR 239.9 on CMS 1500 claim form for payment consideration.. Maximum dosage 0.25mg per week. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2501	Injection paricalcitol 1 mcg	Zemplar	Vitamin D analog	00074-4637-01	None	X	X										X		Requires ICD-9-CM 588.XX on CMS 1500 claim form for payment consideration. Medical necessity documentation (including weight of member) of services must be maintained in the member's individual file.
J2505	Injection pegfilgrastim 6mg	Neulasta	Colony stimulating factor	55513-0190-01	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2510	Injection penicillinG pro-caine aqueous up to 600K U	Wycillin Pfizerpen AS	Antibiotic	61570-0085-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2515	Injection pentobarbital sodium per 50 mg.	Nembutal	Anti-convulsant	00074-3778-04 '00074-3778-05	10 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2540	Injection penicillinG pot-assium up to 600K U	Pfizerpen	Antibiotic	00049-0520-83 '00049-0530-28 '00338-1021-41 '00338-1023-41 '00338-1025-41 '00781-6135-95 '00781-6136-94 '54868-3480-00 '54868-4488-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2543	Injection piperacillin sodium/tazobacta m sodium 1g/0.125g (1.125 g)	Zosyn	Antibiotic	00206-8452-16 '00206-8454-55 '00206-8455-25 '00206-8620-11	24 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2545	Pentamidine isethionate inhalation solution 300mg	Nebupent Pentam 300	Antibiotic	00074-4548-01 '00074-4548-49 '54868-2528-00 '63323-0113-10 '63323-0877-15															Not Covered
J2550	Injection promethazine HCl up to 50mg	Phenergan Prorex-25	Antiemetic	00008-0746-01 '00223-8394-01 '00641-0929-25 '00641-1496-35 '00703-2201-04 '54868-0262-00 '54868-2695-00	6 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2560	Injection phenobarbital sodium up to 120mg	Luminal Sodium	Anticonvul-ant	00641-0476-25	3 per day	X	X												20/mg/kg for status epilepticus. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2590	Injection oxytocin up to 10U.	Pitocin	Oxytocic agent	60793-0416-05 '61570-0416-03 '61570-0416-05 '63323-0012-01 '63323-0012-10	1 per day	X	X												May increase to maximum 4 units for post partum hemorrhage. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2597	Injection desmopressin acetate 1mcg	DDAVP Stimate		00074-2265-01 '00075-2451-01 '00075-2451-53 '00703-5051-03 '00703-5054-01 '54868-3889-00 '55566-5040-01			X												Not Covered
J2650	Injection prednisolone acetate up to 1ml	AK-Pred Inflammase Forte Pediapred Prelone Key-Pred Predcor Predoject Predalone	Antiinflam-matory	00223-5346-10 '00223-8341-30 '00223-8345-10 00223-8345-30 '00223-8346-10 '00223-8346-30 '00463-1019-30 '00463-1020-10 '52637-0325-10 '55553-0249-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2670	Injection tolazoline HCl up to 25mg	Priscoline	Alpha-adrenergic blocking agent	00083-6733-04	8 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2675	Injection progesterone 50 mg	Crinone Progestasert	Progestin	00591-3128-79 '63323-0261-10	8 per day	X	X	X	X										Not for fertility treatment and diagnosis. For menorrhagia, amenorrhea. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2680	Injection fluphenazine decanoate up to 25mg	Prolixin Decanoate	Anti-psychotic	00003-0569-15 '00144-0644-56 '00703-5003-01 '55390-0465-05 '60505-0664-02 '63323-0272-05 '63323-0272-55	2 per day	X	X	X		X							X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2690	Injection procainamide HCl up to 1g	Pronestyl Procanbid	Antiarrhy-thmic	00074-1902-01 '00074-1903-01	None	X	X												Weight based 50mg/kg/day. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2700	Injection oxacillin sodium up to 250mg	Bactocill Prostaphlin PCN Methylphenyl Isoxazolyl	Antibiotic	00015-7103-28 '00015-7103-98 '00015-7970-20 '00015-7970-99 '00015-7981-20 '00015-7981-99	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2710	Injection neostigmine methylsulfate up to 0.5 mg	Prostigmin	Acetychol-inesterase inhibitor	00187-3101-30 '00517-0033-25 '00517-0034-25 '00703-2711-03 '00703-2714-03 '10019-0271-02 '10019-0271-10 '63323-0382-10	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2720	Injection protamine sul-fate 10mg		Antidote	11743-0250-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2725	Injection protirelin 250 mcg	Relefact TRH Thypi-nome		55566-0081-05	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2730	Injection pralidoxime chloride up to 1g	Protopam Chloride	Antidote	00641-0374-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2760	Injection phentolamine mesylate up to 5mg	Regitine	Diagnostic agent	55390-0113-01	1 per day	X	X												Not covered effective7/1/05
J2765	Injection metoclopramide HCl up to 10mg	Reglan	Antiemetic	00074-3413-01 '00703-4502-04 '10019-0450-02 '54868-4167-00	8 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2770	Injection quinupristin/dalfop ristin 500mg (150/350)	Synercid	Antibiotic	00075-9051-10															Non Covered
J2780	Injection ranitidine HCl 25mg	Zantac	Anti-histamine	00173-0362-38 '00173-0363-00 '00173-0363-01	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2783	Injection rasburicase 0.5 mg	Elitek	Enzyme	00024-5150-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2788	Injection Rhod immune globulin human minidose 50 mcg	BAYRho-D MicrhoGam Hyprho-D	Immune globulin	00562-7808-06 '00562-7808-26															See CPT code 90385
J2790	Injection Rhod immune globuliln human full dose 300 mcg	Gamulin RH	Immune globulin	00026-0631-02 '00562-7807-06 '00562-7807-26															See CPT code 90384
J2792	Injection RhoD immune globulin IV human solvent detergent 100 IU	BAYrho-D Winrho SDF	Immune globulin	60492-0024-01															See CPT code 90386
J2794	Injection Risperidone long acting 0.5mg	Risperdal Consta IM	Anti-psychotic	50458-0308-11 50458-0307-11 50458-0306-11	100 every 2 weeks	X	X	X		X									New code 1/1/05. Requires ICD-9-CM code 295XX.on CMS 1500 claim form for payment consideration. Age limit 18>years. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2795	Injection ropivacaine HCl 1mg	Naropin	Local Anesthetic	'00186-0859-44 00186-0859-54 '00186-0863-44 '00186-0863-54 '00186-0867-44 '00186-0867-54 '00186-0868-44 '00186-0868-54															Not Covered
J2800	Injection methocarbamol up to 10ml	Robaxin	Skeletal muscle relaxant	00031-7409-87 '00031-7409-94 '00223-8150-10	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2810	Injection theophylline 40 mg	Theo-Dur	Broncho-dilator	Too numerous to list															Not Covered
J2820	Injection sargramostim (GM-CSF) 50mcg	Leukine Prokine	Colony stimulating factor	58406-0050-14 '58406-0050-30	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2910	Injection aurothioglucose up to 50mg	Solganal		54868-1133-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2912	Injection sodium chloride 0.9% per 2ml			00074-2102-02	None									X	X				Medical necessity documentation of services provided must be maintained in the member's individual file.
J2916	Injection sodium ferric gluconate complex in sucrose injection 12.5mg	Ferriecit	Iron supple-ment	52544-0922-26	20 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2920	Injection methylprednisolone sodium succinate up to 40mg	SoluMedrol Ametha-Pred	Antiinflam-matory	00009-0113-12 '00009-0113-19 '00074-5684-01 '00223-8160-01 '54868-0768-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2930	Injection methlprednisolone sodium succinate up to 125mg	SoulMedrol Ametha-Pred	Antiinflam-matory	00009-0190-09 '00009-0190-16 '00074-5685-02 '00223-8160-02 '00223-8161-02 '54569-1555-01 '54868-3637-00 '54868-3637-01 '58016-9452-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2940	Injection somatrem 1mg	Protropin		50242-0015-64 50242-0016-65 '50242-0028-49 '50242-0030-50															Not Covered
J2941	Injection somatropin 1mg	Humatrope Genotropin Nutropin		00013-2653-02															Not Covered

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J2950	Injection promazine HCl up to 25mg	Sparine Prozine-50		00223-8397-10	40 per day	X	X			X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J2993	Injection reteplase 18.1 mg	Retavase	Fibrinolytic	57894-0040-01 '57894-0040-02															Not Covered
J2995	Injection streptokinase per 250KIU	Streptase	Fibrinolytic	00053-1770-01	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2997	Injection alteplase recombinant 1mg	Activase	Fibrinolytic	50242-0041-64 '50242-0041-65															Not Covered
J3000	Injection streptomycin up to 1g	Streptomycin Sulfate	Antibiotic	39822-0706-01 '39822-0706-02	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3010	Injection fentanyl citrate 0.1mg	Sublimaze Duragesic	Analgesic narcotic	00074-9093-32 '11098-0030-02 '54868-3738-00 '54868-3738-01	1 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J3030	Injection sumatriptan succinate 6mg	Imitrex	Anti-migraine	00173-0449-02 '54569-3704-00 '54569-4505-00 '54868-2652-00	1 per day	X	X												Not covered effective 7/1/05
J3070	Injection pentazocine 30 mg	Talwin	Analgesic narcotic	00074-1941-01	12 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3100	Injection tenecteplase 50 mg	TNKase	Fibrinolytic	50242-0038-61	1 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J3105	Injection terbutaline sulfate up to 1mg	Brethine	Broncho-dilator	00028-7507-01 '00028-7507-23	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3110	Injection teriparatide 10 mcg	Forteo	Parathyroid hormone																Not Covered
J3120	Injection testosterone enanthate up to 100mg	Delatestryl	Androgen	54396-0328-16 '54396-0328-40	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3130	Injetion testosterone enanthate up to 200mg	Delatestryl	Androgen	54396-0328-16 '54396-0328-40	2 per week	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3140	Injection testosterone suspension up to 50mg	Andronaq 50	Androgen	00314-0083-10 '00314-0771-70 '00463-1069-10	3 per week	X	X	X											May increase to 4 doses for post partum breast engorgement. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3150	Injection testosterone propionate up to 100mg	Testex	Androgen	00314-0772-70 '00463-1073-10 '54569-2363-00	3 per week	X	X	X											May increase to 4 doses for post partum breast engorgement. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3230	Injection chlorpromazine HCl up to 50mg	Thorazine	Anti-psychotic	00223-7325-02 '00223-7334-01 '00641-1398-35	10 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3240	Injection thyrotropin alpha 0.9 mg provided in 1.1 mg vial	Thyrogen	Diagnostic agent	58468-1849-04	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3245	Injection tirofiban HCl 12.5 mg	Aggrastat	Antiplatelet	None		X													Code closed 1/1/05
J3246	Injection tirofiban HCL 0.25mg IV	Aggrastat	Antiplatelet	00006-3739-43 61379-0120-05 00006-3739-96 00006-3739-55	1 per day	X	X												New code 1/1/05. Replaces J3245. Note dosage change. Must be billed daily. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3250	Injection trimeth-obenzamide HCl up to 200mg	Tigan	Antiemetic	54868-0608-00 '61570-0540-02															Not Covered
J3260	Injection tobra-mycin sulfate up to 80mg	Nebcin	Antibiotic	00002-1499-25 '00002-7090-01 '00002-7090-16 '00002-8989-25 '00003-2725-10 '00003-2725-30 '00703-9402-04 '00703-9416-01 '54868-4106-00	2 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3265	Injection torsemide 10mg/ml	Demadex	Antihyper-tensive	00004-0267-06 '00004-0268-06															Not Covered
J3280	Injection thiethylperazine maleate up to 10mg	Torecan Norzine	Antiemetic	54868-4579-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3301	Injection triamcinolone acetonide 10mg	Kenalog-10 Kenalog-40 Triam-A	Antiinflam-matory	00003-0494-20 '54868-0234-00	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3302	Injection triamcinolone diacetate 5mg	Aristocort Intralesional Aristocort Forte Cinolone Trilone Clinacort	Antiinflam-matory	00469-5116-01 '00469-5116-05 '00469-5117-05 '54868-0926-00	8 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3303	Injection triamcinolone hexacetonide 5mg	Aristoospan Intralesional Aristospan Intra-articular	Antiinflam-matory	00469-5118-05 '00469-5119-01 '00469-5119-05 54868-3344-00	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3305	Injection trimetrexate glucoronate 25mg	Neutraxin	Antiinflam-matory	58178-0020-10 '58178-0020-50 '58178-0021-01	None	X	X												Weight based. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3310	Injection perphenazine up to 5mg	Trilafon	Anti-psychotic		3 per day	X	X	X		X						X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J3315	Injection triptorelin pamoate 3.75mg	Trelstar LA	Luteinizing hormone-releasing hormone	00009-5215-01 00009-7664-01	3 per month	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3320	Injection spectinomycin dihydrochloride up to 2g	Trobicin	Antibiotic	00009-7664-01		OHP	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3350	Injection urea up to 40g	Ureaphil	Diuretic	00009-0566-01															Not Covered
J3360	Injection diazepam up to 5mg	Valium	Benzodiaze-pine	54569-5351-00 '54868-0617-00 '54868-4061-00															Not Covered
J3364	Injection urokinase 5000 IU vial	Abbokinase open cath	Fibrinolytic	00074-6111-01	2 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3365	Injection IV urokinaase 250000 IU vial	Abbokinase	Fibrinolytic	00074-6109-05															Not Covered
J3370	Injection vancomycin HCl 500mg	Varocin Vancocin	Antibiotic	00002-1444-25 '00074-4332-01 '00074-4332-49 '00074-6534-01 '00074-6534-49		X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3395	Injection verteporfin 15mg	Visudyne																	Code close 1/1/05
J3396	Injection, verteporfin 0.1mg	Visudyne		58768-0150-15	None	X	Ophthal-mologist only												New code 1/1/05. Replaces J3395. Requires ICD-9-CM code 115.02, 115.12, 115.92, 360.21, 362.16, OR 362.52 and meter square on CMS 1500 claim form for payment consideration. . Only bill CPT codes 67221 or 67225 with J3396. Must be billed daily. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3400	Injection triflupromazine HCl up to 20mg	Vesprin		None	150mg per day	X	X			X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3410	Injection hydroxyzine up to 25mg	Vistaril Hyzine-50 Atarax	Antianxiety	00223-7885-01 '00517-4201-25 '54868-0858-00 '63323-0021-01	None	X	X	X		X									Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3411	Injection thiamine HCL 200mg	Thiamilate	Vitamin supplement	63323-0013-02	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3415	Injection pyridoxine HCl 100mg		Vitamin supplement	00223-8403-10 00223-8404-30 00223-8410-10 25332-0073-30 63323-0180-01	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3420	Injection vitamin B-12 cyanocobalamin up to 1000mcg	Sytobex Residol Rubramin PC	Vitamin supplement	00223-8860-30 '00223-8861-01 '00223-8862-25 '00517-0031-25 '00517-0130-01 '49072-0145-30 '52637-0282-10 '52637-0312-30 '54569-2130-00 '63323-0044-01	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3430	Injection phytonadione (viatamin K) per 1mg	Aqua Mephyton Konakion	Vitamin supplement	00006-7784-33 '00074-9157-01 '54868-4434-00	25 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3465	Injection voriconazole 10mg	VFEND	Antifungal	00049-3190-28	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3470	Injection hyaluronidase up to 150units	Wydase		None	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3475	Injection magnesium sulphate 500mg			00074-4075-32 '49072-0475-50 '63323-0064-20 '63323-0064-50															Not Covered
J3480	Injection potassium chloride 2mEq	Kdur Kaon-Cl	Electrolyte Supplement	00074-1513-02 '00074-3907-03 '00074-3934-02 '00223-8322-30 '00223-8330-01 '00223-8330-10 '00223-8331-20 '00223-8332-30 '00264-1940-10 '00264-1940-20 '00338-0318-02 '49072-0571-30 '54868-0767-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3485	Injection zidovudine 10mg	Retrovir	Antiretro-viral	00173-0107-93															Not Covered
J3486	Injection zipraosidone mesylate 10mg	Geodon	Anti-psychotic	00049-3920-83	10 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3487	Injection zoledronic acid 1mg	Zometa	Antidote	00078-0350-84	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3490	**Unclassified drugs. Used only if a more specific code is not available.**																		Refer to the list of Approved Drugs Billed with HCPCS Code J3490 by WV Medicaid. Cost invoice may be required. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3520	Edetate disodium 10mg	Endrate Disotate	Antidote		None	X	X												Covered only for treatment for lead poisoning or heavy metal poisoning; duration <2 weeks. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3530	Nasal vaccine inhalation																		Not Covered
J3535	Drug administered thru a metered dose inhaler.																		Not Covered
J3570	Laetrile amygdalin vitamin B-17.																		Not Covered
J3590	**Unclassified biologics. Used only if a more specific code is not available.**																		Close code effective 7/1/05.
J7030	Infusion normal saline solution 1000cc			00074-1583-02 '00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7040	Infusion normal saline solution sterile (500ml = 1 unit)			00074-1583-02 '00074-7101-02 '00074-7983-02 '00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03 '00338-0049-04 '54868-0710-00 '54868-0710-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7042	5% dextrose/normal saline (500ml - 1 unit)			Too numerous to list		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7050	Infusion normal saline solution 250cc			00074-1583-02 '00074-7983-02 00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03 '00338-0049-04 '54868-0710-00 '54868-0710-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7051	Sterile saline or water up to 5cc			Too numerous to list	1 per day			X						X					Medical necessity documentation of services provided must be maintained in the member's individual file.
J7060	5% dextrose/water (500 ml = 1 unit)			00074-1522-03 '00074-7922-03 '00074-7922-55 '00264-1101-55 '00264-7510-10 '00338-0016-03 '00338-0017-03 '54868-0296-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7070	Infusion D-5-W 1000cc			00074-1500-05 '00074-7922-09 '00264-1107-55 '00264-1110-00 '00264-7510-00		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7100	Infusion dextran 40 500ml	Rheomacrodex Gentran 75		00338-0271-03 61563-0212-65 61563-0211-65 00338-0272-03 00074-7419-03 00338-0270-03 00264-1962-10 00264-1963-10	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7110	Infusion dextran 75 500ml	Gentran 75		00338-0265-03 00338-0263-03 00074-1505-03 00074-1507-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7120	Ringer's lactate infusion up to 1000cc			00074-7953-09 '00264-3500-55 '00264-7750-00 '00338-0117-04	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7130	Hypertonic saline solution 50 or 100 mEq 20cc vial			Too numerous to list	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7190	Factor VIII human per IU	Monarc-M Koate HP Hemofil-M Alphanate SD Humate P Koate DVI MonoclateP vonWille- brand dise- ase	Antihemo-philic	00026-0664-20 '00026-0664-30 '00026-0664-50 '00026-0664-60 '00026-0665-20 '00026-0665-30 '00026-0665-50 '00053-7656-01 '00053-7656-02 '00053-7656-04 '00944-2935-01 '49669-4600-01 '49669-4600-02 '52769-0460-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7191	Factor VIII porcine per IU	Hyate-C	Antihemo-philic	55688-0106-02	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7192	Factor VIII recombinant per IU	Recombi- nate Kogenate Helixate FS Refacto Advate	Antihemo-philic	00944-2938-01 '00944-2938-02 '00944-2938-03 '58394-0005-01 '58394-0006-01 '58394-0007-01 '58394-0011-01 52769-0464-02 52769-0464-05 52769-0464-10 00026-0372-20 00026-0372-30 00026-0372-50 00944-2940-01 00944-2940-02 00944-2940-03 00944-2940-04 00053-8130-01 00053-8130-02 00053-8130-04	None	X	X				X				X	HS			Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7193	Factor IX purified, non-combinant per IU	AlphaNine SD Mononine	Antihemo-philic	00053-7668-01 '00053-7668-02 '00053-7668-04 '49669-3600-02 68516-3600-02	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7194	Factor IX complex per IU	Bevulin VH Profilnine HT Konyne-80 Proplex T, SX-T	Antihemo-philic	00944-0581-01 '49669-3200-02 '49669-3200-03 '64193-0244-02 58394-0001-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7195	Factor IX recombinant per IU	Benefix	Antihemo-philic	58394-0001-01 '58394-0002-01 '58394-0003-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC#and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration.. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7197	Antithrombin III human per IU	Throbate III Atnativ	Antihemo-philic	00026-0603-20 '00026-0603-30	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7198	Anti-inhibitor per IU	Autoplex T FEIBA	Anti-inhibitor coagulant complex	59730-6059-07 '64193-0222-04	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7199	**Hemophilia clotting factor NEC. Used only if a more specific code is not available.**		Antihemo-philic																Close code effective 7/1/05.
J7300	Intrauterine copper contraceptive.	Paragard T380A	Contracep-tive	None	None	X	X	X	X										Medical necessity documentation of services provided must be maintained in the member's individual file.
J7302	Levonorgest releasing intrauterine contraceptive system 52 mg	Minera	Contracep-tive	None	None	X	X	X	X										Medical necessity documentation of services provided must be maintained in the member's individual file.
J7303	Contraceptive supply hormone containing vaginal ring each		Contracep-tive																Not Covered
J7304	Contraceptive supply, hormone containing vaginal patch each		Contracep-tive																Not Covered
J7308	Aminolevulinic acid HCl for topical administra-tion 20%, single unit dosage form (354mg)	Kerastick Levulan	Photosensi-tivity agent	67308-0101-01 '67308-0101-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7310	Ganciclovir 4.5 mg long-acting implant	Vitrasert Cytovene	Antiviral	61772-0002-01	None	X	Ophthal-mologist only												One per each eye per 5 months. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7317	Sodium hyaluronate per 20 to 25 mg dose for intra-articular injection	Hyalgan 20 Supartz 25	Osteoarth-ritic	08024-0724-12 '08363-7765-01	1 per week X 5	X	X	X											Requires ICD-9-CM code 715.XX or 716.XX on CMS 1500 claim form for payment consideration. Maximum 10 injections (5 per knee) in a 6 month period. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7320	Hylan G-F20 16mg/2ml for intra-articular injection	Synvisc	Osteoarth-ritic	00008-9149-01 '00008-9149-02 '66267-0921-03	1 per week X 3	X	X	X											Required ICD-9-CM code 715.XX or 716.XX on CMS 1500 claim form for payment consideration. Maximum 6 inections (3 per knee) in a 6 months period. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7330	Augologous cultured chondrocytes implant	Carticel		63861-1025-01															Not Covered
J7340	Dermal & epidermal tissue human origin with or without bioengineered or processed elements with metabolically active elements per square cm	Dermagraft Dermagraft TC		09978-0001-99 '30170-0000-10	None	X	X					X							Activate code effective 7/1/05. **For diabetes:** ICD-9-CM code 250.XX plus 707.XX for **surgeons**; OR, ICD-9-CM code 250.XX plus 707.13, 707.14, or 707.15 for **podiatrists**. For **venous stasis ulcer**: ICD-9-CM code 454.0, 454.1 or 454.2 plus 707.XX for **surgeons**; OR, ICD-9-CM code 454.0, 454.1 or 454.2 plus 707.13, 707.14, or 707.15 for **podiatrists** required on CMS 1500 claim form. Service limits for diabetic ulcer: 3 applications in 9 weeks per year per ulcer. Service limits for venous stasis ulcer: 3 applications in 12 weeks per year per ulcer. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7342	Dermal tissue human origin with or without other bioengineered or pro-cessed elements with metabolically active elements per square cm.	Applegraft		38172-0202-00	None	X	X					X							Activate code effective 7/1/05. ICD-9-CM code 250.XX plus 707.XX for **surgeons** and ICD-9-CM code 250.XX plus 707.13, 707.14 or 707.15 for **podiatrists** required on CMS 1500 claim form for payment consideration. . Service limits 1 application x 8 weeks per year per ulcer. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7343	Dermal & epidermal tissue nonhuman origin with or without other bioengineered or pro-cessed elements without metabolically active elements per square cm.			84784-0040-02 84784-0040-08 84788-0040-08 84784-0040-06 84788-0040-06 84784-0040-05 84788-0040-05	None	X	X					X							For **surgeons**: ICD-9-CM code(s) 941.30 - 941.39; 941.40 - 941.49; 942.30 - 942.39; 942.40 - 942.49; 943.30 - 943.39; 943.40 - 943.49; 944.30 - 944.38; 944.40 - 944.48; 945.30 - 945.39; 945.40 - 945.49; 946.3; 946.4; 949.3; OR 949.4 required on CMS 1500 claim form for payment consideration. For **podiatrists**: ICD-9-CM code 945.X2 or 945.X3 required on CMS 1500 claim form for payment consideration..

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J7344	Dermal tissue human orgin with or without bio-engineered or processed elements without metabolically active elements per square cm	Dermagraft Dermagraft TC		85600-5X10-10 38172-0001-01 81218-6040-04 86002-X04-04 86004-X07-07 86005-X05-05	None	X	X					X							Not Covered
J7350	Dermal tissue human origin injectable with or without other bioengi-neered or processed elements but without metabolized active elements per 10mg	Dermagraft Dermagraft TC			None	X	X					X							Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7500	Azathioprine oral 50mg	Imuran	Immuno-suppress-ant	00054-4084-25 '00054-8084-25 '00781-1059-01															Not Covered
J7501	Azathioprine parenteral 100mg	Imuran	Immuno-suppress-ant	65483-0551-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7502	Cyclosporine oral 100mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0241-15 '00078-0248-15 '00185-0933-30 '50111-0920-43															Not Covered
J7504	Lymphocyte immune globulin antihymocyte globulin equine parenteral 250mg	Atgam	Immune globulin	00009-7224-02															Medical necessity documentation of services provided must be maintained in the member's individual file.
J7505	Muromonab-CD3 paren-teral 5mg.	Orthoclone OKT3	Immuno-suppress-ant	59676-0101-01	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7506	Prednisone oral per 5mg	Deltasone Meticorten Orasone	Immono-suppress-ant	Too numerous to list	None	X	X												Not Covered
J7507	Tacrolimus oral per 1mg	Prograf	Immuno-suppress-ant	00469-0617-11 '00469-0617-73															Not Covered
J7509	Methylprednisolon e oral per 4mg	Medrol	Immuno-suppress-ant	Too numerous to list															Not Covered
J7510	Prednisolone oral per 5mg	Deltacortef	Immono-suppress-ant	00223-1512-01 '00223-1512-02															Not Covered

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J7511	Lymphocyte immune globulin antithymocyte globulin rabbit parenteral 25mg	Thymoglobulin	Immune globulin	62053-0534-25		X	X												Weight based. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7513	Daclizumab parenteral 25 mg	Zenapax	Immuno-suppress-ant	00004-0501-09	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7515	Cyclosporine oral 25mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0240-15 '00078-0246-15 '00185-0932-30 '50111-0909-43															Not Covered
J7516	Cyclosporine parenteral 250mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0109-01 55390-0122-10	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7517	Mycophenolate mofetil oral 250mg	CellCept	Immuno-suppress-ant	00004-0259-01 '00004-0259-05 '00004-0259-43															Not Covered
J7518	Mycophenolic acid oral 180mg	Myfortic	Immuno-suppress-ant	00078-0386-66 00078-0385-66															Not Covered
J7520	Sirolimus oral 1mg	Rapamune	Immuno-suppress-ant	00008-1031-05 '00008-1031-10															Not covered
J7525	Tacrolimus parenteral 5 mg	Prograf	Immuno-suppress-ant	00469-3016-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7599	**Immunosuppressive drug NOS. Used only if a more specific code is not available**																		Not Covered
J7608	Acetylcysteine inhalation solution unit dose form per g	Mucomyst Mucosil		00087-0570-07 '00087-0572-03															Not Covered
J7611	Albuterol inhalation concentrated form 1mg	Albuterol Sulfate Proventil Ventolin	Broncho-dilator	Too numerous to list															Not Covered
J7612	Levalbuterol inhalation solution concentrated form 0.5mg	Xopenex	Broncho-dilator	63402-0515-30															Not Covered
J7613	Albuterol inhalation solution unit dose 1mg	Albuterol Sulfate Airet Proventil Accuneb	Broncho-dilator	Too numerous to list															Not Covered

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J7614	Levalbuterol inhalation solution unit dose 0.5mg	Xopenex	Broncho-dilator	54868-4409-00 54569-4748-00 63402-0511-24 63402-0512-24 63402-0513-24															Not Covered
J7616	Albuterol up to 5 mg and Ipratropin bromide up to 1 mg compounded inhalation solution	Duoneb	Broncho-dilator	54569-5432-00 49502-0672-60 49502-0672-30															Not Covered
J7617	Levalbuterol up to 2.5 mg and Ipratropin bromide up to 1 mg. compounded in-halation solution		Broncho-dilator	None															Not Covered
J7618	Albuterol all formulations including separated isomers inhalation solutions concentrated form per 1mg. (Albuteral) or per 0.5 mg (Levalbuterol)		Broncho-dilator	00085-0208-02 '00182-6014-65 '00472-0832-20 '00603-1006-43 '50383-0741-20 '52959-0589-00 '54569-3900-00 '54868-3407-00 '54868-3479-00 '59930-1647-02 '63874-0708-20															Code closed 1/1/05
J7619	Albuterol all formulations including separated isomers inhalation solution unit dose per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)		Broncho-dilator	00054-8063-11 '00054-8063-13 '00054-8063-21 '00603-1005-40 '49502-0697-03 '49502-0697-33 '49502-0697-60 '50383-0742-25 '54569-3899-00 '59930-1517-01 '59930-1517-02															Code closed 1/1/05
J7621	Albuterol all formulations including separated isom-ers up to 5mg (albuterol) or 2.5 mg (levoalbuterol) and ipratropium bromide up to 1 mg compounded inhalation solution		Broncho-dilator	49502-0672-30 49502-0672-60															Code closed 1/1/05

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J7622	Bethamethasone inhalation solution unit dose form per mg			38779-0364-01 '38779-0364-03 '38779-0364-06 '49452-0802-01 '49452-0802-02 '49452-0802-03															Not Covered
J7624	Bethamethasone inhalation solution unit dose form per mg																		Not Covered
J7626	Butesonide inhalation solution unit dose form 0.25mg to 0.5mg	Pulmicort Respules		54569-5163-00 00186-1988-04 00186-1989-04															Not Covered
J7628	Bitolterol mesylate inhalation solution con-centrated form per mg	Tornalate		None															Not Covered
J7629	Bitolterol mesylate inhalation solution unit dose form per mg	Tornalate		None															Not Covered
J7631	Cromolyn sodium inhaltion solution unit dose form per 10mg	Gastrocrom Intal Nasalcrom	Antiallergic	00054-8167-21 '00054-8167-23 '00172-6406-49 '00172-6406-59 '00472-0750-21 '00472-0750-60 '49502-0689-02 '49502-0689-12															Not Covered
J7633	Budesonide inhalation solution concentrated form per 0.25mg	Pulmicort	Cortico-steroid	38779-0198-00 '38779-0198-03 '38779-0198-06 '49452-1291-01 '49452-1291-02 '49452-1291-03 '51552-0668-01															Not Covered
J7635	Atropine inhalation solution concentrated form per mg.																		Not Covered
J7636	Atropine inhalation solution administered through DME unit dose form per mg			10019-0250-20															Not Covered

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J7637	Dexamethasone inhalation solution concentrated form per mg			00223-7401-25 '00223-7402-30 '00223-7403-01 '00223-7404-05 '00223-7406-25 '00223-7407-01 '00223-7408-10 '00314-0896-30 '00314-0896-70 '00314-0896-75 '00517-4901-25 '00517-4905-25 '00517-4930-25 '00641-0367-25 '00703-3524-01 '00703-3524-03 '25332-0010-05															Not Covered
J7638	Dexamethasone inhalation administered through DME unit dose form per mg			Too numerous to list															Not Covered
J7639	Dornase alpha inhalation solution unit dose form per mg	Pulmozyme		50242-0100-39 '50242-0100-40															Not Covered
J7641	Flunisolide inhalation solution unit dose per mg			38779-0406-00 38779-0406-06 '38779-0406-09 '51552-0611-01 '51552-0611-05															Not Covered
J7642	Glycopyrrolate inhalation solution concentrated form per mg			00031-7890-06 '00031-7890-83 00223-7722-05 '00223-7723-20 '00517-4605-25 '00517-4620-25 '10019-0016-54 10019-0016-63															Not Covered
J7643	Glycopyrrolate inhalation solution unit dose form per mg			00031-7890-06 00031-7890-83 '00223-7722-05 '00223-7723-20 00517-4605-25 00517-4620-25 '10019-0016-54 '10019-0016-63															Not Covered

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J7644	Ipratropium bromide inhalation solution unit dose form per mg	Atrovent		00054-8402-11 '00054-8402-13 00054-8402-21 '00054-8404-11 '00054-8404-13 '00054-8404-21 '00472-0751-23 '00472-0751-30 '00472-0751-60 '00597-0080-62 '49502-0685-03 '49502-0685-33 '49502-0685-60															Medical necessity documentation of services provided must be maintained in the member's individual file.
J7648	Isoetharine HCl inhalation solution concentrated form per mg																		Not Covered
J7649	Isoetharine HCl inhalation solution unit dose form per mg																		Not Covered
J7658	Isoproterenol HCl inhalation solution con-centrated form per mg	Isuprel HCl Medihaler-150		00641-1438-35															Not Covered
J7659	Isoproterenol HCl inhalation solution unit dose form per mg	Isuprel HCl Medihaler-150		00641-1438-35															Not Covered
J7668	Metaproterenol sulfate inhalation solution con-centrated form per 10mg	Alupent																	Not Covered
J7669	Metaproterenol sulfate inhalation solution unit dose form per 10 mg	Alupent																	Not Covered
J7674	Methacholine chloride as inhalation solution through a nebulizer per 1mg	Provocho-line		64281-0100-12 64281-0100-06															Not Covered
J7680	Terbutaline sulfate inhalation solution con-centrated form per mg	Brethine Bricanyl																	Not Covered

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J7681	Terbutaline sulfate inhalation solution unit dose form per mg	Brethine Bricanyl																	Not Covered
J7682	Tobramycin unit dose form 300mg inhalation solution	Tobi		53905-0065-01															Not Covered
J7683	Triamcinolone inhalation solution concentrated form per mg	Azmacort		00003-0293-05 '00003-0293-20 '00003-0293-28															Not Covered
J7684	Triamcinolone inhalation solution unit dose form per mg	Azmacort		00003-0293-05 '00003-0293-20 '00003-0293-28															Not Covered
J7699	**NOC drugs inhalation drugs. Used only if a more specific code is not available.**																		Not Covered
J7799	**NOC drugs other than inhalation drugs. Used only if a more specific code is not available**																		Not Covered
J8499	**Prescription drug oral non-chemotherapeutic NOS**																		Not Covered
J8501	Aprepitant oral 5mg	Emend Emend Tri-Fold	Antiemetic	00006-0462-30 00006-0461-30 00006-0462-05 00006-0461-05 00006-3862-03															Not Covered
J8510	Bulsulfan oral2 mg	Myleran	Anti-neoplastic	00173-0713-25															Not Covered
J8520	Capecitabine oral 150mg	Xeloda	Anti-neoplastic	00004-1100-51 00004-1100-20															Not Covered
J8521	Capecitabine oral 500mg	Xeloda	Anti-neoplastic	00004-1101-16 00004-1101-50															Not Covered
J8530	Cyclophosphamide oral 25mg	Cytoxan Procytox	Anti-neoplastic	00015-0503-01 00015-0503-02 00015-0504-01 00054-4129-25 00054-4130-25 00054-8089-25 00054-8130-25															Not Covered

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J8560	Etoposide oral 50mg	VePesid	Anti-neoplastic	00015-3091-45 00378-3266-94 51079-0965-05															Not Covered
J8565	Gefitnib oral 250mg	Iressa	Anti-neoplastic																Not Covered
J8600	Melphalan oral 2mg	Alkeran		00173-0045-35 59572-0302-50															Not Covered
J8610	Methotrexate oral 2.5mg	Rheumatrex Dose Pack		00005-4507-04 00005-4507-05 00005-4507-07 00005-4507-09 00005-4507-91 00054-4550-15 00054-4550-25 00054-8550-25 00378-0014-01 00378-0014-50 00555-0572-02 00555-0572-35 00555-0572-45 00555-0572-46 00555-0572-47 00555-0572-48 00555-0572-49 00555-0927-01 00555-0928-01 00555-0929-01 00555-0945-01 00603-4499-21 00904-1749-60 51079-0670-05	N/C													Not Covered
J8700	Temozolomide oral 5mg	Temodar		00085-1244-01 00085-1244-02 00085-1248-01 00085-1248-02 00085-1252-01 00085-1252-02 00085-1259-01 00085-1259-02															Not Covered
J8999	**Prescription drug oral chemotherapeutic NOS. Used only if a more specific code is not available.**																		Not Covered

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J9000	Doxorubicin HCl 10mg	Adriamycin	Anti-neoplastic	00703-5043-03 '55390-0231-10 '55390-0235-10 '55390-0241-10 '55390-0245-10	20 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9001	Doxorubicin HCl all lipid formulation 10mg	Doxil	Anti-neoplastic	17314-9600-01 '17314-9600-02	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9010	Alemtuzumab 10mg	Campath	Anti-neoplastic	50419-0355-10	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9015	Aldesleukin per single use vial.	Proleukin	Biological Response Modulator	53905-0991-01	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9017	Arsenic trioxide 1mg	Trisenox	Anti-neoplastic	60553-0111-10	15 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9020	Asparaginase 10000U	Elspar	Anti-neoplastic	00006-4612-00 00247-1289-10	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9031	BCG live (intravesical) per instillation	TheraCys Tice BCG	Biological Response Modulator	00052-0602-02 49281-0880-01 00052-0603-02	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9035	Injection bevacizumab 10 mg	Avastin		50242-0061-01 50242-0060-02 50242-0060-01	None	X	X												New code 1/1/05. Requires ICD-9-CM code 153.0 - 154.8 on CMS claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9040	Bleomycin sulfate 15U	Blenoxane	Anti-neoplastic	00015-3010-20 '00703-3154-01 '00703-3154-91 '61703-0332-18 61703-0323-22 55390-0006-01 00703-3155-91 00703-3155-01 55390-0005-01	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9041	Injection bortezomib 0.1 mg	Velcade	Proteasome Inhibitor	63020-0049-01	None	X	X												New code 1/1/05 Activate 1/1/05. Must have ICD-9-CM code 203.00 on CMS claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9045	Carboplatin 50mg	Paraplatin	Anti-neoplastic	00015-3213-30	18 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9050	Carmustine 100mg	BICNU	Anti-neoplastic	00015-3012-38	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9055	Injection Cetuximab 10 mg	Erbitux		66733-0948-23	None	X	X												Code opened 1/1/05. Must have ICD-9-CM code 153.0-154.8 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9060	Cisplatin powder or solution per 10mg	Plantinol AQ	Anti-neoplastic	00703-5747-11 '00703-5748-11 '10019-0910-01 '10019-0910-02 '55390-0112-50 '55390-0112-99 '55390-0414-50 '55390-0414-99 '63323-0103-91 '63323-0103-95	18 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9062	Cisplatin 50mg	Plantinol AQ	Anti-neoplastic	00703-5747-11 '10019-0910-01 '55390-0112-50 '55390-0414-50 '63323-0103-91	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9065	Injection cladribine per 1 mg	Leustatin	Anti-neoplastic	55390-0115-01 '55390-0124-01 '59676-0201-01	40 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9070	Cyclophosphamide 100mg	Cytoxan Neosar	Anti-neoplastic	00013-5606-93	68 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9080	Cyclophosphamide 200 mg	Cytoxan Neosar	Anti-neoplastic	00013-5616-93	34 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9090	Cyclophosphamide 500 mg	Cytoxan Neosar	Anti-neoplastic	00013-5626-93 '00015-0547-41	14 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9091	Cyclophosphamide 1g	Cytoxan Neosar	Anti-neoplastic	00013-5636-70 '00015-0548-41	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9092	Cyclophosphamide 2g	Cytoxan Neosar	Anti-neoplastic	00013-5646-70 '00015-0549-12	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9093	Cyclophosphamide lyophilized 100mg	Cytoxan Lyophilized	Anti-neoplastic	00015-0546-41	68 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9094	Cyclophosphamide lyophilized 200 mg	Cytoxan Lyophilized	Anti-neoplastic	00015-0546-41	34 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9095	Cyclophosphamide lyophilized 500 gm	Cytoxan Lyophilized	Anti-neoplastic	00013-5626-93 '00015-0547-41	14 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9096	Cyclophosphamide lyophilized 1g	Cytoxan Lyophilized	Anti-neoplastic	00013-5636-70 '00015-0548-41	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9097	Cyclophosphamide lyophilized 2g	Cytoxan Lyophilized	Anti-neoplastic	00015-0549-12 '00015-0549-41	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9098	Cytarabine liposome 10 mg	DepoCyt	Anti-neoplastic	53905-0331-01	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9100	Cytarabine 100mg	Cytosar-U	Anti-neoplastic	00009-0373-01	75 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9110	Cytarabine 500mg	Cytosar-U	Anti-neoplastic	00009-0473-01 '55390-0132-10 '55390-0807-10	15 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9120	Dactinomycin 0.5mg	Cosmegen	Anti-neoplastic	00006-3298-22	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9130	Dacarbazine 100mg	DTIC-Dome	Anti-neoplastic	63323-0127-10	9 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9140	Dacarbazine 200mg	DTIC-Dome	Anti-neoplastic	00026-8151-20 '00703-5075-01 '00703-5075-03 '55390-0090-10 '63323-0128-12 '63323-0128-20	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9150	Daunorubicin HCl 10mg	Cerubidine	Anti-neoplastic	55390-0281-10 '55390-0805-10	11 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9151	Daunorubicin citrate liposomal formulation 10 mg	Daunoxome	Anti-neoplastic	61958-0301-01	11 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9160	Denileukin diftitox 300mcg	Ontak	Anti-neoplastic	64365-0503-01															Not Covered
J9165	Diethylstilbestrol diphosphate 250 mg	Stilphostrol			4 per day	X	X												Cannot bill with 96545. Only for cancer diagnosis. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9170	Docetaxel 20mg	Taxotere	Anti-neoplastic	00075-8001-20	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9178	Injection epirubicin HCl 2 mg	Ellence	Anti-neoplastic	00009-5091-01 00009-5093-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9181	Etoposide 10mg	VesPesid Toposar	Anti-neoplastic	00013-7336-91 '00013-7346-94 '00013-7356-88 '00015-3061-20 '00015-3062-20 '00015-3084-20 '00015-3095-20 '10019-0930-01 '55390-0291-01 '55390-0292-01 '55390-0293-01 '55390-0491-01 '55390-0492-01 '55390-0493-01 '63323-0104-05 '63323-0104-25 '63323-0104-50	25 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9182	Etoposide 100mg	VesPesid Toposar	Anti-neoplastic	00013-7336-91 '00015-3095-20 '55390-0291-01 '55390-0491-01 '63323-0104-05	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9185	Fludarabine phosphate 50mg	Fludara	Anti-neoplastic	50419-0511-06	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9190	Fluorouracil 500 mg	Adrucil	Anti-neoplastic	00013-1036-91 '00187-3953-64	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9200	Floxuridine 500 mg	FUDR	Anti-neoplastic	55390-0135-01 '55390-0435-01 '61703-0331-09 '63323-0145-07	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9201	Gemcitabine HCl 200mg	Gemzar	Anti-neoplastic	00002-7501-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9202	Goserelin acetate implant per 3.6mg	Zoladex	Anti-neoplastic	00310-0960-36 00310-0951-30 00310-0950-35	1 per month	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9206	Irinotecan 20mg	Camptosar	Anti-neoplastic	00009-7529-01 '00009-7529-02	35 per day	X	X												Requires ICD-9-CM code 153.0 - 154.8.on CMS 1500 claim form for payment consideratin. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9208	Ifosfamide per 1g	Ifex	Anti-neoplastic	00015-0556-05 '63323-0142-10 '63323-0142-12 00015-0557-41	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9209	Mesna 200mg	Mesnex	Anti-neoplastic	00015-3563-02 '00015-3563-03 '00703-4805-03 '63323-0733-10 '63323-0733-11 '63323-0733-12	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9211	Idarubicin HCl 5mg	Idamycin Pfs	Anti-neoplastic	00703-4154-11	12 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9212	Injection interferon alfa-con1 recombinant 1mcg	Infergen	Antiviral	'55513-0562-01 55513-0562-06 '64116-0031-01 '64116-0031-06	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9213	Interferon alfa-2A recombinant 3 million U	Roferon-A	Antiviral	00004-2015-07 '00004-2015-09	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9214	Interferon alfa-2B recombinant 1 million U	Intron-A	Antiviral	00085-0539-01 '00085-0571-02 '00085-1110-01	19 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9215	Interferon alfo-n3 human leukocyte derived 250,000 IU	Alferon-N	Biological Response Modulator	54746-0001-01	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9216	Interferon gamma 1B 3 million U	Actimmune	Biological Response Modulator	64116-0011-01 '64116-0011-12	2 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9217	Leuprolide acetate for depot suspension 7.5mg	Lupron Depot Eligard Lupron Depot Ped	Anti-neoplastic	00024-0597-07 '00300-3642-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9218	Leuprolide acetate 1mg	Lupron	Anti-neoplastic	00182-3154-99 '00185-7400-14 '00185-7400-85 '00300-3612-24 '00300-3612-28 '00703-4014-18 '00703-4014-19	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9219	Leuprolide acetate implant 65mg	Viadur	Anti-neoplastic	00026-9711-01	1 per 3 months	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9230	Mechlorethamine HCl nitrogen mustard 10mg	Mustargen	Anti-neoplastic	00006-7753-31	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9245	Injection melphalan HCl 50mg	Alkeran Lphenylalanine mustard	Anti-neoplastic	00173-0130-93	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9250	Methotrexate sodium 5mg	Rheumatrex Trexall Methotrexate sodium Lpf	Anti-neoplastic	54569-4983-00 '63323-0123-02 '63323-0123-10 '66479-0137-21 '66479-0139-29	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9260	Methotrexate sodium 50mg	Rheumatrex Trexall Methotrexate sodium Lpf	Anti-neoplastic	63323-0123-02	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9263	Injection oxaliplatin 0.5mg	Eloxatin	Anti-neoplastic	00024-0596-02 00024-0597-04	None	X	X												Requires ICD-9-CM code 153.0 - 154.8 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9265	Paclitaxel 20mg	Taxol Onxol	Anti-neoplastic	00015-3475-30 '00015-3479-11 '00172-3753-77 '00172-3753-96 '00172-3754-73 '00172-3754-94 '00172-3756-75 '00172-3756-95 '51079-0961-01 '51079-0962-01 '51079-0963-01 '55390-0114-05 '55390-0114-20 '55390-0114-50	20 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9266	Pegaspargase per single dose vial	Oncaspar	Anti-neoplastic	57665-0002-02	8 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9268	Pentostatin per 10mg	Nipent	Anti-neoplastic	62701-0800-01	1 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9270	Plicamycin 2.5mg	Mithracin Mithramycin	Anti-neoplastic	00026-8161-15	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9280	Mitomycin 5mg	Mutamycin	Anti-neoplastic	00015-3001-20 '55390-0251-01 '55390-0451-01 '62701-0010-01	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9290	Mitomycin 20mg	Mutamycin	Anti-neoplastic	00015-3002-20 '55390-0252-01 '55390-0452-01 '62701-0011-01 '63323-0191-40	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J9291	Mitomycin 40mg	Mutamycin	Anti-neoplastic	00015-3059-20 '55390-0253-01 '55390-0453-01		X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9293	Injection mitaxan-trone HCl 5mg	Navatrone	Anti-neoplastic	58406-0640-03 '58406-0640-05 '58406-0640-07	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9300	Gemtuzumab ozogamicin 5mg	Mylotarg	Anti-neoplastic	00008-4510-01	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9305	Injection pemetrexed 10mg	Alimta	Anti-neoplastic	00002-7673-01	None	X	X												New code 1/1/05. Must have ICD-9-CM code 162-163.9 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9310	Rituximab 100mg	RituXan	Anti-neoplastic	50242-0051-21 50242-0053-06	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9320	Streptozocin 1g	Zanosar	Anti-neoplastic	00247-1394-01 00703-4636-01	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9340	Thiotepa 15mg	Thioplex	Anti-neoplastic	00703-4301-02 '55390-0030-10 '58406-0662-01 58406-0662-36	10 per day	X	X												For Bone Marrow Transplants. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9350	Topotecan 4mg	Hycamtin	Anti-neoplastic	00007-4201-01 '00007-4201-05															Not Covered
J9355	Trastuzumab 10mg	Herceptin	Anti-neoplastic	50242-0134-60	40 per day	X	X												Canot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9357	Valrubicin intravesical 200mg	Valstar	Anti-neoplastic	53014-0216-04 '53014-0216-24	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9360	Vinblastine sulfate 1mg	Vinblastine Sulfate Velban	Anti-neoplastic	63323-0278-10 61703-0310-18 55390-0091-10	46 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9370	Vincristine sulfate 1mg	Oncovin Vincasar Pfs	Anti-neoplastic	00013-7456-86 '00703-4402-11	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9375	Vincristine sulfate 2mg	Oncovin Vincasar Pfs	Anti-neoplastic	00013-7466-86 '00703-4412-11	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9380	Vincristine sulfate 5mg	Vincasar Pfs	Anti-neoplastic	00013-7456-86 '00013-7466-86 '00703-4402-11 '00703-4412-11	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9390	Vinorelbine tartrate 10mg	Navelbine	Anti-neoplastic	00173-0656-01 '00703-4182-01 '00703-4183-01 '59911-5958-01	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9395	Injection fulvestrant 25mg	Faslodex	Antineo-plastic	00310-0720-25 00310-0720-50	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J9600	Porfimer sodium 75mg	Photofrin	Antineo-plastic	58914-0155-75	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9999	**NOC antineoplastic drug. Used only if a more specific code in not available.**					X	X											X	Requires Prior Authorization effective 7/1/05. Submit medical documentation of failed therapy(ies) and confirmation of diagnosis to BMS Medical Director for review prior to providing services. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 16
DRUGS APPROVED TO BE BILLED WITH
HCPCS CODE J3490
PAGE 1 OF 6

West Virginia Department of Health and Human Resources
Office of Healthcare Policy Managed Care Coordination
Unlisted J3490 Medications
July 1, 2005

Description	Brand Name	Dosage	Reimbursable To	Special Instruction
Allopurinal Sodium	Aloprim Zyloprim	500mg	Outpatient Hospital and Physician	ICD-9-CM 174.9 or 790.6 plus ICD-9-CM for Neoplasm and NDC# required on claim. Drug must be billed with the code for Chemotherapy.
Amikacin Sulfate	Amikin	50mg	Physician and Nurse Practitioner	NDC# required on claim form.
Azacitidine	Vidaza	1mg	Outpatient Hospital and Physician	ICD-9-CM 238.7 and NDC# required on claim.
Aztreonam	Azactam	500mg	Physician and Nurse Practitioner	NDC# required on claim.
Bretylium	Tosylate	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Bumetanide	Bumex	0.25mg	Physician and Nurse Practitioner	NDC# required on claim.
Bupivicaine 0.75%, 1ml	Marcaine Sensorcaine	1ml	Physician and Nurse Practitioner	0.75%/10ml allowed when billed with 62310, 62311, 62318, 62319, 64400 - 64484, 64505 - 64530. Not payable when billed with other procedures. NDC# required on claim.
Cimetidine HCl	Tagamet	150mg	Physician and Nurse Practitioner	ICD-9-CM 787.01, 787.02 OR 787.03 and NDC# required on claim.

Clavulanate Potassium/Ticarcillin Disodium	Timentin	0.1-3G	Physician and Nurse Practitioner	NDC# required on claim.
Clindamycin Phosphate	Cleocin Clindamax	150mg	Physician and Nurse Practitioner	NDC# required on claim.
Dantrolene Sodium	Dantrium	20mg	Physician and Nurse Practitioner	NDC# required on claim.
Dextrose 50%		50%	Physician and Nurse Practitioner	NDC# required on claim.
Diltiazem HCl	Cardizem	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Edrophonium Chloride	Tensilon Reverso	10mg	Physician and Nurse Practitioner	ICD-9-CM 358.0 and NDC# required on claim.
Esmolol HCl	Brevibloc	10mg	Physician and Nurse Practitioner	ICD-9-CM 427.89 and NDC# required on claim.
Ethacrynate Sodium	Edecrin	50mg	Physician and Nurse Practitioner	NDC# required on claim.
Famotidine	Pepcid	10mg	Physician and Nurse Practitioner	NDC# required on claim.
Flumazenil	Romazicon Mazicon	0.1mg	Physician and Nurse Practitioner	ICD-9-CM 977.9 and NDC# required on claim.
Folic Acid	Folate	5mg	Physician and Nurse Practitioner	NDC# required on claim.

Glycopyrrolate	Robinul	0.2mg	Physician and Nurse Practitioner	NDC# required on claim.
Heparin Sodium		100U	Physician and Nurse Practitioner	NDC# required on claim.
Histrelin Implant	Vantas	5mg	Physician	ICD-9-CM code 185 and NDC# required on claim. Service limits 1 per year. Males only.
Isoproterenol HCl	Isuprel	0.2mg	Physician and Nurse Practitioner	NDC# required on claim.
Labetalol HCl	Trandate Normodyne	20mg	Physician and Nurse Practitioner	Covered for IV in office only with ICD-9-CM 401.0 and NDC# required on claim.
Lidocaine		1ml	Physician	Covered separately when billed on same day as 62310, 62311, 62318, 62319, 64400-64484, 64505-64530. Not payable when billed with other procedures. NDC# required on claim.
Metoprolol Tartrate	Lopressor	1mg	Outpatient Hospital, Physician, IDTF	Covered only when given IV with Dobutamine J1250 during Dobutamine Stress Test. Bill with both J3490 & J1250. NDC# required on claim.
Metronidazole in NACL	Flagyl	500mg	Physician and Nurse Practitioner	NDC# required on claim.
Minocycline HCl	Dunacin Minocin	100mg	Physician and Nurse Practitioner	NDC# required on claim.

Nafcillin Sodium	Unipen Nallpen	lG	Physician and Nurse Practitioner	NDC# required on claim.
Nitroglycerin	Nitrostat	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Paclitaxel protein-bound particles	Abraxane	1mg	Outpatient Hospital and Physician	New code 04/01/05. Mjust be billed with Chemo. NDC# required on claim.
Pantoprazole Sodium	Protonix	40mg	Physician and Nurse Practitioner	NDC# required on claim.
Pegaptanib Sodium	Macugen	0.3mg	Ophthalmol-ogist ONLY	ICD-9-CM 362.52 and NDC# required on claim. Service limit 1 every 6 weeks. Must be billed with CPT 67028-RT or CPT 67028-LT
Potassium Acetate	Klor-Con	2mEq	Physician and Nurse Practitioner	NDC# required on claim.
Rifampin	Rifacin Rimactane	600mg	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Acetate		2mEq	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Bicarbonate		8.4% in 50ml	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Hyaluronate for Intra-Articular Injection	Orthovisc	30mg	Outpatient Hospital and Physician	ICD-9-CM 715.16, 715.26, 715.36 OR 715.96 and NDC# required on claim. Must be billed with CPT 20610. Service limit 1 injection per knee per week x 6months.

Valproate Sodium	Depacon	100mg	Physician and Nurse Practitioner	ICD-9-CM code 345.00-345.91 and NDC# required on claim.
Vasopressin	Pitressin	20U	Physician and Nurse Practitioner	NDC# required on claim.
Verapamil HCl	Calan Calan SR IsoptinSR	2.5mg	Physician and Nurse Practitioner	NDC# required on claim.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 17
OUTPATIENT SURGERY PA REQUIREMENTS
PAGE 1 OF 15

Confidential

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____

A. **Member** Name: _____ Date of Birth: _____
Last First MI
Member Address: _____
Street City State Zip

B. **Surgical Procedure** Requested: _____
CPT Code **(Required)**: _____ ICD-9-CM Code **(Required)**: _____ Assistant surgeon? ☐ Yes ☐ No

Diagnosis Related to Surgical Procedure: _____

C. **Facility** Performing Surgical Procedure: _____
Facility ID # (10 digits): _____ Facility is: □ In WV □ Outside WV

Referring Physician Name: _____
Mailing Address: _____
Street City State Zip
Surgeon Name: _____
Mailing Address: _____
Street City State Zip

Contact Name: _____ Phone# (_____)_____-_____ Ext: _____
Fax # (_____)_____-_____

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): _____
_____
_____
_____ Date of Onset: _____

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):_____
_____
_____

F. **Related Medications, Treatments, and Therapies (include duration): _____**
_____
_____
_____

G. If procedure routinely performed in office, please document need for OP surgical setting: _____
_____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For <u>WVMI Use Only:</u>
Approved: ___ Authorization Number: _____ Date*: _____

***(Authorization expires 90 days from this date)**

Denied: ____ Detailed letter to follow

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X
11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X

11471	Removal, sweat gland lesion	X	X
11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X
12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	

14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	
14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	
19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	

19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	
19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	

21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	
21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	

22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	
22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	
25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	

26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	
26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	
27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	

28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	
28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	
29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	

29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	
42810	Excision of nect cyst	X	

42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	
43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	
49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	
54409	Removal of inflatable penile prosthesis	X	

54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	
57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	
58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	
64555	Implant neuroelectrodes	X	

64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	
64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervation of extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	
69632	Rebuild eardrum structures	X	

69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	
76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	
51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	

CHAPTER 519

PRACTITIONER SERVICES

JANUARY 16, 2012

ATTACHMENT 18

INFANT AND CHILD ORAL HEALTH FLUORIDE VARNISH PROGRAM FOR PRIMARY CARE PRACTITIONERS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Governor

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Cabinet Secretary

Bureau for Medical Services
Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners
Coverage Criteria

Physician fluoride varnish (FV) services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations specified below in this document. The American Dental Association (ADA) expert panels have reviewed evidence-based (class 1a) studies and concluded that "Fluoride varnish applied every six months is effective in preventing caries in the primary and permanent dentition of children and adolescents." Please see JADA executive Summary 2006 recommendations attached.

Fluoride varnish is a thin coating of resin that is applied to the tooth surface to protect it from decay. According to the Food & Drug Administration (FDA), fluoride varnish falls under the category of "drugs and devices" that presents minimal risk and is subject to the lowest level of regulation. The purpose of applying fluoride varnish is to retard, arrest, and reverse the process of cavity formation.

Fluoride varnish is easy to apply, does not require special dental equipment or a professional cleaning prior to application. It also requires minimal training, and is inexpensive. Fluoride varnish dries immediately upon contact with saliva and is safe and well tolerated by infants, young children, and individuals with special needs.

Effective January 16, 2012, the Bureau for Medical Services (BMS) will start reimbursing primary care providers who have been certified through a face-to-face training for fluoride varnish application offered through the West Virginia University School of Dentistry for the application of fluoride varnish to children ages 6 months to 36 months (3 years) who are at high risk of developing dental caries. The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist.

A child is considered at high risk of developing cavities if he or she:

- ✓ Has had cavities in the past or has white spot lesions and stained fissures
- ✓ Continues to use the bottle past one year of age or sleeps with a bottle containing liquids other than water
- ✓ Breastfeeds on demand at night
- ✓ Has a developmental disability
- ✓ Chronically uses high sugar oral medications
- ✓ Has family members with histories of caries
- ✓ Engages in prolonged or ad lib use throughout the day of a bottle or "sippy" cup containing liquids other than water

Who is not Covered:

- ✓ Children with a low risk of cavity formation who consume optimally fluoridated water or children who receive routine fluoride treatments through a dental office.

BMS recognizes the following types of primary care providers to be eligible for payment of this service:

- ✓ Pediatricians
- ✓ General and Family Practice Doctors
- ✓ Nurse Practitioners
- ✓ Physician Assistants (in FQHC settings only)

Provider Eligibility to Bill for Program Services

Providers must have completed a certified training course from the WVU School of Dentistry prior to performing and billing for these services. The WVU School of Dentistry will provide a list of all current certifications monthly in 2011 and thereafter to BMS and its fiscal agent in order to create a file of reimbursable providers. Information about this course is available at www.hsc.wvu.edu/sod/oral-health.

Reimbursement for the Services

BMS allows coverage of two fluoride varnish applications per year (one every six months). The first application must be provided and billed in conjunction with a comprehensive well-child exam as reported under the CPT codes listed in the table below. The second fluoride varnish application can be reimbursed during the 12-month subsequent period, and may be billed in conjunction with the HCPCS code outlined in the table below.

BMS will use the following codes to reimburse primary care providers for fluoride varnish application:

Code	Description	Comments
99381-99382 99391-99392	Comprehensive well-child exam codes for children less than 1 year and up to age 4 (note FV coverage under this program is only through age 3)	Oral evaluation and counseling are components of comprehensive well –child exams
T1503	Administration of medication, other than oral and/or injectable by a health care agency/professional, per visit Note: Use this code to bill for the topical fluoride varnish; therapeutic application for moderate to high caries risk patients. By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D1206-Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	Covered 2 times per year for children up to age 3; 1st application must be billed in conjunction with one of the comprehensive well child exam codes listed above
T1503-DA	Use Code T1503 with modifier-DA (Oral health assessment by a licensed health professional other than a dentist) to bill for oral evaluation of patient under three years of age and counseling with primary caregiver. Note: By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D0145 – Oral Evaluation for patient under three years of age and counseling with primary caregiver.	Covered once per year in conjunction with 2nd fluoride varnish application; cannot be covered when comprehensive well-child exam is billed on the same day and at least 180 days after billing for the comprehensive well child-exam
V20.2	Routine infant or child health check	Primary diagnosis used when billing well-child exam
V82.89	Special screening for other specified conditions	Secondary diagnosis used when billing comprehensive well-child exam
V72.2	Dental Exam	Primary diagnosis used when billing D0145 – dental exam; cannot report in combination with V20.2

Reimbursement will be made using the dental fee schedule effective on the date of service. The current fee for T1503 (D1206) will be $20.00 and T1503-DA (D0145) will be $25.00.

CHAPTER 520 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PODIATRY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 520.8	Prior Authorization Requirements	01/06/06	February 15, 2006
Attachment I	Level II Alpha Procedure Codes	01/05/06	February 15, 2006
Section 520.5.7	Inserts/Modifications/Repairs/ Replacements/Inlays for Therapeutic Shoes for Diabetes	01/03/06	February 15, 2006
Section 520.5.6	Therapeutic Shoes For Diabetes	01/03/06	February 15, 2006
Section 520.8	Prior Authorization Requirements	10/24/05	Postponed
Section 520.8	Prior Authorization Requirements	9/27/05	11/01/05
Section 520.8.1	Prior Authorization Requirements for Outpatient Services	9/27/05	10/01/05

JANUARY 06, 2006

SECTION 520.8

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment 3.

Change: First paragraph to read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 3, along with the PA form that may be utilized.

Directions: Replace pages.

JANUARY 05, 2006

ATTACHMENT I

Introduction: CMS changes to covered procedure codes.

Change: Procedure code K0628 was deleted, and it was replaced by code A5512. Description stayed the same. Procedure code K0629 was deleted, and it was replaced by procedure code A5513. This procedure code had a small description change.

Directions: Replace pages.

JANUARY 03, 2006

SECTION 520.5.7

Introduction: Implementing changes in policy for prior authorization for inserts for diabetic shoes.

Change: In the first bullet, put a period behind the word “shoes”. Delete the words, “and the inserts are prior authorized”.

Directions: Replace pages.

JANUARY 03, 2006

SECTION 520.5.6

Introduction: Implementing changes in policy for prior authorization to diabetic shoes effective 2/15/06.

Change: Take out the comma after the word “met”, put in the word “and” after the word “met”, and put a semicolon after the word documented. The words “and prior authorized” should be deleted.

Directions: Replace pages.

OCTOBER 24, 2005

SECTION 520.8

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

SEPTEMBER 27, 2005

SECTION 520.8

Introduction: Implementing changes in policy for outpatient surgery effective 11/01/05.

Change: Added sentence, “All surgeries performed in place of service 22 (Outpatient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005”. Added “alpha” to second sentence which now reads “alpha procedures requiring prior authorization are listed in Attachment 1”.

Directions: Replace pages.

SECTION 520.8.1

Introduction: Implementing changes in policy for imaging procedures effective 10/01/05.

Change: Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Directions: Replace pages.

CHAPTER 520—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PODIATRY SERVICES

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TOPIC **PAGE NO.**

CHAPTER 520–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PODIATRY SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

The policies and procedures set forth herein are promulgated as regulations governing the provision of foot and ankle care services in the Medicaid Program administered by the Bureau for Medical Services, West Virginia Department of Health and Human Resources, under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

This chapter sets forth the Bureau for Medical Services requirements for reimbursement of services provided by independently practicing and licensed podiatrists to eligible West Virginia Medicaid members.

IMPORTANT: The fact that a provider prescribes, recommends or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.

520.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for reimbursement of foot and ankle care services described in this chapter.

Podiatric Services - The foot and ankle services provided by a podiatrist licensed to provide such services in the State of West Virginia. For provision of ankle surgery, the podiatrist must have hospital privileges granted by the hospital's medical staff credentialing committee.

Podiatrist - An individual currently licensed under West Virginia law to practice podiatry, or under the laws of the State where the practice is conducted, and is eligible to participate in the West Virginia Medicaid Program.

Prior Authorization - Prior approval is necessary before a service can be rendered. A utilization management method used to control certain services, which are limited in amount, duration, or scope.

Referral - The transfer of total or specific care of a West Virginia Medicaid-eligible member from one practitioner to another and does not constitute a consultation.

Routine Foot Care - Any service performed involving the foot in the absence of localized illness, injury, or symptoms. Routine foot care includes, but is not limited to, such services as: cutting or removal of corns, calluses or warts (excluding plantar warts); treatment of a fungal (mycotic) toenail infection; the trimming of nails, including mycotic nails; cleaning and soaking of feet; applications of topical medication or skin creams; and other hygienic and preventive maintenance care in the realm of self care.

Subluxation Of The Foot - The partial dislocation or displacement of joint surfaces, tendons, ligaments or muscles.

Under The Active Care Of A Practitioner/Physician - The member has seen a practitioner/physician for treatment and/or evaluation of the complicating disease during the six-month period prior to the performance of the routine foot care services.

520.2 PROVIDER PARTICIPATION

In order to participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau, podiatrists must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located.
- Meet and maintain all Bureau provider enrollment requirements. (Chapter 300 and Section 520.5.1 of this chapter.)
- Have a valid signed provider enrollment application/agreement on file.

520.3 MEMBER ELIGIBILITY

Reimbursement for foot and ankle care services is available on behalf of all eligible West Virginia Medicaid members subject to the conditions and limitations that apply to these services.

520.4 DESCRIPTION OF COVERED SERVICES

The Bureau will reimburse podiatrists for the following medically necessary and appropriate foot and ankle care services provided to eligible West Virginia Medicaid members:

- Treatment services for acute conditions such as infections, inflammations, and ulcers
- Surgeries for such conditions as bunions, exostoses, hammertoes, neuromas, and ingrown toenails.
- Reduction of fractures and dislocations of the foot and ankle, if specific requirements outlined in Section 520.5.1 are met
- Surgical correction of a subluxated foot structure is covered if:
  - It is an integral part of the treatment of a foot injury
  - It is performed to improve function of the foot
  - It alleviates an induced or associated symptomatic condition.
- Treatments of symptomatic conditions associated with partial displacement of the foot are covered. Symptomatic conditions include:
  - Osteoarthritis
  - Bursitis
  - Bunions
  - Tendonitis
- Treatment of sprains and strains.
- Treatment of plantar warts.
- Orthotics necessary for treatment of the feet and limited to the following items:
  - Footrest, removable, molded to member model
  - Orthopedic footwear, custom molded shoe, removable inner mold, orthotic shoe, and modifications
  - Therapeutic shoes and inserts for members with severe diabetic foot disease and provided for the purpose of averting amputation.
- Consultations for further evaluation and management of the member as requested by a licensed practitioner, including a written report to the requesting practitioner (usually the member's attending

practitioner).

- Evaluation and management services and covered treatment services provided to members who are inpatients of a hospital.
- Covered treatment/surgical services provided to members who are residents of a nursing home except screening services.
- Non-invasive peripheral vascular studies are covered for pre-operative evaluation of members with diabetes or other signs of peripheral vascular disease (93922, 93923, 93925, 93926).

520.5 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

The following limitations apply to the requirements for reimbursement of foot and ankle care services described in this chapter.

520.5.1 SPECIFIC REQUIREMENTS FOR ANKLE PROCEDURES

In order to participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau for ankle surgical procedures, podiatrists must:

- Meet the requirements of Chapter 30, Article 3, Section 4 of the West Virginia Code.
- Provide a copy of their current hospital privileges sheet outlining the ankle surgery procedures that they can perform in that facility upon request by the Bureau for Medical Services. The chairperson, who is a practitioner, must sign the hospital privilege sheet.
- Provide a list of the procedure codes within the provider's scope of practice as outlined in their hospital privileges related to the ankle and for which he/she plans to submit a claim upon request by the Bureau for Medical Services.

520.5.2 ROUTINE FOOT CARE SERVICES

Reimbursement for medically necessary and medically appropriate routine foot care services is limited and contingent on the following:

- Must have referral from treating practitioner who has treated patient within six months.
- The member, under the active care of a practitioner, including inpatient hospital and nursing home residents, must have one or more of the following diseases or systemic conditions, along with documented evidence that unskilled care would be harmful to the member:
  - Diabetes mellitus.
  - Chronic thrombophlebitis.
  - Peripheral neuropathies involving the feet related to malnutrition, alcoholism, malabsorption (celiac disease, tropical sprue) or pernicious anemia, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, chronic renal disease, traumatic injury, neurosyphilis, hereditary sensory radicular neuropathy, angiokeratoma corporis diffusum and amyloid neuropathy.
  - Arteriosclerosis of the extremities.

- Thromboangiitis obliterans or Buerger's disease.

- In addition to the above covered diagnoses, the severity of the condition must be established and supported by clinical findings in conjunction with the practitioner, as follows:

  Class A:

  - A finding of "non-traumatic amputation of foot or integral skeletal portion."

  Class B:

  - Or, any two findings of:
    - Absent posterior tibial pulse
    - Advanced tropic changes, such as decrease in hair growth, nail thickening, discolorations, thin or shiny texture and reddening of skin color (three of these required)
    - Absent dorsalis pedis pulse.

  Class C:

  - Combination of one from Class B and two from Class C or, one finding from the preceding list and two findings of:
    - Claudication
    - Temperature changes, such as cold feet
    - Edema
    - Abnormal spontaneous sensations in the feet
    - Burning

  When billing for the above services, use the appropriate modifier from the list below:

  Q7 One Class A finding.

  Q8 Two Class B findings.

  Q9 One Class B and two Class C findings.

- Podiatrists must obtain and document:
  - The name of the practitioner who has seen the member within the last six months, and with a diagnosis previously provided.
  - The name of the practitioner presently in charge of the member's care if not the same as the referring practitioner.

520.5.3 MYCOTIC NAIL SERVICES

Reimbursement for debridement of mycotic nails is limited as follows:

- Clinical evidence of mycosis of the toenail, and
- Medical evidence documenting the member has a marked limitation of ambulation requiring active treatment of the nails, or
- Medical evidence documenting a non-ambulatory member has a condition that is likely to result in significant medical complications in the absence of such treatment.

Medical record documentation must include:

- Evidence of mycosis for both ambulatory and non-ambulatory members, and
- A detailed description of the affected nails, or
- A photograph of the affected nails, or
- A culture report from an approved and participating laboratory that states the specific organism identified. "Positive for fungus, mycosis, or onychomycosis" is not an acceptable culture report for reimbursement purposes.

520.5.4 NON-INVASIVE PERIPHERAL VASCULAR STUDIES

Reimbursements for non-invasive peripheral vascular studies are covered for feet only subject to a diagnosis of diabetes or peripheral vascular disease. These studies include:

93922 Non-invasive physiologic studies of lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement).

93923 Non-invasive physiologic studies of lower extremity arteries, multiple levels or with provocative functions maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmorgraphy, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia).

93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study.

93926 Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study.

Medical record documentation must include, but is not limited to a clinical summary of the member's condition and a copy of the test results and any other pertinent information documenting the need for non-invasive peripheral vascular studies.

520.5.5 ORTHOPEDIC FOOTWEAR

Custom Orthopedic Shoes: Shoes that are custom molded and manufactured according to the member's specifications and prescribed by a practitioner, doctor of osteopathy, nurse practitioner, or podiatrist.

- **Coverage Guidelines:** Custom shoes are covered for diagnosis of foot deformity. Prior to submitting a request for prior approval, the practitioner must document the nature and severity of the deformity, evidence of pain, indication of tissue breakdown or high probability of tissue breakdown, a description of any limitation on walking, and a practitioner/physician or podiatrist order. Custom shoes must also have a copy of the materials and labor cost itemized.

  A custom molded shoe is covered when the foot deformity cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the supplier's records and submitted to the Bureau for Medical Services' contracted agency for prior authorization. If there is insufficient justification for the custom-molded shoe, but the general coverage criteria are met, reimbursement will be based on the allowance for the least costly medically appropriate alternative.

Stock Orthopedic Shoes: An orthopedic shoe that is not built to a person's individual specifications, as prescribed by a practitioner, podiatrist or other practitioner acting within their licensure.

520.5.6 THERAPEUTIC SHOES FOR DIABETES

Therapeutic shoes, inserts and modifications are covered by West Virginia Medicaid when the following coverage standards are met and documented:

- The member has diabetes (ICD-9-CM diagnosis code required on claims)
- The member has one or more of the following conditions:
  - Previous amputation of a foot, or part of either foot
  - History of previous foot ulceration of either foot
  - History of pre-ulcerative calluses of either foot
  - Peripheral neuropathy with evidence of callous formation of either foot
  - Foot deformity of either foot; and/or
  - Poor circulation of either foot.

520.5.7 INSERTS/MODIFICATIONS/REPAIRS/REPLACEMENTS/INLAYS FOR THERAPEUTIC SHOES FOR DIABETES:

- Separate inserts are covered when the patient has covered diabetic custom-molded or depth shoes. Inserts used in non-covered shoes are not covered.
- Shoe modifications can be substituted for an insert. Common shoe modifications are: rigid rocker bottoms, roller bottoms, wedges, metatarsal bars, or offset heels.
- A podiatrist knowledgeable in the fitting of diabetic shoes and inserts must prescribe shoe inserts and modifications. The footwear must be fitted and furnished by a podiatrist or other qualified individuals such as a pedorthist, orthotist, or prosthetist.
- Replacement will be considered when adequate documentation is provided which supports the medical justification for replacement.
- The practitioner shall be responsible to document the need for replacement. Replacement is not automatic. The current therapeutic shoes for members with a diagnosis of diabetes may still be serviceable.
- The member's current shoes will need to be evaluated for repair and/or modification prior to considering replacement. Medical necessity should indicate why present shoes cannot be repaired or modified.

520.6 NON-COVERED SERVICES

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, the following services are not covered:

- Treatment and supportive devices for flat foot conditions, regardless of underlying pathology.
- Treatment of subluxations of the foot; i.e., correcting a subluxated structure in the foot as an isolated entity.
- Routine foot care performed in the absence of localized illness, injury, or symptoms involving the foot. (See 520.5.2)
- Therapeutic shoes, inserts and/or modifications that are provided to members who do not meet the coverage criteria.
- Consultations or visits when the sole purpose of the encounter is to dispense or fit the shoes.
- Deluxe features of any kind.

- Telephone calls/consultations, including but not limited to, information or services provided to a member or on her/his behalf.
- Services/items for the convenience of the patient or caretaker.
- Failed appointments, including, but not limited to, missed or canceled appointments.
- Time spent in preparation of reports.
- A copy of medical report when the DHHR or the Bureau paid for the original service.
- Experimental services or drugs.
- Research/study projects.
- Services/items that are not least costly that will meet patient's medical needs.
- Services rendered outside the scope of a provider's license.
- Treatment in podiatrist's office, etc. when patient is able to do self care at home.
- Denial of services by a primary payer for "not medically necessary" or "deemed not medically necessary."
- Conscious sedation, local anesthesia, regional anesthesia, IV sedation are non-covered. These are included in the procedure/service being provided.

520.7 MANAGED CARE

- If the individual is a member of a Health Maintenance Organization (HMO), the providers must follow the HMO's prior authorization requirements and applicable rules related to podiatry services and bill the HMO.
- If the individual is a Physician Assured Access System (PAAS) member, authorization/referral is required from the Primary Care Provider (PCP) for reimbursement of services.
- Medicaid will not reimburse for services provided when requirements of the HMO/PAAS Program are not followed.

520.8 PRIOR AUTHORIZATION REQUIREMENTS

Certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 3, along with the PA form that may be utilized.

Alpha procedures requiring prior authorization are listed in Attachment I.

- Prior authorization requests must be completed according to the instructions contained in Attachment 2 to this chapter. The form to be completed follows the instructions in Attachment 2. The form may be duplicated.
- Prior authorization requests must be submitted at a minimum 10 days prior to providing or continuing services that require approval by the Bureau's contracted agency.
- Podiatrists may order and substantiate the need for medical equipment by completing the Certificate of Medical Necessity. However, the item/service must be related to their specialty area.
- If a procedure requires prior authorization, the prior authorization is necessary before the service is

provided. If it is not obtained, reimbursement for the service provided will not be made. The member cannot be billed.

- Requests for prior authorization must be submitted to:

  West Virginia Medical Institute
  Podiatry Review
  3001 Chesterfield Place
  Charleston, West Virginia 25304
  Fax: 304-346-8185

Disclaimer: Prior authorization does not guarantee reimbursement.

520.8.1 Prior Authorization Requirements for Outpatient Services

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

520.9 GENERAL DOCUMENTATION REQUIREMENTS

- Providers must maintain a specific record for all services provided for each West Virginia Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, referral from the member's attending practitioner, pertinent diagnostic information, a current treatment plan signed by the practitioner, documentation of services provided, the dates the services were provided, and the date and signature of individuals providing the service and their titles. Documentation must substantiate medical necessity of the service provided.
- Podiatrists must also comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 00, General Administration of the Provider Manual.

520.10 BILLING PROCEDURES/CODING

- "A" (Alpha) procedure codes for inserts or modifications is used for items related to therapeutic shoes for members with a diagnosis of diabetes. Prior authorization is required.
- Inserts and modifications for footwear other than for diabetes must be coded using the appropriate "L" codes. Prior authorization is required.
- Procedure code A5507 (for diabetics only not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe) requires prior approval. A narrative description of the feature to be provided and the cost invoice is required before authorization will be considered.

Procedure code A5507 is not to be used for deluxe upgrades to therapeutic shoes for members with a diagnosis of diabetes. Deluxe features of any kind are considered a non-covered service for Medicaid.

- When billing for shoes, follow unit description in code book. Enter the correct unit(s) and the prior authorization number on the claim. The PAAS approval number must appear on the claim if the patient has a PAAS provider.
- Podiatrists should refer to Chapter 100, General Information of the Provider Manual for a list of Medicaid Contacts to obtain additional information.

520.11 REIMBURSEMENT LIMITATIONS

- The cost of drugs dispensed by a podiatrist is considered to be included in the podiatric service charge and is not payable as an additional item of service.
- All codes for orthoses or repairs of orthoses billed with the same date of service must be submitted on the same claim.
- Reimbursement may be made for a visit to determine a need for therapeutic shoes, inserts, or modifications if the podiatrist documents that the purpose of such visit was not solely to fit or dispense the shoe, insert, or modification. A podiatrist called in (e.g., nursing facility) by the attending practitioner should bill specific codes for services rendered, i.e. consultation, minor surgeries, etc.
- For custom fabricated orthoses, there must be documentation in the podiatrist's records to support the medical necessity of that type of device rather than a prefabricated orthosis. This information must be available to the Bureau for Medical Services on request.
- There is no separate reimbursement for fitting, evaluation, measurement, casting, fabrication, follow-up, or adjustment of therapeutic shoes, inserts or modifications, or for the certification of need or prescription of the footwear.

520.12 LABORATORY SERVICES

Laboratory services within scope of podiatry state licensure may be ordered. An order for medically necessary laboratory services can be given to the Medicaid member who will present the order with his/her Medicaid card to a participating laboratory or hospital outpatient department.

520.13 PHARMACY SERVICES

When medically necessary, the licensed medical practitioner within the scope of their licensure may write a prescription for their Medicaid patient. The patient presents the prescription to the pharmacy of their choice and the pharmacy will bill the Medicaid Program for covered prescription services.

520.14 RADIOLOGICAL SERVICES

The Medicaid Program provides coverage of radiological services, including interpretation and taking, for eligible members; radiological services must be provided by practitioners/facilities properly licensed and/or certified as required by state law and practicing within the scope of their licensure.

An order for radiological services may be given to the member to be taken to an approved and participating radiological facility or outpatient hospital. The radiological facility and/or outpatient hospital bills the Medicaid Program directly for services provided.

520.15 INPATIENT HOSPITAL SERVICES

All inpatient hospital services covered under the program are subject to the utilization review process, which determines medical necessity for admission and continued stay. This certification is the responsibility of the Bureau for Medical Services' contracted agency.

520.16 ADDITIONAL INFORMATION

For general information concerning procedure codes and diagnosis codes, please refer to Chapter 100, General Information of the Provider Manual. In addition, please refer to the following attachment for procedure codes and prior authorization:

- For detailed information regarding procedure codes for orthopedic/therapeutic footwear, see **Attachment 1**.
- Refer to **Attachment 2** for the instructions and form for "Certificate of Medical Necessity" for Orthotics and Prosthetics.

CHAPTER 520
PODIATRY SERVICES
JULY 1, 2004

ATTACHMENT 1:
LEVEL II "ALPHA"
PROCEDURE CODES FOR
PODIATRY SERVICES
Page 1 of 6

Revised February 15, 2006

West Virginia Department of Health and Human Resources

Bureau For Medical Services

HCPCS Level II

Podiatry Procedure Codes

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	NOT COVERED BY MEDICARE	SPECIAL INSTRUCTIONS
A5500	For diabetics only, fitting (including follow up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5501	For diabetics only, fitting (including follow up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth inlay shoe with wedge(s), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe		2 per year Cost Invoice		Diagnosis Requirements: 250.00 - 250.93
A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer of 3/16 inch material of shore a 40 (or higher), prefabricated, each	A5509	6 per year		Diagnosis Requirements: 250.00 - 250.93
A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom	A5511	2 per year		Diagnosis Requirements: 250.00 - 250.93

	fabricated, each				
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg				
J0704	Injection, betamethasone sodium phosphate, per 4 mg				
J1094	Injection, dexamethasone acetate, 1 mg				
J1100	Injection, dexamethosone sodium phosphate, 1 mg				
J1885	Injection, ketorolac tromethamine, per 15 mg				
J2001	Injection, lidocaine HCI for intravenous infusion, 10 mg				
J3301	Injection, triamcinolone acetonide, per 10 mg				
J3302	Injection, triamcinolone, diacetate, per 5 mg				
J3303	Injection, triamcinolone hexacetonide, per 5 mg				
J3490	Unclassified drugs				
L1902	AFO; ankle gauntlet, prefabricated, includes fitting and adjustment		4 per year		
L1906	multiligamentus ankle support, prefabricated, includes fitting and adjustment		4 per year		
L1930	Ankle foot orthosis; plastic or other material, prefabricated, includes fitting and adjustment		2 per year		
L1970	plastic with ankle joint, custom fabricated		2 per year		
L2112	soft, prefabricated, includes fitting and adjustment		4 per year		
L2114	semi-rigid, prefabricated, includes fitting and adjustment		4 per year		
L3000	Foot, insert, removable, molded to patient model; "UCB" type, Berkeley Shell, each		4 per year Prior Authorization		
L3001	Spenco, each		2 per year		
L3002	plastazote or equal, each		4 per year		
L3003	silicone gel, each		2 per year		
L3010	longitudinal arch support, each		2 per year		
L3020	longitudinal/metatarsal support, each		4 per year		
L3030	Foot, insert, removable, formed to patient foot each		2 per year	X	
L3040	Foot, arch support, removable, premolded; longitudinal, each		4 per year		
L3050	metatarsal, each		2 per year		
L3060	longitudinal/metatarsal, each		2 per year		**Not** covered for diagnosis 250.00 thru 250.93

L3170	Foot, plastic heel stabilizer		2 per year		
L3201	Orthopedic shoe, oxford with supinator or pronator; infant		6 units per year		
L3202	child		6 units per year		
L3203	junior		6 units per year		
L3204	Orthopedic shoe, hightop with supinator or pronator; infant		6 units per year		
L3206	child		6 units per year		
L3207	junior		6 units per year		
L3208	Surgical boot, each; infant		6 units per year		
L3209	child		6 units per year		
L3211	junior		6 units per year		
L3212	Benesch boot, pair; infant		3 pair per year		
L3213	child		3 pair per year		
L3214	junior		3 pair per year		
L3215	Orthopedic footwear, ladies shoes; oxford		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3216	depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3217	hightop, depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3219	Orthopedic footwear, mens shoes; oxford		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3221	depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3222	shoes, hightop, depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3224	Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)		4 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3225	Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)		4 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3230	Orthopedic footwear, custom shoes, depth inlay		2 pair per year		**Not** covered for diagnosis 250.00 thru 250.93

L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each		4 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3251	Foot, shoe molded to patient model; silicone shoe, each		2 per year Prior Authorization Cost Invoice		**Not** covered for diagnosis 250.00 thru 250.93
L3252	plastazole (or similar), custom fabricated, each		2 per year Prior Authorization		**Not** covered for diagnosis 250.00 thru 250.93
L3253	Foot, molded shoe plastazote (or similar) custom fitted, each		2 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3254	Non-standard size or width		2 units per year		
L3255	Non-standard size or length		2 units per year		
L3257	Orthopedic footwear, additional charge for split size		1 unit per year		
L3260	Surgical boot/shoe, each		2 units per year		
L3265	Plastazote sandal, each		2 units per year	X	
L3300	Lift, elevation; heel, tapered to metatarsal, per inch		6 units per year		
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch		6 units per year		
L3350	Heel wedge		4 units per year		
L3450	Heel, SACH, cushion type		2 units per year		
L3480	Heel, pad and depression for spur		2 units per year		
L3485	Heel, pad, removable for spur		2 units per year		
L3580	Orthopedic shoe addition, convert instep to velcro closure		8 units per year		
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified		Prior Authorization Cost Invoice		
L4350	Ankle control orthosis, stirrup style, rigid, includes any type interface (eg., pneumatic gel), prefabricated, includes fitting and adjustment		4 per year		
L4360	Walking boot, pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment		4 per year		
L4392	Replacement, soft interface material; static AFO		4 per year		
L4394	Replace soft interface material, foot drop splint		4 per year		
L4396	Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and		2 per year		

	adjustment				
L4398	Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment		2 per year		
Q4037	Cast supplies, short leg cast, adult (11 years +), plaster				
Q4038	Cast supplies, short leg cast, adult (11 years +), fiberglass				
Q4039	Cast supplies, short leg cast, pediatric (0-10 years), plaster				
Q4040	Cast supplies, short leg cast, pediatric (0-10 years), fiberglass				
Q4045	Cast supplies, short leg splint, adult (11 years +), plaster				
Q4046	Cast supplies, short leg splint, adult (11 years +), fiberglass				
Q4047	Cast supplies, short leg splint, pediatric (0-10 years), plaster				
Q4048	Cast supplies, short leg splint, pediatric (0-10 years), fiberglass				
S9981 *	Medical records copying fee, administrative				

***** This code (S9981) is to be used for copying medical reports for eligibility purposes (diagnosis code (V68.0). Reimbursement is made only for reports relevant to eligibility determination for the Medicaid Program. (Reports requested for review of claims for payment, auditing, etc. must be provided free of charge.) DFS Form from the local office of the West Virginia Department of Health and Human Resources requesting the medical report must be attached to the claim. If paid without the DFS Form, monies will be recouped.

CHAPTER 520

PODIATRY SERVICES

JULY 1, 2004

ATTACHMENT 2

CERTIFICATE OF MEDICAL NECESSITY

INSTRUCTIONS AND APPLICATION

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Orthotics and Prosthetics

Form Completion Instructions:

Section I

Member Data

- Complete Member identification number
- Complete Member full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone number (include area code).

Servicing Provider

- Complete provider number (10 digits)
- Complete provider name
- Complete name of contact person to call if BMS has questions.

CMN Status

- Check appropriate box.

Section II

Member Information

- Check all boxes that apply.
- Identify functional limitations related to Member and need for DME service.
- If requesting oxygen, the results of PO2 saturation levels (room air) must be submitted.
- Date last examined by practitioner.
- Clinical diagnosis/narrative diagnosis must be clearly identified and item(s) requested must be related to diagnosis.
- ICD 9 code (optional).
- Check appropriate line for date of on-set for each diagnosis.

Section III

- Begin service date (month, day, year).
- Item(s) ordered description. Must be narrative description of item (DME vendor may identify by HCPCS code).
- Length of time needed. Length of time item will be needed for all durable equipment.
- Quantity ordered. Identify quantity ordered. For expendable supplies, designate supplies needed for 1 month. If items are required greater than 1 month, note time frame in the length of time needed column.
- Quantity/frequency of use. Justification/comments. Practitioner's order for frequency of use must be identified.

Section IV

Practitioner Certification

- Practitioner's full name (print)
- Must be personally signed and fully dated by practitioner. (Note: Attached practitioner's prescription will not be accepted in lieu of practitioner's signature on this form)
- If orders for DME services are written on both sides of form, practitioner must sign/date both sides of form
- Complete practitioner Medicaid provider number (optional)
- Telephone number (include area code).

The Certificate of Medical Necessity form to complete follows this page. The form may be duplicated.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity For Orthotics and Prosthetics

SECTION I

MEMBER DATA	**SERVICING PROVIDER**	**CMN STATUS**
ID#_____	**Provider #**_____	____**Initial**
Name_____	**Provider Name**_____	____**Revised**
D.O.B._____	**Contact Person**_____	____**Renewed**
Phone # (___)_____	**Phone #** (____)_____	

SECTION II - MEMBER INFORMATION

Answer all questions that are applicable to **ORTHOTIC / PROSTHETIC** services being requested. If answer is Yes, you must describe/ attach additional information to support medical justification. (Additional Space on Reverse).

DOES PATIENT:	YES	NO
1. Have impaired mobility?	____	____
2. Have impaired endurance?	____	____
3. Have restricted activity?	____	____
4. Have skin break down? (Describe site, Size, Depth, and Drainage on reverse side of form)	____	____
5. Have impaired respiration? (Identify most recent PO2/ saturation level for Pts. on O2) (Room air)	____	____
6. Require assistance with ADL'S ?	____	____
7. Have impaired speech?	____	____
8. Is item suitable for use in home and does the Patient/Care giver demonstrate willingness and ability to use the equipment?	____	____

ICD 9- CODES **CLINICAL DIAGNOSIS** **DATE OF ONSET**

_____

_____

_____

_____

DATE PATIENT LAST EXAMINED BY PRACTITIONER: _____/_____/_____

FUNCTIONAL LEVEL: (As per Medicare standard classification for specific prosthetic components) Attach supporting documentation.

_____Level – 0 ____Level – I __Level - II __Level - III __Level - IV

SECTION III (Additional space on reverse side)

Begin Service Date	HCPCS Code	Description of HCPCS Code	Length of Time Needed	Quantity Ordered	Frequency of Use	Dollar Amount

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective," and is not a convenience item for the recipient, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

_____ _____ ____/____/_____ _____ (___)_____

Prescribing Practitioner's Name Practitioner's Signature Date ID# Phone #

(Please Print)

CHAPTER 520

PODIATRY SERVICES

JULY 1, 2004

ATTACHMENT 3

OUTPATIENT SURGERY PA REQUIREMENTS

Confidential

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____

A. **Member** Name: _____ Date of Birth: _____
Last First MI

Member Address: _____
Street City State Zip

B. **Surgical Procedure** Requested: _____

CPT Code **(Required)**: _____ ICD-9-CM Code **(Required)**: _____ Assistant surgeon? ⎸Yes ⎸No

Diagnosis Related to Surgical Procedure: _____

C. **Facility** Performing Surgical Procedure: _____
Facility ID # (10 digits): _____ Facility is: □ In WV □ Outside WV

Referring Physician Name: _____
Mailing Address: _____
Street City State Zip

Surgeon Name: _____
Mailing Address: _____
Street City State Zip

Contact Name: _____ Phone# (_____)_____-_____ Ext: _____
Fax # (_____)_____-_____

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): _____
_____
_____
_____ Date of Onset: _____

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):_____
_____
_____

F. **Related Medications, Treatments, and Therapies (include duration): _____**
_____
_____
_____

G. If procedure routinely performed in office, please document need for OP surgical setting: _____
_____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For <u>WVMI Use Only:</u>
Approved: ___ Authorization Number: _____ Date*: _____

***(Authorization expires 90 days from this date)**

Denied: ____ Detailed letter to follow

*** REMINDER: Preauthorization for medical necessity does not guarantee payment*

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X
11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X
11471	Removal, sweat gland lesion	X	X

11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X
12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	
14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	

14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	
19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	
19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	

19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	

21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	
21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	

22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	
25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	
26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	

26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	
27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	
28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	

28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	
29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	
29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	

30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	
42810	Excision of nect cyst	X	
42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	

43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	
49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	
54409	Removal of inflatable penile prosthesis	X	
54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	

57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	
58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	
64555	Implant neuroelectrodes	X	
64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	

64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervation of extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	
69632	Rebuild eardrum structures	X	
69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	

76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	
51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	

CHAPTER 521–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PSYCHOLOGICAL SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
521.10.1	Psychological Testing 96101	12-05-2005	01-01-2006
521.10.4	Neurobehavioral Status Exam – 96116	12-05-2005	01-01-2006
521.10.5	Neuropsychological Testing Battery 96118	12-05-2005	01-01-2006
521.11.1	Services Requiring Registration – Prior Authorization	12-05-2005	07-01-2004
521.11.2	Registration – Prior Authorization Requirements	12-05-2005	07-01-2004

DECEMBER 05, 2005

Section 521.10.1

Introduction:	New CPT codes for Psychologist – Psychological Testing
Old Policy:	CPT code prior to January 1, 2006 was 96100
New Policy:	2006 CPT code listed as 96101
Change:	96101 will replace 96100
Directions:	Replace Section 521.9.1

Section 521.10.4

Introduction:	New CPT codes for Psychologist – Psychological Testing
Old Policy:	CPT code prior to January 1, 2006 was 96115
New Policy:	2006 CPT code listed as 96116
Change:	96116 will replace 96115
Directions:	Replace Section 521.9.4

Section 521.10.5

Introduction:	New CPT codes for Psychologist – Psychological Testing
Old Policy:	CPT code prior to January 1, 2006 was 96117
New Policy:	2006 CPT code listed as 96118
Change:	96118 will replace 96117
Directions:	Replace Section 521.9.5

Section 521.11.1

Introduction:	Update manual to reflect policy change effective 07-01-2004
Old Policy:	Authorizations were process by BMS
New Policy:	Registration and Authorizations are process by BMS' contracted agent
Change:	Addition of Registration – Change in who processes authorizations
Directions:	Replace Section 521.11.1

Section 521.11.2

Introduction:	Update manual to reflect policy change effective 07-01-2004
Old Policy:	Authorizations were process by BMS
New Policy:	Registration and Authorizations are process by BMS' contracted agent
Change:	Reference to Appendix M – which list BMS's contracted agent.
Directions:	Replace Section 521.11.

CHAPTER 521—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PSYCHOLOGICAL SERVICES

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CHAPTER 521–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PSYCHOLOGICAL SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed, in writing, otherwise by the Bureau for Medical Services.

West Virginia Medicaid covers and reimburses Psychologist services rendered to Medicaid beneficiaries, subject to medical necessity and appropriateness criteria. This chapter sets forth the Bureau for Medical Services requirements for payment of services provided by independently practicing licensed psychologists to eligible West Virginia Medicaid beneficiaries.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Psychological services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

521.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of psychological services described in this chapter.

Event - one episode of contact with the beneficiary regardless of time for which reimbursement is a flat rate for all providers.

Psychological Services - the evaluation and therapy services provided by a Medicaid eligible and enrolled licensed psychologist.

Psychologist - an individual currently licensed under the state in which they are to practice psychology.

Psychologist under supervision for licensure - an individual who:

- Is an unlicensed psychologist with a documented completed degree in psychology at the level of a Ph.D., Psy.D., Ed.D., M.A., M.S. or M. Ed.;
- Has met the requirements of and is formally enrolled in the West Virginia Board of Examiners of Psychologist Supervision process;
- Is working towards licensure under supervision in accordance with the West Virginia Board of Examiners; and,
- Is employed or under contract with the supervision of a psychologist and is working towards licensure in compliance with West Virginia Board of Examiners.

Qualified neuropsychologist - a licensed psychologist with specialized training in neuropsychology and is recognized by the West Virginia Board of Examiners to provide services.

521.2 PROVIDER PARTICIPATION

In order to participate in the West Virginia Medicaid Program and receive payment from the Bureau, psychologists must:

- Meet all applicable State and Federal Laws governing the provision of their services;
- Meet all applicable licensing, accreditation, and certification requirements;
- Meet all Bureau enrollment requirements;
- Have a valid provider enrollment form on file;
- Ensure and maintain documentation that services provided by a psychologist under supervision for licensure meet the requirements of section 521.1 of this Chapter.

521.3 BENEFICIARY ELIGIBILITY

Payment for medically necessary and appropriate psychological services is available on behalf of all eligible West Virginia Medicaid beneficiaries subject to the conditions and limitations that apply to these services.

521.4 SERVICE EXCLUSION/PAYMENT LIMITATIONS

In addition to the exclusions listed in Chapter 100 General Information in the Provider Manual, the Bureau will not pay for the following:

- Individual and Group Psychotherapy services for beneficiaries with a diagnosis of dementia which has progressed to a severe cognitive deficit.
- Individual and Group Psychotherapy services for beneficiaries with a diagnosis of severe and profound mental retardation.
- Group Psychotherapy services which only consist of activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, and motion therapy.
- Services provided by a psychologist under supervision for licensure in a “satellite” office, which is not the primary site of the practice and the licensed, enrolled supervising psychologist is not available for direct face-to-face supervision.
- Telephone consultations.
- Failed appointments, including but not limited to, canceled appointments and appointments not kept.
- A copy of the psychological report when the Bureau paid for the original service.

- Experimental services or drugs.

- Services rendered outside the scope of a provider's license.

- Services completed by an employee other than a licensed psychologist or a psychologist under supervision for licensure.

- If facility is reimbursed for psychological services, the psychologist cannot be reimbursed separately.

- Services provided by a "psychologist under supervision for licensure" is limited to the extent that billing for these services is restricted to four(4) individual supervised psychologists per Medicaid enrolled licensed psychologist.

- Family Psychotherapy services when the service constitutes taking a history or documenting evaluation and management services.

- Unlisted Psychiatric/Psychological Services is subject to review and pricing. The completed reports must be attached to the claim form and submitted for consideration to the Bureau.

- Developmental Testing (extended assessment) when Psychological Testing has been billed.

- Neurobehavioral Status Exam when Psychological Testing, Developmental Testing (limited or extended) and Neuropsychological Testing Battery have been billed.

521.5 MEDICAL NECESSITY

All psychological services covered in this chapter are subject to a determination of medical necessity. Medically necessary also means that services are directly related to the diagnostic, preventative, curative treatment of the beneficiary.

Psychologists must document medical necessity to support any services provided and billed to Medicaid. When taking a beneficiary's history, the following factors must be included in the determination of medical necessity and documented in the beneficiary's medical record:

- Chief complaint or presenting problem (s);
- Symptoms;
- Current functioning (GAF-global assessment of functioning);
- Mental status observations;
- Past psychiatric/treatment history;
- Family psychiatric history;
- Pertinent medical history;
- Current medications including over the counter items;
- Diagnostic impressions;
- Current treatment strategy/plan.

521.6 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements and Chapter 800 General Administration of the Provider Manual. In addition, psychologists must comply with the following documentation requirements:

- Psychologists must maintain a specific record for all services provided to each WV Medicaid eligible beneficiary and reimbursed by the Bureau, including at a minimum: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan signed by the supervising enrolled psychologist and the psychologist under supervision, if applicable, documentation of services provided, and the dates the services were provided.

- Documentation must justify that the services being provided meet the definition for the service and the criteria for medical necessity.

- All required documentation must be maintained for at least five years in the provider's file and is subject to review by authorized Bureau personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or three years, whichever is greater.

- Failure to maintain all required documentation may result in the disallowance and recovery by the Bureau of any amounts paid to the provider for which the required documentation is not maintained and not provided to the Bureau upon request.

521.7 THERAPEUTIC SERVICES

Services designed to alleviate emotional disturbances, reverse, or change maladaptive patterns of behavior, and to encourage personality growth and development. These services include individual psychotherapy, family psychotherapy and group psychotherapy.

521.7.1 INDIVIDUAL PSYCHOTHERAPY

521.7.1a **Procedure Code:** **90806**
Service Unit: **1 Session**
Service Limit: **10 sessions per year/ per client with registration**

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual Psychotherapy services are face-to face interventions with a beneficiary for approximately forty-five (45) minutes to one hour, depending on the service and the appropriate procedure. Individual psychotherapy is insight-oriented, behavior-modifying and/or supportive services that may be provided in an office or outpatient facility, in an inpatient hospital, partial hospital or residential care setting.

521.7.1b Procedure Code: 90818

Service Unit: One Session

Service Limit: 10 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting 45 to 50 minutes face to face with patient.

521.7.1c Procedure Code: 90804

Service Unit: One Session

Service Limit: 10 Sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or out patient facility, 20 to 30 minutes face-to-face with the patient.

521.7.1d Procedure Code: 90816

Service Unit: One Session

Service Limit: 10 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, 20 to 30 minutes face to face with the patient.

521.7.1e DOCUMENTATION OF INDIVIDUAL PSYCHOTHERAPY SERVICES

Documentation of psychotherapy should include the following:

- Date, name, age, length of session
- Reason for the encounter and pertinent interval history
- Pertinent themes discussed
- Appropriate high risk factors
- Interventions used including: cognitive therapy, behavioral therapy, reality therapy, etc
- Patient assessment (progress or regression)
- Changes in treatment plan, diagnosis, and medication when appropriate
- Expected treatment outcomes on a periodic basis

Codes 90806, 90818, 90804, and 90816 are time specific codes. The face-to-face time spent with the patient during psychotherapy must be documented in the medical record along with the documentation criteria outlined above.

521.7.2 FAMILY PSYCHOTHERAPY

Family Psychotherapy services are face-to-face interventions for the purpose of treating the beneficiary's condition. These services may be provided with the beneficiary present when there is a need to observe and correct, through psychotherapeutic techniques, the beneficiary's interaction with family members. These services may be provided without the beneficiary present where there is a need to assess the conflicts or impediments within the family, and/or assist, the family members in the management of the beneficiary.

521.7.2a **Procedure Code:** **90847**

Service Unit: **One Session**

Service Limit: **10 sessions per year/ per client (10 sessions is a combined l limit for 90846 and 90847) with registration**

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Family psychotherapy (conjoint psychotherapy) (with patient present)

521.7.2b **Procedure Code:** **90846**

Service Unit: **One Session**

Service Limit: **10 sessions per year/ per client (10 sessions is a combined limit for 90846 and 90847)**

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Family Psychotherapy (without patient present)

521.7.2c DOCUMENTATION FOR FAMILY PSYCHOTHERAPY

At a minimum, psychologists must include in the beneficiary's medical record the following documentation:

- Statement regarding the beneficiary's condition relative to the need for family psychotherapy sessions with or without the beneficiary present;
- Justification that the primary purpose of such psychotherapy is the treatment of the beneficiary's condition. Justification includes, but is not limited to. documentation of the clinical need, such as:

  (1) To observe and correct the beneficiary's interaction with family members.

  (2) To assess the conflicts or impediments within the family, and assist the family members in the management of the beneficiary.

521.7.3 GROUP PSYCHOTHERAPY

Group Psychotherapy services are face-to-face interventions where personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. Group Psychotherapy services are administered in a group

setting (other than a multiple-family group) by a trained leader. Group Psychotherapy services do not include activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, and motion therapy.

521.7.3a Procedure Code: 90853

Service Unit: One Session

Service Limit: 10 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

521.7.3b DOCUMENTATION OF GROUP PSYCHOTHERAPY SERVICES

The medical record must indicate that all applicable criteria are met. Group therapy, since it involves psychotherapy, must be led by a person who is authorized by state statute to perform this service.

521.8 PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION

Psychiatric Diagnostic Interview Examination Services are face-to-face services with the beneficiary that include the elicitation of a medical (including past, family, social) and psychiatric history, mental status, establishment of a tentative diagnosis, and an evaluation of the beneficiary's ability and willingness to participate in the therapeutic process. Additional information may be obtained from the beneficiary, the beneficiary's physicians, other psychologists, family or other sources.

521.8.1 Procedure Code: 90801

Service Unit: 1 Examination

Service Limit: 1 per provider per year/ per client (Maximum 2) with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

521.9 DOCUMENTATION OF PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATINATION SERVICES

At a minimum, psychologists must include in the beneficiary's medical record the following documentation at an initial examination:

- Beneficiary's name, age, gender, date of birth (DOB), date of service (DOS), chief complaint (these items are registration items needed in chart but not in notes for the service;
- Pertinent history of present illness (including current medications);
- Pertinent past psychiatric history;
- Pertinent medical history;
- Pertinent mental status examination and symptoms (might include ADL, posture/gate, eye-contact, motor activity (increased/decreased), affect, memory, rate/volume of speech, mood, associations, general knowledge, concentration, orientation, abstraction, paranoid ideation, hallucinations, ideas of reference, appetite, sleep disturbance, etc.)
  Appropriate high-risk factors, such as suicidal or homicidal ideation
  Diagnosis including :

Axis I – Clinical Disorders
Axis II - Personality Disorders, Mental Retardation
Axis III - General Medical Conditions
Axis IV - Psychosocial and Environmental Problems
Axis V - Global Assessment of Functioning

- Initial treatment plan (including diagnostic test results, medications)
- Where psychotherapy is planned and there is a diagnosis of dementia, confusion, or any type of impaired cognition, the documentation should indicate that the client consents to and is able to participate in and benefit from the psychotherapy.
- Long term goals and prognosis when possible
- Anticipated treatment duration (interval) where applicable.

521.10 TESTING SERVICES

Services provided during psychodiagnostic testing of the cognitive function of the central nervous system. Testing services must include administration of psychodiagnostic tests, the interpretation of the results generated by the tests, and a report based on the results of the tests.

521.10.1 Procedure Code: 96101

Service Unit: 1 hour Session

Service Limit: 4 hours per consumer/per provider/per year with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Psychological Testing (includes psychodiagnostic assessment of personality, psychopathology; emotionality, intellectual abilities, academic achievement (e.g. Wechsler Scales, Rorschach, MMPI, Woodcock/Johnson Tests of Achievement) with interpretation and report per hour.

521.10.2 Procedure Code: 96110- Developmental Testing – Limited

Service Unit: 1 event

Service Limit: 4 hours/per consumer/per year/per provider with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Developmental Testing: Limited (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.

521.10.3 Procedure Code: 96111 – Developmental Test - Extended

Service Unit: 1 hour Session

Service Limit: 4 hours per year/ per provider/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Extended (includes assessment of motor, language, social adaptive, and/or cognitive functions by standardized developmental instruments, e.g. Bayley Scales of Infant Developmental) with interpretation and report, per hour.

Cannot be billed in addition to 96100.

521.10.4 Procedure Code: 96116 – Neurobehavioral Status Exam

Service Unit: 1 hour session

Service Limit: 2 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Neurobehavioral Status Exam (clinical assessment of thinking, reasoning, and judgment e.g. acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report per hour.

Cannot be billed in conjunction with 96100 and 96118.

521.10.5 Procedure Code: 96118

Service Unit: 1 hour Session

Service Limit: 12 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Neuropsychological Testing Battery (e.g. Halstead-Reitan, Luria, WAIS-R) with interpretation and report per hour.

Cannot be billed on same day as 96116. Cannot be billed in addition to 96100 and 96111.

521.10.6 DOCUMENTATION FOR TESTING SERVICES

At a minimum, psychologist must include in the beneficiary's medical record the follow documentation:

(1) Results of tests performed;
(2) Interpretation of the results;
(3) Copy of the written report.

521.11 UNLISTED PSYCHIATRIC/PSYCHOLOGICAL SERVICES

This procedure code can be used to cover evaluations and assessments not otherwise described in this manual. An example could be a juvenile sexual offender assessments or substance abuse assessments, etc. This service must be prior authorized for payment.

521.11.1 Procedure Code: 90899

Service Unit: Event

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

521.12 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of Behavioral Health Rehabilitation Services described in this chapter.

521.12.1 SERVICES REQUIRING REGISTRATION - PRIOR AUTHORIZATION

The Bureau for Medical Services requires that providers register and/or prior authorize all services described in this manual with BMS' contracted agent. Registration and prior authorization must be obtained from BMS' contracted agent.

521.12.2 REGISTRATION - PRIOR AUTHORIZATION REQUIREMENTS

General information on registration requirements, prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' contracted agent

CHAPTER 522—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

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CHAPTER 522–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and behavioral health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of services provided by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to eligible WV Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of services by RHC and FQHC facilities in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia State Code.

522.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of services provided by RHCs and FQHCs as described in this chapter.

Physician Assistant - An individual who meets the applicable education, training experience and other requirements of 42 CFR 491.2 and applicable WV requirements governing the qualifications of physician assistants as promulgated in West Virginia Code § 30-3-16, the provisions of which are implemented by West Virginia Legislative Rule 11 CSR 1B.

Rural Health Clinic (RHC) - A class of providers authorized by Section 1102 of the Social Security Act, September 19, 1978, which are located in designated medical shortage areas, employing nurse practitioners and/or physician assistants under the supervision of physicians.

Rural Health Clinic/Federally Qualified Health Center Services - The services furnished by a physician within the scope of practice of his/her profession under State law and services furnished by a physician assistant, nurse practitioner, nurse midwife, and licensed clinical social worker or licensed clinical psychologist, who is duly authorized to perform such services under state law. Such services may be furnished in the RHC/FQHC location or away from the clinic by one of the above mentioned practitioners who has an agreement with the clinic that the practitioner will be paid by the clinic for such services.

522.2 PROVIDER PARTICIPATION REQUIREMENTS

In addition to requirements established in Chapter 300, RHCs and FQHCs must meet the specific requirements below in order to participate in and receive payment from BMS:

- Be certified by the Centers for Medicare and Medicaid Services (CMS) as a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)
- Submit the CMS certification notice to BMS or designated fiscal agent.
- Submit the State licensure documentation to BMS or designated fiscal agent.
- Submit the reimbursement rate as determined by the federally designated fiscal intermediary
- RHCs and FQHCs must either directly employ or contract the services of legally credentialed professional staff who are authorized within their scope of practice under state law to provide the services for which claims are submitted to Medicaid. Those professional staff includes physicians, physician assistants, nurse practitioners, nurse midwifes, licensed clinical psychologists, and licensed clinical social workers. Professional staff contracted or employed by the FQHC or Rural Health Clinic will be required to individually enroll with the Bureau for Medical Services and will be affiliated with the facility which employs them. The reimbursement for the services rendered at or on behalf of the RHC or FQHC will be made to the facility. It should be noted that this provider enrollment and reimbursement process in no way changes the Bureau for Medical Services' policy with regard to reimbursement of practitioners. Licensed clinical social workers and physician assistants are still not eligible for direct reimbursement as practitioners. Their services are recognized for reimbursement only, to their employers in those clinical settings in which they are currently approved to render services.
- The RHC/FQHC may only be reimbursed for those services defined in Section 522.4.5. If the facility chooses to provide other Medicaid State Plan covered ambulatory services which are not included in the RHC/FQHC definition, the practitioners of those services, dentists, optometrists, pharmacists, etc., must be individually enrolled as participating providers and bill for those services over their assigned provider number, consistent with program coverage limitations and billing procedures described by the Bureau.
- The application and required certification, licensing, reimbursement documentation and any other information required by the Bureau must be returned to:

Unisys Provider Enrollment
P.O. Box 625
Charleston, West Virginia 25322

522.3 MEMBER ELIGIBILITY

Payment for covered medically necessary and medically appropriate services provided by RHCs and FQHCs is available on behalf of all Medicaid members subject to the conditions and limitations that apply to these services.

522.4 COVERED SERVICES

The Bureau will reimburse RHCs and FQHCs on a per visit basis for covered medically necessary and appropriate professional services rendered to eligible Medicaid members by their affiliated, enrolled practitioners: (Reference Section 522.10).

522.4.1 PHYSICIAN SERVICES

Physician services are defined as professional services performed by a physician at the RHC or FQHC or away from the clinic by a physician whose agreement with the clinic provides that he/she will be paid by the clinic for such services.

522.4.2 OTHER PRACTITIONER SERVICES

Nurse Practitioner services and Physician Assistant services are professional services furnished by a nurse practitioner, physician assistant, or nurse midwife who are employed by or receiving compensation from the RHC or FQHC for such services performed under the medical direction or oversight of a physician in accordance with established protocols or medical orders for the care and treatment of a member.

522.4.3 LICENSED CLINICAL PSYCHOLOGIST AND LICENSED CLINICAL SOCIAL WORKER SERVICES

Licensed clinical psychologist and licensed clinical social worker services are professional behavioral health services furnished by a licensed clinical psychologist or licensed clinical social worker, who is duly authorized to perform such services under state law, when said services are performed at or on behalf of the RHC or FQHC by a licensed clinical psychologist or licensed social worker employed by or receiving compensation from the RHC or FQHC.

522.4.4 SERVICES/SUPPLIES INCIDENTAL TO PRACTITIONER SERVICES

The reimbursement for professional services includes services/supplies incidental to the services being rendered. Such supplies are:

- commonly furnished in the practitioner's office
- commonly furnished without charge or included in the RHC or FQHC's private pay bill
- furnished as an incidental, though integral part, of a practitioner's professional service by the practitioner or a member of the clinic's staff
- a drug or biological that cannot be self administered, including vaccinations

522.4.5 FACILITY SERVICES

RHC and FQHC services are covered on a per visit basis established by a face-to-face encounter between a clinic, patient (Medicaid member), and a practitioner.

- Encounters with more than one medical healthcare practitioner, or multiple encounters with the same medical healthcare practitioner that take place on the same date of service and at a single location, constitute a single visit. Reimbursement will be available for two visits per day only when the member has a medical visit/encounter and a behavioral health visit, or the member has two medical encounters that are unrelated See **Attachment 1** for the procedures considered to be included in a medical visit. See

Attachment 2 for the procedures considered to be included in the behavioral health visit.

- A medical visit is a face-to-face encounter between the patient and a physician, nurse practitioner, nurse midwife, or physician's assistant.
- A behavioral health visit is a face-to-face encounter between the patient and the clinical psychologist or clinical social worker.

522.5 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual. In addition, the following limitations and requirements apply to services provided by RHC and FQHC facilities:

- If two unrelated medical encounters occur on the same day, documentation must be provided with (accompany) the claims and mailed directly to the Bureau's claims processing provider relations department. In an RHC, if a member is seen in the clinic and subsequently admitted on the same day as the clinic visit, the above rules apply. FQHC services are not covered in a hospital as defined in 1861E1 of the Social Security Act.
- Psychologist and social worker services are limited to those services furnished to members at or on behalf of the clinic or center. Behavioral health visits are limited to ten occurrences per eligible member per calendar year.
- Supplies and materials, and any drugs that are administered to the member, are considered a part of the physician's or other health care practitioner's service and are included in the per-visit rate.
- Laboratory procedures performed by a RHC or FQHC (not an independently certified enrolled laboratory) are considered part of the health care practitioner's service and are included in the per-visit rate.

522.6 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, BMS will not pay for the following services:

- Duplicating and providing medical records requested by the U.S. Department of Health and Human Services (DHHS) for eligibility determination purposes. The cost for providing such records is an administrative cost to the RHC or FQHC which is included in the per visit rate and not reimbursable as a separate service.
- Telephone consultations, including, but not limited to, information or services provided to a member
- Failed appointments, including, but not limited to, appointments that are cancelled
- Time spent in preparation of reports
- A copy of a medical report when the DHHR or the Bureau paid for the original service

522.7 PRIOR AUTHORIZATION REQUIREMENTS

RHC/FQHC visits, whether medical or behavioral health, are not subject to prior authorization. Other state plan covered services which the RHC/FQHC chooses to provide are subject to all applicable Medicaid regulations which govern the provision and coverage for that service. Ref. Section 522.10.1. Services rendered to HMO members are subject to the HMO rules with regard to prior authorization requirements and service limitations.

522.8 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

RHC and FQHC facilities must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information; Chapter 300, Provider Participation; and Chapter 800, General Administration of the Provider Manual.

- Must maintain documentation that substantiates the nature and scope of services rendered and for which these providers submit claims to the WV Medicaid Program, which includes at a minimum a service note describing the activity performed, the date of service, signature and title of person providing the service.
- Must make such documentation and information available to the Bureau or designated representatives upon request.

522.9 BILLING PROCEDURES

Claims for services rendered to Medicaid members must be filed by the RHC/FQHC on the UB92 claim form or the ASC X12N 837 (004010X096A1) electronic claim format. Claims must be filed within 12 months of the date of service. The encounter code is T1015, billed with Revenue Code 52X for a medical visit. For a behavioral health visit, the encounter code is billed with the behavioral health program modifier (T1015 HE) and Revenue Code 91X. The RHC/FQHC claim must list actual CPT/HCPCS procedure codes and appropriate revenue codes (as defined by the Medicare carrier) to identify the services included in the encounter. The facility may bill the actual charge or indicate a charge of zero for those individual services, but must bill the total charge for the encounter.

522.10 RHC/FQHC REIMBURSEMENT METHODOLOGY

Reimbursement is based on an all-inclusive per visit rate as determined by the Medicare fiscal intermediary. The behavioral health visit is reimbursed at 62.5 (62.5%) percent of the facility's Medicare (medical) encounter rate.

Ambulatory services not included in the encounter rate and covered by the West Virginia Medicaid State Plan are reimbursed at the rate set for each service. The professional practitioners (i.e. dentists, optometrists, etc.) providing those services, must be individually enrolled as participating providers and bill for those services. Both RHC and FQHC services are subject to year-end cost reconciliation and cost settlement.

522.10.1 MEDICAID MANAGED CARE REIMBURSEMENT

The West Virginia Medicaid Managed Care Program reimburses RHC and FQHC facilities using the per visit rate established by Medicare for the medical visits. Effective with services rendered on and after July 1, 2004, Mountain Health Trust HMOs will begin to use the same reimbursement methodology to pay for the medical visit. This change in policy and reimbursement methodology will eliminate the need for the supplemental or wrap-around payment from BMS to reimburse facilities directly for the difference between the encounter rate.

Behavioral health visits are not reimbursed by the HMOs. Behavioral health visits for Medicaid members must be billed directly to the Medicaid Program.

If a member is enrolled in an HMO, the prior authorization requirements of the member's HMO must be followed. If a member is participating in the PAAS Program, the PCP on the member's card is responsible for treatment or referrals for reimbursement. Medicaid will not reimburse providers when these requirements are not followed.

522.11 REPORTING REQUIREMENTS

RHC and FQHC facilities must file a copy of their annual cost report, as submitted to the Medicare fiscal intermediary, with the Bureau for Medical Services. That cost report must be submitted annually to:

Bureau for Medical Services
Department of Health and Human Resources
Division of Rate Setting
350 Capitol Street Room 251
Charleston, West Virginia 25301

CHAPTER 522
RHC & FQHC SERVICES
JULY 1, 2004

ATTACHMENT 1
SERVICES INCLUDED
IN MEDICAL VISIT
PAGE 1 of 3

Services Included in the Encounter Rate of FQHC and RHC

E/M SERVICES
99201
99202
99203
99204
99205
99211
99212
99213
99214
99215

PREVENTIVE SERVICES/EPSDT
99381
99382
99383
99384
99385
99391
99392
99393
99394
99395
92551
96110 EP

W0001
99178
W2292

LABS
Any CLIA Waived designated test performed by the facility that is billed in conjunction with a face to face visit is considered inclusive of the encounter rate. A list of CLIA Waived designated tests are found on CMS' website at www.cms.hhs.gov/clia.

SURGICAL
10000 - 69999

VACCINES (ADMININSTRATION OF)
90471 - 90749 BILLED IN CONJUNCTION WITH EPDST OR E/M SERVICE

MEDICAL SUPPLIES
Any supply defined within the procedure code definition as included in the professional service
For Example:
A4570 – Splint
A4565 – Slings
A4580 - Cast Supplies
A4590 - Special Casting Material

MEDICAL SUPPLIES
A4550 - Surgical Trays
Considered incidental and inclusive of the encounter rate

ELIGIBILITY EXAMS
Prior to 7/1/04
W1500
W1505
W1507

On or after 7/1/04
99450
99456
96100

PRENATAL CARE
W5948 / 99213 TH

INJECTABLES
J0000 - J9999
When billed in conjunction with a face to face encounter,

MEDICINE :
Ophthalmological (92002 -92499)
Otorhinolaryngologic (92502 - 92700)
Cardiovascular (92950 - 93990)
Pulmonary (94010 -94799)
Health & Behavior Assessment/Intervention (96150 - 96155)
Allergy & Clinical Immunology (95004-95199)

FAMILY PLANNING
Family planning encounters including supplies are inclusive of the encounter rate

SERVICES EXCLUDED FROM THE ENCOUNTER RATE
Radiology
Lab (except for those services listed as inclusive when billed in conjunction with a face to face encounter)
Pathology
Physical Therapy
Occupational Therapy
Speech Therapy
Inpatient Hospital
Emergency room services
Observation
Dental
EKG / EEG /ECG (Technical portion only)
Fetal Non-Stress Test (Technical portion only)
Prosthethic Devices
DME
Nursing Home Services
Optometric Services

CHAPTER 522
RHC & FQHC SERVICES
JULY 1, 2004

ATTACHMENT 2
BEHAVIORAL HEALTH

The following lists the allowable procedure codes for RHC/FQHC Behavioral Health Visit.

96150 Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 Re-assessment

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual

96153 Group (2 or more patients)

96154 Family (with the patient present)

96155 Family (without the patient present)

CHAPTER 523 - COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
New Chapter	Entire Chapter	XXXX	January 1, 2013

CHAPTER 523 - COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICE

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CHAPTER 523–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICE

INTRODUCTION

The relationship of the targeted case manager with a Medicaid member and his or her family should be one of a partnership. As such, members, parents, and families are not merely spectators of case management recommendations, but active participants in care planning throughout the case management process. This is a necessary perspective in order for the member's needs and/or preferences to be considered and addressed individually and within the environment in which the person resides.

Accordingly, organized strategies that empower members, parents, and families to assume and carry out their responsibilities must be included in this mutual planning process. It is very important that a targeted case manager is aware of and sensitive to the values, attitudes, and beliefs that are unique to each family. Values concerning approaches and styles of parenting and/or family life vary according to culture. The effectiveness of Targeted Case Management (TCM) is positively impacted by a demonstrated respect for cultural variations among families. Thus, it is critical that case managers be able to identify and understand cultural beliefs, values, attitudes, and morals by which beneficiaries and their families operate.

TCM effectiveness is further enhanced when integrated with other services and resources identified through a systems perspective, considering all active participants in the individual's life (including the individual's parents, family, and significant others and any involved service providers). Interagency collaboration is crucial to ensuring that a member's needs are adequately met without duplication of services. Thus, it is important for a system to exist within each agency to ensure that targeted case managers are communicating with other professionals and involved parties, coordinating care and services and meeting the specific needs of each individual and, as appropriate, the needs of families.

TCM is the coordination of services to ensure that eligible Medicaid members have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying individual problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist beneficiaries and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid beneficiary are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs.

This chapter sets forth the Bureau for Medical Services' requirements for payment of Targeted Case Management Services for persons with mental illness, developmental disabilities, substance-related disorders, and/or victims of domestic violence; rendered by qualified providers to eligible West Virginia Medicaid members.

523.0 DEFINITIONS

Direct Service – a service that is designed to support the individual in his or her community-based setting. A direct service is not designed to change behavior or emotional functioning.

Designated Legal Representative (DLR) – Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a consumer and operating within the scope of his/her authority.

Credentialing – an individual approved to provide Targeted Case Management Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Internal Curriculum - The training protocol developed and approved by the agency for staff providing Targeted Case Management services.

Service Plan - A written description of the behavioral health services and/or supports that the consumer is to receive. A Service Plan may be otherwise named a "Plan of Service," "Treatment Plan" or other appropriate title.

523.1 TARGETED CASE MANAGEMENT SERVICE

Targeted Case Management Services are federally defined as "those services which assist Medicaid eligible recipients in the target group to gain access to needed medical, behavioral health, social, educational and other services." **Targeted Case Management is not a direct service.**

523.1.1 Child Medical Necessity Standards

(Must meet one of the two categories below):

1. **Documentation indicates that a child member is eligible for TCM because:**

    a. The child is between the ages of 3 through 17, and
    b. The child demonstrates a serious and persistent emotional, behavioral,

developmental and/or substance abuse or dependence disturbance as exemplified by a valid and documented Axis I diagnosis and/or diagnosis of developmental disability as described in the language of the current Diagnostic and Statistical Manual of the American Psychiatric Association; and

c. The Designated Legal Representative or older child member is documented to be unable to access/provide the service proposed without training or support; and
d. By virtue of age and effects of the emotional and/or developmental impairments, the child is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting.

OR

2. Documentation indicates that the Child is eligible due to actual or pending removal from placement and:

a. The child is between the ages of 3 and 17 inclusively and/or is in the custody of the DHHR and;
b. The child is removed or is pending removal from placement due to allegations of abuse and neglect; and
c. The appointed foster care entity is not able or qualified to perform the case management task in question.

523.2 Exclusions (Child): The child does not qualify for TCM if:

1. The child is currently eligible for case management services through the West Virginia Birth to Three Program, or is in a residential treatment facility, or is in a Psychiatric Residential Treatment Facility (PRTF), or Long-Term Care, or is receiving acute psychiatric care, and/or is enrolled through the I/DD Waiver program, or is residing in an ICF/MR. provided that the community-based provider may supply discharge planning services through Targeted Case Management for eligible children 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a long- term care program.

2. The child is receiving TCM services from another entity including a county school system.

523.3 Adult Medical Necessity Standards (3 categories)

1. Documentation indicates that an adult member is eligible for TCM because:

a. The adult is age 18 or older;

b. The adult demonstrates a serious and persistent emotional, behavioral, developmental and/or substance abuse or dependence disturbance as exemplified by a valid and documented Axis I diagnosis and/or diagnosis of developmental disability as described in the language of the current Diagnostic and Statistical Manual of the American Psychiatric Association;
c. By virtue of age and effects of the emotional and/or developmental impairments, the adult is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting; and
d. The Designated Legal Representative or spouse is documented to be unable to provide the service proposed without training or support.

OR

2. **Documentation indicates that the adult is approved for but pending initiation of I/DD Waiver Services.** The adult is determined to be eligible to receive services through the I/DD Community-Based Waiver Program however is not yet receiving services.

OR

3. **Documentation indicates that the adult is currently and temporarily residing in a licensed domestic violence shelter.**

523.4 Exclusions: The adult is not eligible for TCM services if:

1. The adult is currently receiving services through an acute psychiatric care facility; a state-operated psychiatric facility; or a long-term care facility; is enrolled through the I/DD Waiver program; or is an active recipient of Assertive Community Treatment (ACT); Provided that the community-based provider may supply discharge planning services through Targeted Case Management for eligible individuals 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a longer term care program.

2. The adult is receiving TCM services from another entity.

In order to demonstrate the linkage between emotional/behavioral/developmental disability and functional impairment, the provider's documentation must reflect one or both of the following:

1. Because of inability to process and comprehend information, the individual is unable to properly act upon documents or utilize processes regarding benefit eligibility, medication management, budgeting, or otherwise performing activities required to continue to live in a community based setting;

2. Because of interpersonal problems or psychiatric symptomatology, the individual is unable to cooperate with others in order to achieve goals and obtain services necessary for community living.

523.5 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, each provider of Targeted Case Management Services must meet all enrollment criteria as described in Chapter 300 Provider Participation and:

- Meet and maintain all BMS enrollment, certification, and service provision requirements as described in this manual
- Have a current, valid TCM provider agreement on file
- Be licensed under the laws of the State of West Virginia as a Behavioral Health Agency; unless the provider is a domestic violence center. Based on the 1989 Domestic Violence

Act, an agency (domestic violence center) must be licensed as a domestic violence center under Chapter 48, Article 2C of the West Virginia Code.

523.6 TCM AGENCY ADMINISTRATION REQUIREMENTS

- Targeted Case Management agencies must promote effective operation of the various programs and agencies in a manner consistent with applicable State laws, regulations, and procedures. There must be clear policy guidelines for decision making, program operations, and provision for monitoring the same.

- Targeted Case Management providers must have:

  - Provisions for orientation, continuing education, and on-going communication with all applicable governing boards

  - Policies and procedures to protect the rights of members

  - A comprehensive set of personnel policies and procedures

  - Job descriptions and qualifications, including licensure, for all staff employed either directly or by contract with the provider or with an agency contracting with the provider or program

  - Provisions for ensuring staff or contractors possess the skills, attitudes, and knowledge needed to perform job functions, and provisions for performing regular staff evaluations.

  - Written definitions and procedures for use of all volunteers must be maintained.

- Targeted Case Management providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of the specific program goals of other human service agencies, and maintain current information regarding the types of services offered and limitations on these services. Similarly, providers must ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services.

523.7 Criminal and Investigation Background Checks (CIB)

A CIB must be initially conducted by the West Virginia State Police for all staff rendering TCM. Prior to providing any TCM, prospective employees must have a CIB conducted by the West Virginia State Police. If a CIB request has been sent to the West Virginia State Police, TCM providers may do a preliminary check utilizing on-line internet companies and use these results until results from the West Virginia State Police are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

1) Abduction
2) Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
3) Any type of felony battery
4) Child/adult abuse or neglect
5) Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
6) Felony arson
7) Felony or misdemeanor crime against a child or incapacitated adult which causes harm
8) Felony drug related offenses within the last 10 years
9) Felony DUI within the last 10 years
10) Hate crimes
11) Kidnapping
12) Murder/ homicide
13) Neglect or abuse by a caregiver
14) Pornography crimes involving children or incapacitated adults including, but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian depicting a child engaged in sexually explicit conduct
15) Purchase or sale of a child
16) Sexual offenses including, but not limited to incest, sexual abuse, or indecent exposure

17) Healthcare fraud
18) Felony forgery

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual

Results which include a history of Medicaid fraud or abuse or which may place members at risk of personal health and safety must be taken into consideration prior to employment.

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

All payments will be recovered by BMS for services provided by staff:
1) Without a valid CIB in their personnel record,
2) Convicted of any of the crimes listed above, or
3) Excluded by the State or Federal government.

523.8 REQUIREMENTS: STAFF QUALIFICATIONS

Targeted Case Management providers must assure that all staff that provides Targeted Case Management Services to members possesses one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program

- A licensed social worker

- A licensed registered nurse

- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:

  - Psychology
  - Criminal Justice
  - Board of Regents with health specialization
  - Recreational Therapy
  - Political Science
  - Nursing
  - Sociology
  - Social Work

- Counseling
- Teacher Education
- Behavioral Health
- Liberal Arts or;
- Other Degrees approved by the West Virginia Board of Social Work.

- Previous certification on the basis of training and experience by the Bureau of Behavioral Health and Health Facilities.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

- Targeted Case Management providers must have a review process to ensure that employees providing Targeted Case Management Services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.

- Targeted Case Management providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.

- Targeted Case Management providers must credential their staff by an internal curriculum specific to Targeted Case Management prior to the staff assuming their Targeted Case Management duties.

- Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and Targeted Case Management Training must be maintained in staff personnel files.

523.9 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning and documentation and case record review. Case records should be arranged so information can be found quickly and easily. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record. Copies of completed release of information forms and consent forms must be filed in the case record.

- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a

comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Termination reports must be filed upon case closure. There should be on-going case record reviews to ensure that records contain current, accurate, and complete information.

523.10 METHOD OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Administrative requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. Bureau for Medical Services' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS.

These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in Chapter 800 – Quality and Program Integrity.

523.11 PROCEDURE CODE UNITS, COMPONENTS, LIMITS, AND EXCLUSIONS

PROCEDURE CODE: T1017
SERVICE UNITS: 15 minutes
SERVICE LIMITS: All units must be prior authorized by APS Healthcare, Inc.
PRIOR AUTHORIZATION: Yes

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the case management section of his/her service plan, both the member (or their legal guardian) and their case manager must agree and attach an addendum addressing the needed service to the plan.

For continued eligibility for TCM services, a Medicaid member must meet face to face with an individual providing a Behavioral Health service to them every 30 days. The documentation of such contact must be completed by the targeted case manager or an individual with the minimum of a bachelor's degree such as a physician, nurse practitioner, physician's assistant, therapist, counselor, or case manager. The Bachelor's degree must be in one of the eligible areas described under the section entitled "Staff Qualifications."

The case manager must have at least one face-to-face contact for a valid Targeted Case Management activity with the member every 90 days. Any TCM service may be conducted via Tele-medicine with the exception of the 90 day Face to Face encounter with the Targeted Case Manager.

523.12 COMPONENTS OF TARGETED CASE MANAGEMENT SERVICES

Within Targeted Case Management are a number of activities federally recognized as components of case management. These components are:

- **Assessment:**
  The case manager ensures an on-going formal and informal process to collect and interpret information about a member's strengths, needs, resources, and life goals. This process is to be used in the development of an individualized service plan. Assessment is a collaborative process between the member, his/her family, and the case manager.

- **Service Planning:**
  The case manager ensures and facilitates the development of a comprehensive, individualized service plan. The service plan records the full range of services, treatment, and/or other support needs necessary to meet the member's goals. The case manager is responsible for regular service planning reviews based on the member's needs at regularly scheduled intervals. (**Note**: When the case manager participates in a treatment team meeting, the services provided are not billable as Targeted Case Management.)

- **Linkage/Referral:**
  Case managers ensure linkage to all internal and external services and supports identified in the member's service plan.

- **Advocacy:**
  Targeted Case Management advocacy refers to the actions undertaken on behalf of the member in order to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities, and resources, and accessibility to services. This includes assuring that the member's legal and human rights are protected.

- **Crisis Response Planning:**
  The case manager must ensure that adequate and appropriate crisis response procedures are available to the member and identified in the individual service plan. The case manager assists the member as necessary in accessing crisis support services and interventions.

- **Service Plan Evaluation:**
  The case manager continually evaluates the appropriateness of the member's service plan and makes appropriate modifications, establish new linkages, or engage in other dispositions as necessary, up to and including discharge planning as appropriate.

- **Monitoring and Follow-up:**
  The Case Manager ensures appropriate quality, quantity and effectiveness of service in accordance with the Service Plan. The Case Manager may only utilize and bill for this component when one of the above stated components have been utilized and determined to be a valid TCM activity. The amount of time spent to "monitor/follow-up" a TCM service shall not exceed the amount of time spent rendering the valid activity.

Note: These components do not constitute separate services and cannot be billed as separate services, but are identified and defined here to assist case managers in understanding their roles and responsibilities.

523.13 SERVICE LIMITATIONS

General Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual. In addition to the requirements for payment of services described in this chapter, Targeted Case Management Services will not be authorized prior to a member's discharge from an Intermediate Care Facility/Mental Retardation (ICF/MR) or an inpatient psychiatric facility except for those provided within 30 days prior to discharge as part of the discharge process.

523.14 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, members who receive case management services under the Home and Community-Based Services Waivers granted under Section 1915(c) of the Social Security Act are excluded from receiving Targeted Case Management reimbursement through this service option.

Payment for Targeted Case Management Services must not duplicate payments made to other entities for case management/service coordination services.

523.15 MEMBER CHOICE OF SINGLE TARGETED CASE MANAGEMENT PROVIDER

Each member or their legal guardian must be provided information, by the provider with whom they are seeking services, about the availability of all Medicaid-enrolled providers rendering Targeted Case Management services.

The member must be given an opportunity to choose only one approved Targeted Case Management provider and must indicate this choice on BMS-approved "Medicaid Targeted Case Management Client Enrollment" form.

A signed copy of the "Medicaid Targeted Case Management Client Enrollment" form must be retained in the member's record and must serve as an enrollment, disenrollment, or re-enrollment of the member with the provider.

The Bureau for Medical Services reimburses only for Targeted Case Management Services provided by the Medicaid-enrolled provider chosen by the member.

A member may choose a new Targeted Case Management provider at any time. The effective date of the change of providers will be the first day of the month following the change.

523.16 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Targeted Case Management providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information and Chapter 300, Provider Participation, of the BMS Provider Manual. In addition to the documentation requirements described in this chapter, the following requirements also apply to payment of Targeted Case Management Services:

A Medicaid-enrolled provider of Targeted Case Management Services must maintain the following information/documentation:

- An individual permanent clinical record for each member receiving Targeted Case Management Services.
- Evidence in each clinical record that the member is shown to be in a targeted population as defined in Section 523.1 or 523.3.
- An individualized service plan detailing the need for Targeted Case Management Services which is updated at 90-day intervals or more frequently if indicated by member need.
- A clinical record that must include documentation specific to services/activities reimbursed as Medicaid Targeted Case Management. This includes a specific note for each individual case management service/activity provided and billed.

Each case note must:

- Be dated and signed by the case manager along with a listing of the case manager's credentials, e.g. LSW, MA;
- Have relevance to a goal or objective in the individual's plan of service;

- Include the purpose and content of the activity as well as the outcome achieved;
- Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts);
- Detail the TCM component of the valid activity provided; (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan evaluation and monitoring/follow-up);
- List the location the activity occurred; and
- List the actual time spent providing each activity by itemizing the start - and - stop time.

A Targeted Case Management unit of service consists of a 15-minute period of time. Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement, the amount of time documented in minutes must be totaled and divided by 15. Partial units must be rounded down to arrive at the number of units billed. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months.**

The documentation must demonstrate that only one staff person's time is billed for any specific activity provided to the member.

523.17 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of Targeted Case Management Services will apply pursuant to the following limitations.

523.18 PRIOR AUTHORIZATION PROCEDURES

BMS requires that providers prior authorize all Targeted Case Management Services with BMS's contracted agent. Refer to the BMS website http://www.dhhr.wv.gov/bms/Pages/default.aspx regarding information on the BMS Utilization Management Contractor.

General information on prior authorization requirements for Targeted Case Management Services and contact information for submitting a request may be obtained by contacting BMS' contracted agent.

523.19 PRIOR AUTHORIZATION REQUIREMENTS

- Prior authorization requests for Targeted Case Management Services must be submitted within the timelines required by BMS' contracted agent.

- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.

CHAPTER 524–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRANSPORTATION SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment 3	Covered Codes for Transportation Services	08/10/05	09/15/05

SEPTEMBER 15, 2005

Attachment 3

Introduction: Made changes in procedure code reimbursement rate for Non-Ambulance Transportation.

Change: Changed reimbursement rate for procedure codes A0120 from $10.00 to $9.00 and S0215 with a reimbursement rate of $0.75 per mile each mile exceeding 15 to a rate of $0.66 per mile each mile exceeding 15.

Directions: Replace the pages containing these sections.

CHAPTER 524 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR TRANSPORTATION SERVICES

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CHAPTER 524–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRANSPORTATION SERVICES

INTRODUCTION

The WV Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise by the Bureau for Medical Services (BMS) in writing.

WV Medicaid covers and reimburses air and ground ambulance services rendered to Medicaid members, subject to medical necessity and appropriateness criteria. In addition, WV Medicaid covers the non-ambulance transportation of members to appropriate medical appointments for diagnostic and therapeutic services, subject to various requirements.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV. The BMS in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program.

524.1 SPECIFIC MEDICAID ENROLLMENT REQUIREMENTS

To enroll and participate in the WV Medicaid Program, a transportation provider must meet applicable general requirements in Chapter 300, as well as the specific requirements summarized here. The provider must also meet the certification requirements of Part B of the Medicare Program. Ambulance transportation providers must be licensed by and meet the personnel certification requirements of the WV Bureau for Public Health, Office of Emergency Medical Services (OEMS). Transportation providers must also comply with all applicable Federal and State laws, regulations, and certification requirements, including those established and regulated by the WV Public Service Commission (PSC).

All transportation providers shall have a valid and current WV business license, and remain current with Workers Compensation and Employment Security premiums and all State and local taxes. All participating patient transportation providers must have current coverage of errors and omissions liability and/or auto insurance liability of an amount not less than one million dollars or as required under current WV law. Copies of documentation verifying compliance must be submitted with application.

524.1.1 AIR AND GROUND AMBULANCES

In addition to the provider enrollment application, an ambulance transportation provider must submit a copy of its license as an Emergency Medical Services (EMS) agency by the WV Office of EMS and a copy of its Medicare Part B certification.

All vehicles and personnel must be in compliance with requirements as set forth by WV State Code §16-4C and WV Health Legislative Rule §64 CSR 48.

524.1.2 NON-AMBULANCE TRANSPORT VEHICLES

This category includes two types of specialty transport vehicles—specialized multi-passenger vans and specialized multi-patient medical transport vans along with common carriers and individual transportation.

524.1.2.a SPECIALIZED MULTI-PASSENGER VAN TRANSPORTATION (SMPVT)

Providers must submit a PSC Certificate of Convenience and Necessity to the Bureau for Medical Services at the time of application and with all changes and renewals. (Senior Services Centers may be exempt from PSC certification pursuant to W. Va. Code §24A-1-3(11)).

Multi-passenger van drivers must have current certification in first aid and CPR as evidenced by a certification document filed with the BMS Enrollment Unit. Re-certification documents are to be current, and kept on site and made available for review upon request by BMS or their authorized representative.

Multi-passenger van services must operate an approved multi-passenger vehicle as evidenced by a copy of the vehicle registration that must be filed with the Provider Enrollment Unit in the BMS. Standard passenger sedans and limousines are not acceptable as transportation vehicles for this category.

524.1.2.b SPECIALIZED MULTI-PATIENT MEDICAL TRANSPORT (SMPMT)

Applicants must submit a copy of their EMS agency license with their application. The applicant must meet and adhere to the requirements set forth in WV Health Legislative Rule §64 CSR 29.

524.1.2.c COMMON CARRIERS AND INDIVIDUAL TRANSPORTATION

The WV DHHR, Office of Family Support (OFS) administers these transportation programs through their county offices. Providers of these services do not need to register with the BMS enrollment unit. All services are subject to procedural requirements outlined in the OFS Income Maintenance Manual.

524.2 ONGOING COMPLIANCE

All transportation providers must maintain a valid and current WV business license, and remain in good standing with Workers Compensation and Employment Security Premiums and all State and local taxes. Documentation that verifies compliance with the requirements must be provided upon request to the BMS or its authorized representative.

Records and documentation that fully disclose the type, level, and volume of services provided must be maintained for 6 years from the date of service and made available upon request to the BMS. For ambulance services, the documentation must include a fully completed pre-hospital care record and any other required documents. For non-ambulance transportation services, the documentation must include the necessary signed certification verification forms as described in Section 524.30.3.

All participating transportation providers must maintain and be able to verify current errors and omissions liability and/or auto insurance liability coverage of an amount not less than one million dollars or as required under WV current law.

All transport vehicles must be inspected annually by appropriate regulatory authority and satisfy

the corresponding requirements. Additionally, providers must maintain their license and remain in good standing with the appropriate regulatory agency. Any modifications made to organization, personnel, or fleet must be submitted in writing to the enrollment unit of the WV Medicaid Program.

524.3 COVERED TRANSPORTATION SERVICES

The following is a list of WV Medicaid covered transportation services:

Patient Transportation Services	Patient Care Service	Classifications
Air Ambulance		1. Fixed Wing 2. Rotary Wing
Ground Ambulance		1. Advanced Life Support 2. Basic Life Support – Emergency 3. Basic Life Support - Non-emergency
Non-Ambulance Transportation		1. Specialized Multi-Passenger Van Transport 2. Specialized Multi-Patient Medical Transport 3. Common Carrier 4. Individual Transportation
	Paramedic Intercept	1. Advanced Life Support

NOTE: The fact that a medical provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided. Payment is based on the level of service provided and only when that level of service is medically necessary and within benefit limits.

524.3.1 AIR AMBULANCE SERVICES

WV Medicaid covers fixed wing and rotary wing transportation services for eligible members who need emergency transportation by an air ambulance.

524.3.1.a FIXED WING

Transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a fixed wing air ambulance and is designed, constructed or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in WV Health Legislative Rules §64 CSR 48.

Transport by fixed wing may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude rapid delivery by ground transport to the nearest appropriate facility.

524.3.1.b ROTARY WING

Transportation by a helicopter that is certified by the FAA as a rotary wing ambulance and is designed, constructed or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in WV Health Legislative Rules §64 CSR 48.

Transport by rotary wing may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude rapid delivery by ground transport to the nearest appropriate facility.

524.3.2 GROUND AMBULANCE

There are three levels of ground ambulance service—advanced life support (ALS), basic life support- emergency, and basic life support-non-emergency. Each level has it own medical necessity requirements, documentation standards, and payment rates. The patient care report must contain documentation to support the medical necessity for the level of transport service provided. Providers should use **Attachment 1** as a guideline to assist in determining medical necessity for ground ambulance services.

Current conditions or history that is not identified as a current disabling condition with ongoing or present limitations do not constitute a need for ambulance transport. Describing a patient as being "non-ambulatory," "bed confined," or needing "stretcher transport" without more specific description of the patient's condition, is not adequate documentation to support ambulance as the only means of transport that could be utilized without endangering the patient's health. A physician order for ambulance transportation does not negate the need for documentation describing the medical condition that necessitates ambulance transport, nor does a physician order for ambulance transportation guarantee that the transport is reimbursable by the WV Medicaid Program.

Medicaid reimbursement for ambulance services is based upon the patient's condition at the initial assessment by the ambulance squad and the medical intervention provided throughout the transport. The WV OEMS Patient Care Record provides the documentation to support the billing submitted to Medicaid. The documentation on this form should include all pertinent information regarding the patient's condition and support the need for transport as well as providing sufficient information to determine the appropriate level of service for billing.

If a post payment review is conducted, decisions will be based on the documentation on the patient care record. This documentation should stand alone to verify billing. Supporting information regarding the patient's status gathered after the fact will not be considered in the review process.

524.3.2.a ADVANCED LIFE SUPPORT (ALS)

Transportation by ground ambulance and the provision of medically necessary supplies and services including the provision of an ALS assessment and at least one ALS intervention as defined in West Virginia State Code 16-4C, related legislative rules, and protocols established by the Office of Emergency Medical Services.

ALS service is deemed appropriate when the member has experienced a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to patient's health
2. Impairment to bodily functions, or
3. Serious dysfunction to any bodily organ or part.

ALS services are also deemed necessary and reasonable when a patient is transferred from one health care facility and admitted to another health care facility for treatment not available at the sending facility, and certified advanced life support personnel are needed to insure continuity of ALS medical care.

524.3.2.b BASIC LIFE SUPPORT - EMERGENCY

Transportation by ground ambulance and the provision of medically necessary supplies and services, including BLS ambulance services as defined in West Virginia State Code 16-4C, related legislative rules and protocols established by the Office of Emergency Medical Services.

An emergency transport is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to patient's health
2. Impairment to bodily functions, or
3. Serious dysfunction to any bodily organ or part.

Personnel staffing and vehicles must conform to the requirements listed in WV Health Legislative Rule §64 CSR 48.

524.3.2.c BASIC LIFE SUPPORT - NON-EMERGENCY

Scheduled or unscheduled transports that do not meet the criteria for emergency as defined above, regardless of the origin or destination, are considered non-emergency services. Scheduled services are generally regularly scheduled transportation for the diagnosis or treatment of a patient's medical condition.

Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicaid ambulance benefits. It is simply one element of the member's condition that may be taken into account in the determination of medically necessary. The term "bed-confined" is not synonymous with "bed rest" or "non-ambulatory." Bed confined requires all the following criteria to be met:

- The member is unable to get up from bed without assistance
- The member is unable to ambulate
- The member is unable to sit in a chair or wheelchair.

Personnel staffing and vehicles must conform to the requirements listed in WV Health Legislative Rule §64 CSR 48.

524.3.3 NON-AMBULANCE TRANSPORTATION

There are two types of non-ambulance transportation services—Specialized Multi-Patient Medical Transport, which is provided in vans operated by EMS, and Specialized Multi-Passenger Van Transportation provided in all other approved multi-passenger vans.

In general, a provider of van transportation services must transport the member from the member's home to the scheduled medical service or from the location of the medical

appointment directly to the member's residence. The transporting company is responsible for maintaining records that verify the transport was appropriate and completed. **Mileage can only be calculated using the shortest, most direct route between the recipient's residence and medical facility.** Mileage cannot be accumulated over this distance even if recipient remains in vehicle while other recipients are being transported. Only those miles that exceed fifteen (15) miles are reimbursable.

If transportation to more than two medical appointments is scheduled on the same day, documentation that supports the additional transport(s) must be submitted for review to:

Bureau for Medical Services
Transportation Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707

Attachment 2 is an example of the form for Member/Provider Verification/Certification of Attendance at Scheduled Medical Appointment. This specific format does not have to be used, but all of the data required to complete the form must be collected for each trip and retained at the provider's location for review by the BMS when applicable.

524.3.3.a SPECIALIZED MULTI-PATIENT MEDICAL TRANSPORT (SMPMT)

Emergency medical services providers furnish Specialized Multi-Patient Medical Transport for ambulatory patients with a medical history, but who have no apparent immediate need for any level of medical supervision while being transported to and from scheduled medical appointments and as defined in WV Code 16-4-C. This category of provider submits claims directly to the BMS.

Ambulance companies that provide Multi-Patient Medical Transport Services must use vehicles that conform to definitions and requirements in Division of Health Rule (64 CSR 29-3.1.d.1).

524.3.3.b SPECIALIZED MULTI-PASSENGER VAN TRANSPORT (SMPVT)

Providers of Specialized Multi-Passenger Medical Transport services transport Medicaid members to and from medical appointments in a safe, sanitary, and comfortable manner. Providers of this service must have a Certificate of Convenience and Necessity from the WV Public Service Commission in order to participate in the WV Medicaid Program. The vehicles and personnel may not be utilized for the transportation of BLS or ALS medical patients. This category of provider submits claims directly to the BMS.

Medicaid-approved providers of multi-passenger van services are prohibited from identifying themselves in any way as ambulance services or entities associated with emergency medical services agencies. The organization or entity may not advertise or utilize a company name or logo that could be misinterpreted by the general public as having the capacity to provide medical care, or be construed as associated with an emergency medical service agency.

524.3.3.c COMMON CARRIER

Common carrier services are transportation services provided by public railways, buses, cabs, airlines or other common carriers at rates established by the WV Public Service Commission, or applicable Federal regulatory agency. The local DHHR office must prior approve these services

for Medicaid members.

524.3.3.d INDIVIDUAL TRANSPORTATION

The transportation of individual Medical members by a private vehicle is also reimbursed through the Non-Emergency Medical Transportation Program. The local DHHR reimburses for these services. The local DHHR office must approve in advance any room allowances or lodging and out-of-state travel by private automobile in order for these costs to be reimbursed.

524.3.4 PARAMEDIC INTERCEPT (PI)

Paramedic intercept refers to advanced life support (ALS) procedures performed by an EMS agency other than the EMS agency that provides transport. Under these circumstances, the EMS agency that provides basic life support and transportation may bill for the BLS services and loaded mileage. The EMS agency that assists and provides paramedic intercept ALS may bill for the ALS services at the established ALS add-on rate but no mileage. As an example, Agency X provides basic life support services to a critical patient. Agency X's crew requests an advanced life support unit to meet them on the way to the hospital. Agency Y's ALS unit responds to Agency X's request. Agency Y's paramedic boards Agency X's ambulance and provides ALS service while the patient is being transported to the hospital. Agency X will be reimbursed the current BLS rate and mileage, while Agency Y will be reimbursed at the current paramedic intercept rate (ALS add-on). Agency Y cannot bill for mileage since its unit did not transport the patient.

The exception would be if the patient were removed from the BLS unit and transported in the ALS unit. Then the EMS agency providing transport may bill for the ALS services and mileage, while the BLS agency would not have any billable services.

524.4 LIMITATIONS, CONDITIONS, AND SPECIAL CIRCUMSTANCES

WV Medicaid covers transportation services subject to the following limitations conditions, and special circumstances:

- Ground and air ambulances must transport the member to the nearest facility that has the appropriate equipment and personnel necessary to diagnose and treat the member.
- Ambulance transportation from one hospital to a more distant hospital must be for specialized medical care that is not available at the first hospital.
- Ambulance transportation to or from a helipad, airport or landing zone is covered when such transportation is provided in conjunction with air ambulance transport.

524.5 NON-COVERED TRANSPORTATION SERVICES

WV Medicaid does not cover or reimburse transportation services provided to Medicaid members under the following circumstances:

- Ground or air ambulance services beyond the nearest appropriate facility.
- Scheduled air ambulance transportation without prior approval.
- Same-day, round-trip, ambulance transportation from one medical facility to another.
- Transportation to any location that does not render covered medical, diagnostic, or

therapeutic services.

- Transportation of multiple Medicaid members in the same ambulance at the same time, unless an emergency warrants that multiple patients be transported, as in the case of mass casualty incidents. In this event, mileage may be billed as if only one patient was transported.
- Transportation using inadequate or inappropriate level of staff personnel on board transporting vehicle.
- Transportation of members who do not meet the medical necessity requirements for level of service billed.
- Transportation of patient's guardian or family members.

524.6 MANAGED CARE

Health Maintenance Organizations (HMOs) are responsible for all covered medically necessary scheduled and emergency ambulance trips that their Medicaid members require. The HMO is responsible for paying the costs associated with transporting a member when a life-threatening medical emergency exists, regardless of whether the particular ambulance is enrolled as a participant or contractor with the HMO.

Scheduled ambulance transportation services require HMO approval. Providers should follow the particular prior authorization rules of the member's HMO.

524.7 REIMBURSEMENT AND BILLING

Attachment 3 is a list of the procedure codes for covered transportation services and the corresponding WV Medicaid reimbursement rates.

524.7.1 CODE MODIFIERS

Below is a list of the modifiers that are affixed to the procedure codes to indicate a trip's origin or destination. The appropriate code modifier must be entered in the proper space on the CMS-1500 claim form.

D	Diagnostic or therapeutic site
E	Residential, domiciliary, custodial facility
H	Hospital
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of an accident or acute event

The preceding codes are combined to report a trip's origin and destination of a member's trip. For example:

EH	From an extended care facility to a hospital
EP	From an extended care facility to a physician's office
HE	From a hospital to an extended care facility
HR	From a hospital to patient's residence
PH	From a physician's office to a hospital

RH From a patient's residence to a hospital
SH From the scene of an accident to a hospital
RPPR Van round trip from a member's residence to a physician's office and back to the member's residence

CHAPTER 524

TRANSPORTATION

SEPTEMBER 3, 2003

ATTACHMENT 1

MEDICAL NECESSITY CHART

FOR GROUND AMBULANCE SERVICES

MEDICAL NECESSITY

Ambulance Transportation

Note: The listed symptoms and transport suggestions are guidelines only and are not intended to be all-inclusive or to guarantee medical necessity and payment. The medical necessity and appropriate method transport must be determined on a case-by-case basis.

On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Abdominal pain	With other signs or symptoms	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	Advanced Life Support (ALS)
Abdominal pain	Without other signs or symptoms		Basic Life Support – Non-Emergency
Abnormal cardiac rhythm/ Cardiac dysrhythmia	Potentially life-threatening	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6/min., bi and trigeminy, vtach, vfib, atrial flutter, PEA, asystole.	Advanced Life Support (ALS)
Abnormal skin signs		Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled, other ALS emergency conditions.	Advanced Life Support (ALS)
Abnormal vital signs (includes abnormal pulse oximetry)	With symptoms	Other ALS emergency conditions.	Advanced Life Support (ALS)
Alcohol intoxication, drug overdose (suspected)	Unable to care for self; unable to ambulate; airway at risk, pharmacological intervention, cardiac monitoring		Advanced Life Support (ALS)
Alcohol intoxication, drug overdose (suspected)	Unable to care for self; unable to ambulate; no risk to airway; no other symptoms		Basic Life Support – Non-Emergency
Allergic reaction	Potentially life-threatening	Other ALS emergency conditions, rapid progression of symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing.	Advanced Life Support (ALS)
Allergic reaction	No life-threatening signs or symptoms	Hives, itching, rash, slow onset, local swelling, redness, erythema	Basic Life Support – Emergency
ALS monitoring required	Cardiac/hemodynamic monitoring required en route	Expectation monitoring is needed before and after transport	Advanced Life Support (ALS)
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
ALS monitoring required	IV meds required en route	Does not apply to self administered IV medications	Advanced Life Support (ALS)

Animal bites/sting/envenomation	Potentially life or limb-threatening	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other ALS emergency conditions.	Advanced Life Support (ALS)
Animal bites/sting/envenomation	Not potentially life or limb-threatening	Local pain and swelling, special handling considerations and patient monitoring required	Basic Life Support – Emergency
Bed confined (at the time of transport)	Unable to get up from bed without assistance; and Unable to ambulate; and Unable to sit in a chair or wheelchair	Patient is being transported to medical facility for treatment, medical procedure, testing, or evaluation that is medically necessary and reimbursable by Medicaid. Also included are: admissions to and discharges from hospitals, nursing homes or other medical facilities.	Basic Life Support – Non-Emergency
Blood glucose	Abnormal - <80 or >250, with symptoms.	Altered mental status, vomiting, signs of dehydration, etc.	Advanced Life Support (ALS)
Burns	Major – per ABA	Partial thickness burns >10% TBSA; involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical, chemical; inhalation burns with preexisting medical disorders; burns and trauma	Advanced Life Support (ALS)
Burns	Minor – per ABA	Burns other than those listed in ALS	Basic Life Support – Emergency
Cardiac Arrest – Resuscitation in progress			Advanced Life Support (ALS)
Cardiac symptoms other than chest pain	Atypical pain or other symptoms	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom and other ALS emergency conditions	Advanced Life Support (ALS)

On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Choking episode		Partial or complete airway obstruction	Advanced Life Support (ALS)
Cold exposure	Potentially life or limb threatening	Body temperature <95^{o} F, deep frost bite, other emergency conditions.	Advanced Life Support (ALS)
Cold exposure	With symptoms	Shivering, superficial frost bite, and other emergency conditions	Basic Life Support – Emergency
Convulsions/Seizures	Seizing, immediate post-seizure, or at risk of seizure & requires medical monitoring/observation.		Advanced Life Support (ALS)
Difficulty breathing	With signs and symptoms	Other ALS emergency conditions.	Advanced Life Support (ALS)

Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations		Basic Life Support – Emergency
Heat exposure	Potentially life-threatening	Hot and dry skin, Temp >105^{o} F, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other ALS emergency conditions	Advanced Life Support
Heat exposure	With symptoms	Muscle cramps, profuse sweating, fatigue	Basic Life Support – Emergency
Hemorrhage	Severe (quantity)	Active, uncontrolled bleeding with significant signs of shock, Active vaginal, rectal, or post-surgical bleeding, hematemesis, hemoptysis, epistaxis, other emergency conditions.	Advanced Life Support (ALS)
Infectious diseases requiring isolation procedures/public health risk			Basic Life Support – Non-Emergency
Medical device failure	Life or limb threatening malfunction, failure, or complication	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device	Advanced Life Support (ALS)
Medical conditions that may contraindicate transport by other means	Patient safety: Danger to self or others. Seclusion (Flight risk)	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely.	Basic Life Support – Non-Emergency
Medical conditions that may contraindicate transport by other means	Patient safety. Danger to self and others. In restraints.		Basic Life Support – Emergency
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Medical conditions that may contraindicate transport by other means	Special handling en route; Orthopedic device	Backboard, halotraction, use of pins and traction etc.	Basic Life Support – Non-Emergency
Medical Device Failure	Health maintenance device failures	0_2 supply malfunction	Basic Life Support – Emergency
Near Drowning			Advanced Life Support (ALS)
Neurological distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations, paralysis, paresis (focal weakness; abnormal movements; vertigo; unsteady gait/balance; slurred speech, unable to speak		Advanced Life Support (ALS)
Pain, severe not otherwise specified in this list	Acute onset, unable to ambulate or sit	Patient receiving out-of-hospital pharmacologic intervention	Advanced Life Support (ALS)
Pain, severe, not otherwise specified in this list	Acute onset, unable to ambulate or sit	Pain is the reason for the transport	Basic Life Support – Emergency
Poisons, ingested, injected, inhaled, absorbed	Adverse drug reaction, poison exposure by inhalation, injection or absorption		Advanced Life Support (ALS)

Post-operative procedure complications	Major wound dehiscence, evisceration, or requires special handling for transport	Orthopedic appliance; prolapse	Basic Life Support – Emergency
Pregnancy complication/ abnormal delivery		High risk delivery, newborn distress, other ALS emergency conditions	Advanced Life Support (ALS)
Pregnancy/labor/normal delivery			Basic Life Support – Emergency
Psychiatric/Behavioral	Abnormal mental status; drug withdrawal	Suicidal, homicidal, hallucinations, violent, disoriented, DT's, withdrawal symptoms, transport required by state law/court order	Basic Life Support – Emergency
Psychiatric/Behavioral	Threat to self or others, severe anxiety, acute episode or exacerbation of paranoia, or disruptive behavior		Basic Life Support – Non-Emergency
Respiratory arrest		Apnea, hypoventilation requiring ventilatory assistance and airway management.	Advanced Life Support (ALS)
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Trauma, major	As defined by ACS field triage decision scheme	Trauma with two or more of the following conditions: Glasgow <12; systolic BP <90; RR <10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; pelvic fracture; 2 or more long bone fractures; paralysis; severe mechanism of injury including ejection, death of another passenger in same compartment as patient, falls >20 feet, 20" deformity of passenger compartment, auto vs. pedestrian/bike, motorcycle accident at speeds >20 mph and rider separated from vehicle	Advanced Life Support (ALS)
Trauma	Need to monitor or maintain airway	Decreased LOC, bleeding into airway; trauma to head, face, or neck	Advanced Life Support (ALS)
Trauma	Major bleeding	Uncontrolled or significant bleeding with significant hemodynamic changes	Advanced Life Support (ALS)
Trauma	Amputation (other than digits)		Advanced Life Support (ALS)
Trauma	Suspected internal, head, chest, or abdominal injuries	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdomen signs on exam, internal bleeding criteria, evisceration	Advanced Life Support (ALS)

Trauma	Severe pain requiring pharmacologic pain control		Advanced Life Support (ALS)
Trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport	Spinal, long bones, and joints, including shoulder elbow, wrist, hip, knee, and ankle deformity of bone or joint	Basic Life Support – Emergency
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Trauma	Amputation – digits		Basic Life Support – Emergency
Trauma	Penetrating extremity injuries	Isolated with bleeding stopped and good CSM	Basic Life Support – Emergency
Unconscious, Fainting, Syncope	Transient unconscious episode or found unconscious	With other ALS emergency conditions	Advanced Life Support (ALS)

CHAPTER 524

TRANSPORTATION

SEPTEMBER 1, 2003

ATTACHMENT 2

FORM FOR MEMBER/PROVIDER VERIFICATION/CERTIFICATION OF ATTENDANCE AT SCHEDULED MEDICAL APPOINTMENT

RECIPIENT/PROVIDER VERIFICATION/CERTIFICATION OF ATTENDANCE

AT SCHEDULED MEDICAL APPOINTMENT

The West Virginia Medicaid Program reimburses approved providers for non-ambulance non-emergency medical transportation of Medicaid eligible individuals to scheduled medical appointments. Such reimbursement is allowed only after the transportation has been provided, and recipient attendance at the scheduled medical service verified. By affixing their signatures below on this document, the medical service provider, transportation provider, and Medicaid recipient certify that the named Medicaid recipient attended a scheduled medical appointment with the named medical provider, transported by the named transportation provider, on the date or dates indicated on this form.

Date of Scheduled Medical Appointment: ____/____/____ Appointment Time: _____:_____ AM/PM

Patient's Name:_____ Medicaid I.D. Number_____

Name and Address of Medical Vendor:_____

_____

Name and Address of Transportation Provider:_____

_____

Vehicle Identification:_____

Time of Client Pickup:_____:_____AM/PM Mileage at Point of Pickup:_____

Time of Client Drop-off:_____:_____AM/PM Mileage at Point of Drop-off:_____

I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Signature of Medical Vendor's Representative:_____Date:____/____/____

Signature of Driver:_____ Date:____/____/____

Signature of Medicaid Patient:_____Date:____/____/____

Revised 05/03

BMS Form 26-01

CHAPTER 524

TRANSPORTATION

SEPTEMBER 1, 2003

ATTACHMENT 3

WEST VIRGINIA MEDICAID REIMBURSEMENT RATES FOR COVERED TRANSPORTATION SERVICES

REVISED SEPTEMBER 15, 2005

Air Ambulance-Rotary Wing

Code	Item	Description	Payment Rate
A0431	Base rate	All inclusive	$940.00
A0436	Mileage	Distance patient transported	$25.00 per mile
A0021	Ground transport	Out of State	Up to $350.00 per occurrence

Air Ambulance - Fixed Wing

Code	Item	Description	Payment Rate
A0430	Base rate	All inclusive	$972.00
A0435	Mileage	Distance patient transported	$9.00 per mile
A0021	Ground transport	Out of State	Up to $350.00 per occurrence

Ground Ambulance - Basic Life Support Emergency

Code	Item	Description	Payment Rate
A0429	Base rate	BLS, emergency transport	$112.50
A0422	Oxygen	Unit rate	$25.00 per unit up to a $100.00 maximum
A0425	Mileage	Distance patient transported	$3.80 per mile

Advanced Life Support

Code	Item	Description	Payment Rate
A0426	Base Rate	ALS, non-emergency transport	$377.50
A0427	Base Rate	ALS, emergency transport (level 1)	$377.50
A0433	Base Rate	ALS, emergency transport (level 2)	$377.50
A0425	Mileage	Distance patient transported	$3.80 per mile

Basic Life Support Non-emergency

Code	Item	Description	Payment Rate
A0428	Base rate	All inclusive	$90.00
A0425	Mileage	Distance patient transported	$3.80 per mile

Non-Ambulance Transportation

a. Specialized Multi-Patient Medical Transport (SMPMT)

b. Specialized Multi-Passenger Van Transport (SMPVT)

Code	Item	Description	Payment Rate
A0120	Base rate	Transportation to and/or from therapeutic or diagnostic medical service that is covered by Medicaid.	$9.00
S0215	Mileage	Mileage exceeding 15 miles	$0.66 per each mile over 15

Common Carrier

- PSC approved rate per mile

Private Vehicle

- State travel allowance per mile
- Turnpike fees
- $5 for certain meals
- Economic room allowances

Paramedic Intercept

Code	Item	Description	Payment Rate
S0207	Base rate	Hospital based EMS agency	$265.50
S0208	Base rate	Non-hospital based EMS agency	$265.50

CHAPTER 525 - COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR VISION CARE SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 525.2	Medicaid Enrollment Requirements	3/06/06	04/14/06
Section 525.4	Comprehensive Eye Examinations	3/06/06	04/14/06
Section 525.5	Eyeglasses	3/06/06	04/14/06
Section 525.5.2	Complete Replacements	2/28/06	Policy Clarification
Section 525.5.3	Replacement Frames or Lenses	2/28/06	04/14/06
Section 525.7	Covered Services	3/06/06	04/14/06
Introduction	Introduction	08/02/05	08/15/05
Section 525.5	Eyeglasses	08/02/05	08/15/05
Section 525.6	Artificial Eyes	08/02/05	08/15/05
Section 525.7	Covered Services	08/02/05	08/15/05
Section 525.7.1	Contact Lenses	08/02/05	08/15/05
Section 525.7.2	Orthoptics-Visual Training	08/02/05	08/15/05
Section 525.7.3	Photochromatic Lenses	08/02/05	08/15/05
Section 525.7.4	Unlisted Services, Procedure, or Appliances	08/02/05	08/15/05

Section 525.9	Eye Appliances/ Services That Are Not Covered	08/02/05	08/15/05
Section 525.10	Billing and Reimbursement	08/02/05	08/15/05
Attachment 1	Procedure Codes Covered by WV Medicaid	08/02/05	08/15/05
Attachment 2	Prior Authorization Form For Vision Care Services	08/02/05	08/15/05

March 06, 2006

Section 525.2

Introduction: Clarification of policy.

Change: Add the sentence, “Ophthalmologists performing medical services should refer to the Practitioner manual for additional information regarding services.”

Directions: Replace old pages with new pages.

March 06, 2006

Section 525.4

Introduction: Clarification of policy.

Change: Remove the words “without prior authorization” from the first sentence. The sentence should now read “One comprehensive ophthalmologic examination per year is covered for members under 21 years of age.”

Directions: Replace old pages with new pages.

March 06, 2006

Section 525.5

Introduction: Clarification of policy.

Change: Change the last sentence in the first paragraph to a bullet. Wording will stay the same.

Directions: Replace old pages with new pages.

February 28, 2006

Section 525.5.2

Introduction: Clarification of policy regarding replacement glasses.

Change: Bolded the sentence “A complete replacement includes both the lenses and the frame.”

Directions: Replace old pages with new pages.

February 28, 2006

Section 525.5.3

Introduction: Clarification of policy regarding replacement glasses.

Change: Added a bullet sentence “Replacement lenses due to breakage or loss of a lens or lenses. Added the sentence “Any replacement within this category is considered a repair, since a complete replacement is both lenses and the frame.

Directions: Replace old pages with new pages.

March 06, 2006

Section 525.7

Introduction: Clarification of policy.

Change: Add the sentence “See section 525.7.4.” to the last bullet.

Directions: Replace old pages with new pages.

August 2, 2005

Introduction

Introduction: Discontinued prior authorization of eye care services.

Change: Removed the sentence “Certain vision care services and appliances are covered without any prior approval requirements: however, other services may require prior authorization for reimbursement of services rendered.” Delete the words “and authorized” in the first paragraph, 2nd sentence.

Directions: Replace old pages with new pages.

Section 525.5

Introduction: Discontinued prior authorization of eye care services.

Change: Removed the sentence “Prior authorization is not necessary.”

Directions: Replace old pages with new pages.

Section 525.6

Introduction: Discontinued prior authorization of eye care services.

Change: Removed the words “without prior authorization.”

Directions: Replace old pages with new pages.

Section 525.7

Introduction: Discontinued prior authorization of eye care services.

Change: Remove “REQUIRING PRIOR AUTHORIZATION” from the heading. Remove the sentence “However, prior approval is required for reimbursement.” Delete paragraphs 2,3, and 4.

Directions: Replace old pages with new pages.

Section 525.7.1

Introduction: Discontinued prior authorization of eye care services.

Change: Remove the sentence “The request for prior authorization must include a description of the member’s eye condition, reasons for recommending contact lenses, prognosis for successful contact lenses wear, and probable need for supplemental spectacle lenses.

Directions: Replace old pages with new pages.

Section 525.7.2

Introduction: Discontinued prior authorization of eye care services.

Change: Remove the words “may be authorized” in the first sentence. Delete the 2nd sentence.

Directions: Replace old pages with new pages.

Section 525.7.3

Introduction: Discontinued prior authorization of eye care services.

Change: Delete first sentence. Remove the word “approval” in the second sentence, and replace it with the word “Coverage.”

Directions: Replace old pages with new pages.

Section 525.7.4

Introduction: Discontinued prior authorization of eye care services.

Change: Delete first sentence. Remove the words “Where approval is given” and replace with the words “When billing” in the second sentence. Add the word “procedure” to the second sentence after the word unlisted.

Directions: Replace old pages with new pages.

Section 525.9

Introduction: Discontinued prior authorization of eye care services.

Change: Delete “Note: There is no exception/prior authorization for non covered services.”

Directions: Replace old pages with new pages.

Section 525.10

Introduction: Discontinued prior authorization of eye care services.

Change: Remove the words “with prior authorization” from the third paragraph, second sentence.

Directions: Replace old pages with new pages.

Attachment 1

Introduction: Discontinued prior authorization of eye care services.

Change: Delete the sentence “All procedure codes which are followed by an asterisk (*) require prior approval by the Eye Care Consultant at The Bureau for Medical Services contracted agency. Remove all asterisks from the procedure code list. Remove the words “copy of the prior authorization form, a” from the sentence after procedure codes V2199, V2299, V2399, V2499, V2599, V2615, & V2799. Remove the words “also requires prior authorization under code 92499” from the sentence after procedure codes V2610 & V2629.

Directions: Replace old pages with new pages.

Attachment 2

Introduction: Discontinued prior authorization of eye care services.

Change: Delete attachment 2.

Directions: Replace old pages with new pages.

CHAPTER 525—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR VISION SERVICES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

CHAPTER 525–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR VISION CARE SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise by the Bureau for Medical Services (BMS) in writing.

WV Medicaid covers eye examinations, optical fitting services, and eye appliances.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV. The Bureau for Medical Services in the West Virginia Department of Health & Human Resources is the single state agency responsible for administering the WV Medicaid Program.

525.1 QUALIFIED EYE CARE PROVIDERS

A qualified eye care provider is an individual licensed to provide eye care services in the State in which he or she practices. Eye Care providers must comply with all applicable Federal and State laws, regulations, and licensing and certification requirements.

525.2 MEDICAID ENROLLMENT REQUIREMENTS

Qualified vision care providers (e.g., ophthalmologists, optometrists, opticians, ocularists, and appliance dispensers) who wish to participate in the WV Medicaid Program must meet the general requirements in **Chapter 300,** as well as the specific requirements outlined below.

An ophthalmologist or optometrist may provide professional services and eye examinations, optical fitting services, and eye appliances to Medicaid members, or they may provide professional services and eye examinations only. An optician or other qualified provider may furnish optical fittings and eye appliances only.

Ophthalmologists who dispense eye appliances require two Medicaid provider numbers for billing purposes. The first number is used to bill for eye examinations and all other covered medical services. The second number is used to bill for eyeglasses and contact lenses. Ophthalmologists performing medical services should refer to the **Practitioner Manual** for additional information regarding services.

Answers to questions about the enrollment application can be obtained by calling the Provider Enrollment Unit at 304-348-3360 or 888-483-0793. Providers must meet all of the provider requirements and their practices must be fully operational before they may enroll as Medicaid providers.

All eye care providers must be enrolled in the WV Medicaid Program in order to be paid for covered services furnished to Medicaid members.

525.3 COVERED SERVICES

WV Medicaid covers vision care services for the examination, diagnosis, treatment, and management of ocular and adnexal pathology. This includes diagnostic testing, treatment of eye disease or infection, specialist consultation and referral, comprehensive ophthalmologic evaluations, and eye surgery (but not cosmetic surgery). Visual examinations to determine the need for eyeglasses are covered for children only.

Full vision care benefits are available for Medicaid members under 21 years of age. Limited vision care benefits are available for members 21 years and older. There is no coverage for cosmetic purposes.

All covered services for members under 21 years must be started before the twenty-first birthday. Vision care services provided on or after the birth date are not covered even if eligibility extends to the end of the month in which the birth date occurs.

Attachment 1 lists the procedure codes for eye care.

- *IMPORTANT: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.*

525.4 COMPREHENSIVE EYE EXAMINATIONS

One comprehensive ophthalmologic examination per year is covered for members under 21 years of age. If a member needs an additional eye examination, the provider may bill other appropriate service codes.

West Virginia Medicaid does not reimburse for both an evaluation and management visit and a comprehensive or intermediate ophthalmologic eye exam on the same day for the same member.

525.5 EYEGLASSES

One of the following criteria must be met for WV Medicaid to cover eyeglasses for members who are under 21 years of age and have never worn eyeglasses previously.

- There is a .50 diopter sphere and/or cylinder and the beneficiary's visual acuity is decreased more than 20/25 and will improve to 20/20 with eyeglasses
- Bifocals are required
- Eyeglasses give at least one line improvement on standard visual acuity chart.

West Virginia Medicaid covers the first pair of eyeglasses an a visual examination after cataract surgery for adults age 21 years and older.

A participating ophthalmologist or an optometrist must prescribe eyeglasses. Both the prescribing and the supplying provider must keep a copy of the prescription in the member's medical record.

NOTE: Sometimes an eye appliance may not be dispensed on the prescribing date. In situations where Medicaid coverage ends before the appliance can be dispensed, the provider

should use the prescribing date to bill for the appliance. In all cases, a claim should not be submitted until the complete service has been provided.

525.5.1 FITTINGS

The fitting, adjustment, and dispensing of eyeglasses are included in the payment for the frames, lenses, and other materials that make up the eyeglasses. The fitting, adjustment, and dispensing include the measurement of the beneficiary's anatomical facial characteristics, preparation of the prescription form, the writing of laboratory specifications, ordering the prescription, and adjusting the visual axes and anatomical topography.

525.5.2 COMPLETE REPLACEMENTS

WV Medicaid covers one complete replacement pair of eyeglasses a year (between eye examinations) due to breakage, loss, etc for members less than 21 years of age. **A complete replacement includes both the lenses and the frame.**

525.5.3 REPLACEMENT FRAMES OR LENSES

WV Medicaid will replace frames only when the member's current frames can no longer be used. WV Medicaid covers new replacement lenses for members who are under 21 years of age and meet one of the following criteria:

- Vertical prism change of one prism diopter or greater
- Horizontal prism change of three prism diopters or greater
- A change of .50 in the spherical equivalent of the member's prescription
- There is a change of cylinder axis of at least:
  - 10 degrees for under 1.00D cylinder
  - 5 degrees for 1.00D to 2.00D cylinder
  - 2-1/2 degrees for 2.25D cylinder or greater.
- Any change which gives at least one line improvement on the standard visual acuity chart.
- Replacement lenses due to breakage or loss of a lens or lenses.

Any replacement within this category is considered a repair, since a complete replacement is both lenses and the frame.

525.5.4 REPAIRS

WV Medicaid covers repairs made to the eyeglasses of a member under 21 years of age. The repair must be cost efficient and not exceed the cost of purchasing new eyeglasses.

Repairs must be documented in the member's medical record.

WV Medicaid does not pay separately for simple, one-step adjustments or realignment of the frame or temples. The West Virginia Medicaid program will allow separate payment for procedure codes 92370, (repair and refitting spectacles; except for aphakia) and 92371, (repair and refitting spectacles; spectacle prosthesis for aphakia). The lenses and frames are sometimes mangled, scratched, bent, etc. but are able to be repaired and refitted, rather than require a complete replacement.

525.6 ARTIFICIAL EYES

WV Medicaid covers artificial (or prosthetic) eyes. Prescriptions for an artificial eye must identify the type of artificial eye required and summarize the member's need for such an eye. The member's medical record must contain written documentation of the provider's evaluation leading to a recommendation for an artificial eye.

525.7 COVERED SERVICES

WV Medicaid will consider coverage for the following medically necessary services and appliances, depending on a member's age.

- Contact lenses for the diagnosis of aphakia, keratoconus, aniseikonia, and anisometropia—members under 21 years
- Contact lenses for the diagnosis of aphakia and keratoconus—members 21 years and older
- Orthoptics-visual training—members under 21 years
- Photochromatic lenses for albinism only—members under 21 years
- Unlisted ophthalmologic services or procedure/appliances—members under 21 years. See section 525.7.4

525.7.1 CONTACT LENSES

Contact lenses (hard, soft, and gas-permeable) may be considered for authorization when they enable better vision than can be achieved with spectacle lenses.WV Medicaid does not provide reimbursement for contact lenses for cosmetic purposes.

Contact lenses for members 21 years of age and over are limited to a diagnosis of surgical aphakia, (unilateral or bilateral) or keratoconus (conical cornea). Not covered for Pseudo-aphakia.

A participating ophthalmologist or an optometrist must prescribe contact lenses; both the prescribing and supplying providers must retain a copy of the prescription in the member's medical record.

525.7.2 ORTHOPTICS–VISUAL TRAINING

Orthoptics-visual training is covered when the prognosis is for substantial improvement or correction of a member's ocular or visual condition.

525.7.3 PHOTOCHROMATIC LENSES

Coverage is limited to the diagnosis of albinism only.

525.7.4 UNLISTED SERVICES, PROCEDURE, OR APPLIANCES

When billing for an unlisted procedure or appliance, the provider must submit a copy of the laboratory invoice with the claim for payment.

525.8 CATARACT SURGERY- POST OPERATIVE CARE ONLY

Optometrists billing for cataract postoperative care must bill the surgical code with a 55 modifier using the date of service of the surgery. Reimbursement will represent only the postoperative

portion of the global surgical fee or charge, whichever is less. Evaluation and management services related to the surgical procedure must not be billed during the global period.

525.9 EYE APPLIANCES/ SERVICES THAT ARE NOT COVERED

WV Medicaid does not cover the following:

- Plano sunglasses
- Prescription sunglasses
- Anti-reflective lenses
- Repair or replacement of glasses for members 21 years or older
- Designer frames
- Other optional/ deluxe features
- Conscious sedation, local anesthesia, regional anesthesia, and IV sedation with an optical/ophthalmic procedure. These are included in the procedure/service being provided.

A Medicaid member who chooses to receive vision care services or appliances that WV Medicaid does NOT cover is financially liable for the payment. Before services are rendered, the provider should make appropriate financial arrangements with the member for payment for such services and appliances.

525.10 BILLING AND REIMBURSEMENT

Reimbursement for eye care examinations, consultations, surgical and other procedures is based on WV Medicaid's RBRVS fee schedule. For surgical procedures, the Medicaid "global" fee amount covers a standard package of pre-operative, intra-operative, and post-operative services. The preoperative period is the day before the surgery and the day of the surgery. The postoperative period is 90 days for major surgery and 0 days or 10 days for minor surgery.

Reimbursement for an eye appliance is based on WV Medicaid's fee schedule.

Reimbursement for contact lenses covers all professional services, follow-up visits, contact lenses, and required care kits. Separate payment is available for contact lens fittings. In all cases, claims for payment should not be submitted until vision care services have been completed.

Providers must submit directly to the Medicare carrier on the appropriate claim form all charges for artificial eyes or eyeglasses following cataract surgery which have been furnished to members with both Medicare and Medicaid coverage. WV Medicaid limits coverage to the Medicare deductible and coinsurance, up to the Medicare fee schedule amount.

525.11 MANAGED CARE

Vision benefits are covered by the Health Maintenance Organizations (HMO's) for their members. Prior authorization rules must be followed for the respected member's HMO. General vision services, eye examinations and glasses, for PAAS members do not require PCP authorization for reimbursement, however, surgery and other more complicated procedures do require PCP authorization, but still may require prior authorization according to HMO guidelines.

CHAPTER 525

VISION CARE SERVICES

JULY 1, 2004

ATTACHMENT 1
PROCEDURE CODES COVERED BY
WEST VIRGINIA MEDICAID

PROCEDURE CODE LIST EYE CARE

PROCEDURE CODES	DESCRIPTION
	EYE EXAMS
92002	Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Comprehensive, new patient, one or more visits
92012	Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Comprehensive, established patient, one or more visits
	Evaluation and management codes may be used for lesser service examinations.
	SPECIAL OPHTHALMOLOGICAL SERVICES
92015	Determination of refractive state
92019	Limited
92020	Gonioscopy (separate procedure)
92060	Sensorimotor examination with medical diagnostic evaluation
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation

92081	Visual field examination, unilateral or bilateral
92082	Intermediate examination
92083	Extended examination
92100	Serial tonometry with multiple measurements of intraocular pressure over an extended time period
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130	Tonography with water provocation
92135	Scanning computerized ophthalmic diagnostic imaging, unilateral
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92140	Provocative tests for glaucoma, with interpretation
92225	Ophthalmoscopy, extended, with retinal drawing, initial
92226	Subsequent
92230	Fluorescein angioscopy with interpretation and report
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report
92250	Fundus photography with interpretation and report
92260	Ophthalmodynamometry

92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes
92275	Electroretinography with interpretation and report
92283	Color vision examination, extended, anomaloscope or equivalent
92284	Dark adaptation examination with interpretation and report
92285	External ocular photography with interpretation and report for documentation of medical progress

CONTACT LENS SERVICES

92310	Prescription of optical and physical characteristics of and fitting of contact lens with medical supervision of adaptation; corneal lens, both eyes, except for aphakia.
92311	Corneal lens for aphakia, one eye
92312	Corneal lens for aphakia, both eyes
92313	Corneoscleral lens
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens both eyes except for aphakia.
92315	Corneal lens for aphakia, one eye
92316	Corneal lens for aphakia, both eyes
92317	Corneoscleral lens
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation

92326	Replacement of contact lens

SPECTACLE SERVICES

92370	Repair and refitting spectacles; except for aphakia
92371	Spectacle prosthesis for aphakia

OTHER PROCEDURES

92499	Unlisted ophthalmological service or procedure

Optometrists may also bill for the following CPT codes

62505	**65210**	**65220**	**65222**	**65430**	**65435**	**66761**	**66999**
67820	**68761**	**68801**	**68810**	**68840**	**99201**	**99202**	**99203**
99204	**99205**	**99211**	**99212**	**99213**	**99214**	**99215**	**99241**
99242	**99243**	**99244**	**99245**				

The following procedure codes are payable to an optometrist with the modifier (55)

65855 55 66821 55 66983 55 66984 55 66985 55

SUPPLIES FOR VISION CARE SERVICES

FRAMES

V2020	Frames, purchases

SPECTACLE LENSES

Single Vision - Glass or Plastic

V2100	Sphere only; single vision, plano to plus or minus 4.00D - per lens
V2101	Plus or minus 4.12 to plus or minus 7.00D - per lens
V2102	Plus or minus 7.12 to plus or minus 20.00D - per lens
	Spherocylinder; single vision, plano to plus or minus 4.00D sphere:
V2103	.12 to 2.00D cylinder, per lens
V2104	2.12 to 4.00D cylinder, per lens
V2105	4.25 to 6.00D cylinder, per lens
V2106	Over 6.00D cylinder, per lens
	Spherocylinder; single vision, plus or minus 4.25 to plus or minus 7.00D sphere
V2107	.12 to 2.00D cylinder, per lens
V2108	2.12 to 4.00D cylinder, per lens
V2109	4.25 to 6.00D cylinder, per lens
V2110	Over 6.00D cylinder, per lens
	Spherocylinder; single vision, plus or minus 7.25 to plus or minus 12.00D sphere:
V2111	.12 to 2.00D cylinder, per lens
V2112	2.12 to 4.00D cylinder, per lens
V2113	4.25 to 6.00D cylinder, per lens
	Spherocylinder: single vision, over plus or minus 12.00D sphere:

V2114	Over 6.00D cylinder, per lens
V2115	Lenticular; (myodisc), per lens, single vision
V2118	Aniseikonic: per lens, single vision
V2121	Lenticular lens, per lens, single
V2199	Not otherwise classified, single vision lens.

When billing for the above codes, please include a
completed HFCA - 1500 form, and a copy of the lab invoice for the services.

Bifocal: glass or plastic (up to and including 28MM seg width, add power up to and including 3.25D)

SPECIAL NOTE: See V2219 and V2220 for "add ons" seg width over 28mm, add over 3.25D

V2200	Sphere only: bifocal, plano to plus or minus 4.00D, per lens
V2201	Plus or minus 4.12 to plus or minus 7.00D, per lens
V2202	Plus or minus 7.12 to plus or minus 20.00D, per lens
	Spherocylinder: bifocal, plano to plus or minus 4.00D sphere:
V2203	.12 to 2.00D cylinder, per lens
V2204	2.12 to 4.00D cylinder, per lens
V2205	4.25 to 6.00D cylinder, per lens
V2206	Over 6.00D cylinder, per lens

	Spherocylinder: bifocal, plus or minus 4.25 to plus or minus 7.00D sphere:
V2207	.12 to 2.00D cylinder, per lens
V2208	2.12 to 4.00D cylinder, per lens
V2209	4.25 to 6.00D cylinder, per lens
V2210	Over 6.00D cylinder, per lens
	Spherocylinder: bifocal, plus or minus 7.25 to plus or minus 12.00D sphere:
V2211	.12 to 2.00D cylinder, per lens
V2212	2.12 to 4.00D cylinder, per lens
V2213	4.25 to 6.00D cylinder, per lens
	Spherocylinder: bifocal, over plus or minus 12.00D sphere:
V2214	Over 6.00D cylinder, per lens
V2215	Lenticular: (myodisc), per lens, bifocal
V2218	Aniseikonic: per lens, bifocal
V2219	Bifocal: seg width over 28mm
V2220	Add over 3.25D
V2221	Lenticular lens, per lens, bifocal
V2299	Special bifocal
	When billing for the above code, please include a completed HFCA - 1500 form, and a copy of the lab invoice for the services.

	Trifocal: glass or plastic (up to and including 28mm seg width, add power up to and including 3.25D)
	SPECIAL NOTE: See V2319 and V2320 for "add ons" seg width over 28mm, add over 3.25D
V2300	Sphere only: trifocal, plano to plus or minus 4.00D per lens
V2301	Plus or minus 4.12 to plus or minus 7.00D, per lens
V2302	Plus or minus 7.12 to plus or minus 20.00D, per lens
	Spherocylinder: trifocal, plano to plus or minus 4.00D, sphere:
V2303	.12 to 2.00D cylinder, per lens
V2304	2.12 to 4.00D cylinder, per lens
V2305	4.25 to 6.00D cylinder, per lens
V2306	Over 6.00D cylinder, per lens
	Spherocylinder: trifocal, plus or minus 4.25 to plus or minus 7.00D, sphere:
V2307	.12 to 2.00D cylinder, per lens
V2308	2.12 to 4.00D cylinder, per lens
V2309	4.25 to 6.00D cylinder, per lens
V2310	Over 6.00D cylinder, per lens
	Spherocylinder: trifocal, plus or minus 7.25 to plus or minus 12.00D sphere:
V2311	.12 to 2.00D cylinder, per lens

V2312	2.12 to 4.00D cylinder, per lens
V2313	4.25 to 6.00D cylinder, per lens
	Spherocylinder: trifocal, over plus or minus 12.00D sphere:
V2314	Over 6.00D cylinder; per lens
V2315	Lenticular; (myodisc), per lens, trifocal
V2318	Aniseikonic; per lens, trifocal
V2319	Trifocal; seg width over 28mm
V2320	Add over 3.25D
V2321	Lenticular lens, per lens, trifocal
V2399	Special trifocal
	When billing for the above codes, please include a completed HFCA - 1500 form, and a copy of the lab invoice for the services.
	Variable sphericity (Welsh 4-drop, hyperaspheric, double drop, etc.)
V2410	Variable asphericity lens; single vison, full field, glass or plastic, per lens
V2430	Bifocal, full field, glass or plastic, per lens
V2499	Not otherwise classified, variable asphericity lens.
	When billing for the above codes, please include a completed HFCA - 1500 form, and a copy of the lab invoice for the services.

MISCELLANEOUS

V2700	Balance lens, per lens
V2710	Slab off prism, glass or plastic, per lens
V2715	Prism, per lens
V2718	Press-on lens, fresnell prism, per lens
V2730	Special base curve, glass, or plastic per lens
V2744	Photochromatic, per lens, (covered for albinism only)
V2755	U-V lens: per lens (covered for children only for the diagnosis of aphakia)
V2770	Occluder lens; per lens
V2780	Oversize lens, per lens
V2799	Not otherwise classified miscellaneous "add ons"
	When billing for the above codes, please include a completed HFCA - 1500 form, and a copy of the lab invoice for the services.
S0580	Polycarbonate "add-on" per lens
S0590	Integral lens service, misc.

SUPPLY OF CONTACT LENSES

Coverage limitations:

ADULTS: Contact lenses are covered only for the diagnosis of aphakia and keratoconus.

CHILDREN: Contact lenses are covered only for the diagnosis of aphakia, keratoconus, aniseikonia, or anisometropia.

V2500	Contact lens, PMMA: spherical, per lens
V2501	Toric or prism ballast, per lens
V2502	Bifocal, per lens
V2503	Color vision deficiency, per lens
V2510	Contact lens, gas permeable; spherical, per lens
V2511	Toric or prism ballast, per lens
V2512	Bifocal, per lens
V2513	Extended wear, per lens
V2520	Contact lens, hydrophilic; spherical, per lens
V2521	Toric or prism ballast, per lens
V2522	Bifocal, per lens
V2523	Extended wear, per lens
V2530	Contact lens, scleral; per lens
V2599	Not otherwise classified, contact lens.

When billing for the above code, please include a
completed HFCA - 1500 form, and a copy of the lab invoice for the services.

SUPPLY OF LOW VISION AIDS **(NO COVERAGE FOR ADULTS)**

V2600	Hand held low vision aids and other nonspectacle mounted aids

V2610	Single lens spectacle mounted low vision aids
	Prescribing and fitting of low vision aids must be billed using CPT code 92499.
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system.
	When billing for the above code, please include a completed HFCA - 1500 form, and a copy of the lab invoice for the services.

SUPPLY OF PROSTHETIC EYE

V2623	Prosthetic eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2629	Not otherwise classified prosthetic eye.
	When billing for the above code, send a completed HCFA - 1500 form, and a copy of the lab invoice.
	Prescribing and fitting of an ocular prosthesis must be billed using CPT code 92499.
92499	Unlisted eye care code. Please give complete description of service required.

CHAPTER 526

COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM (CDCSP)

TABLE OF CONTENTS

CHAPTER 526 CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM (CDCSP)

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed, otherwise in writing, by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS eligibility and reimbursement requirements for services provided to eligible WV Medicaid members under the Children with Disabilities Community Services Program (CDCSP).

The policies and procedures set forth herein are the regulations governing the provision of services under the Children with Disabilities Community Services Program of the Medicaid Program administered by the Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the WV Code. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 allowed the State of West Virginia to elect the option of providing CDCSP (Federal Title "Disabled Child In-Home Care Program" otherwise known as Katie Beckett) under Medicaid.

The CDCSP allows a child with a severe disability who is eligible to receive the level of care provided in a medical institution (i.e., nursing facility, ICF/MR, hospital) to receive Medical Assistance, i.e., the child will receive a West Virginia Medical card. Medicaid may pay the premiums, deductibles, coinsurance and other cost sharing obligations for eligible members who have primary insurance. The member will remain eligible for CDCSP State plan services. CDCSP applicants are encouraged to inquire about the guidelines for this program.

To be eligible for the CDCSP, the child must (a) live at home with his/her biological or adoptive parents and (b) have a program of community services developed by a health care provider. The level of services provided in the community must serve the child as well as or better than comparable services in a medical institution and must cost less than the same services delivered in a comparable medical institution (nursing facility, ICF/MR, hospital).

526.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of the services in the **CDCSP** described in this chapter.

Complex medication regimen means the child must have a complex range of new medications (including medications by mouth) following a hospitalization where there is a high probability of adverse reactions and/or a need for changes in the dosage or type of medication

to maintain stability; and documentation must include the child's unstable condition, medication changes, continuing probability of complications and need for monitoring by skilled personnel.

Complex teaching services to the child and/or family requiring 24-hour skilled nursing facility setting vs. intermittent home health setting means the teaching itself is the skilled service that must be provided by the appropriate professional. The activity being taught may or may not be considered skilled; documentation should include the reasons why the teaching was not completed in the hospital, as well as the child's or family's capability of compliance.

Cost Effectiveness means the cost of care for the child in the home cannot exceed the cost of care in an institution.

Children with Disabilities Community Services Program (CDCSP) is a West Virginia optional program that provides Medicaid benefits to severely disabled children who meet the program's eligibility requirements. It is administered by the Bureau for Medical Services (BMS) and approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for Title XIX. The CDCSP is an alternative to institutionalization and provides medically necessary services that are community-based and costs less than institutional services.

Developmental Disability: This term is used to describe a child who has not attained normal development when compared with the standard population. It may be attributable to mental retardation, cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; it is likely to continue indefinitely; it results in substantial functional limitations in three or more of the following areas of major life activity: (1) self-care, (2) understanding and use of language, (3) learning (functional academics), (4) mobility, (5) self-direction and (6) capacity for independent living. (Code of Federal Regulations 42, 435.1010).

Disability for CDCSP means that the child must be disabled according to the SSI definition of disability.

Forms:

- DD1: CDCSP Information Sheet
- DD2A: Medical Evaluation (ICF/MR Level of Care)
- DD2B: Medical Evaluation (Acute Hospital/Nursing Home Level of Care)
- DD3: Comprehensive Psychological Evaluation
- DD4: Social History
- DD6: Cost Estimate Worksheet Instructions

Level of Care for CDCSP references the medical eligibility criteria for level of care provided in a hospital, nursing facility, and ICF/MR facility.

Mental Retardation means significantly sub-average intellectual functioning which manifests itself in a person during his/her developmental period and which is characterized by inadequacy in adaptive behavior. West Virginia Code § 27-1-3.

Observation, assessment and monitoring of a complicated or unstable condition means unstable condition of the child must require the skills of a licensed nurse or rehabilitation personnel in order to identify and evaluate the child's need for possible modification of the treatment plan or initiation of additional medical procedures; there must be a high likelihood of a change in a child's condition due to complications or further exacerbations; Daily nursing notes must give evidence of the child's condition and indicate the results of monitoring; Documentation must indicate the child's condition and indicate the results of monitoring.

Wound care [including decubitus ulcers] Skilled nursing facility services solely for the purpose of wound care should be rare. **All** of the following criteria must be met:

- Wound care must be ordered by a physician,
- The child must require extensive wound care that consists of packing, debridement and/or irrigation.

526.2 MEMBER ELIGIBILITY AND ENROLLMENT PROCESS

Targeted Population includes:

- A child from newborn up through the age of 18 [Soc. Sec. Act, Sect. 1902(e)(3)(A)], who lives with his/her adoptive or biological family, and;
- who has a disability that qualifies him/her to receive Supplemental Security Income (SSI), but who is denied SSI because his/her parents' income or assets exceeds the Social Security Administration guidelines;
- whose care is provided in his/her home and community setting at the same level of quality and does not exceed the cost of care in a medical institution, and:
- whose care requires the level of services provided in one of the following medical facilities:

Acute Care Hospital: A child with a significant need for medical services and/or nursing services who is at risk of hospitalization in an acute care hospital setting. Inpatient services are defined as services ordinarily furnished in a hospital for care and treatment of inpatients and are furnished under the direction of a physician. CFR §440.10.

- Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent hospitalizations. This level of care is highly skilled and provided by professionals in amounts not normally available in a skilled nursing facility but available in a hospital.

Intermediate Care Facility for Individuals with Mental Retardation and/or Related Conditions (ICF/MR): A child with mental retardation and/or related conditions (e.g., cerebral palsy, autism, traumatic brain injury) who is at risk of being placed in an ICF/MR facility. CFR §440.50.

- An ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and habilitation services to persons with mental retardation or related conditions.

Nursing facility (NF): A child with a significant need for medical services and/or nursing services who is at risk of hospitalization or placement in a nursing facility.

- Nursing facility services are skilled services that are needed on a daily basis that must be provided on an inpatient basis and ordered by, and provided under the direction of a physician. (42 CFR)
- Nursing facility level of care is appropriate for individuals who do not require acute hospital care, but, on a regular basis, require nursing services, or other health-related services ordinarily provided in an institution. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

526.3 MEMBER MEDICAL AND FINANCIAL ELIGIBILITY

The member must have a determination of Medical Eligibility. Medical eligibility is comprised of two components:

1. The applicant must meet the level of care stated in the application; and
2. All medical costs [billed charges] the child incurred in the 12 months prior to application are less than the costs that would have been incurred in the institution for the distinct level of care during the same period. The child's proposed costs for the forthcoming year are also compared to the costs in the institution and may not exceed the 'ceiling' for the specific level of care. Please refer to Appendix A.

The member must have a determination of Financial Eligibility. Once medical eligibility is established, members make application at the local Department of Health & Human Resource (DHHR) office for assessment of financial eligibility. A child will be assessed as an individual applicant regardless of his/her family's income. Income and assets of the child will be used in determining his/her financial eligibility for the program.

Financial eligibility will be determined by the local Department of Health and Human Resources (DHHR) Economic Services (ES) Worker. Financial Eligibility will be based on:

- INCOME: Only the applicant's income is considered available to him/her. The parents' income is not considered available to the child. The child's income will be established as a single applicant with eligibility determined independently of other members of his/her family.
- ASSETS: An individual's assets, excluding residence and furnishings, may not exceed $2,000 for Medicaid eligibility under CDCSP.

Once medical and financial eligibility is determined, the member is eligible for a West Virginia Medicaid card under CDCSP for a period of one year or until the cost exceeds that which can be provided in an institution. The member must be a resident of the State of West Virginia.

Medicaid may pay the premiums, deductibles, coinsurance and other cost sharing obligations for eligible members who have primary insurance. The member will remain eligible for CDCSP

State plan services. CDCSP applicants are encouraged to inquire about the guidelines for this program.

526.4 APPLICATION PROCESS

1. Parent applies at Social Security Administration (SSA) for Supplemental Security Income (SSI).
    i. If the child is eligible for SSI, he or she receives a Medicaid Card.
    ii. If the child is ineligible for SSI due to parents' income or assets exceeding the Social Security Administration guidelines, then the application process for CDCSP should be initiated.
2. A member (family) may obtain an application for CDCSP and information packet from: the Bureau for Medical Services, the local Behavioral Health Centers, or the local/county DHHR Offices. An application and information packet is also available at www.wvdhhr.org/bms/manuals/bms_manuals_main.htm.
3. The Application packet must be **fully** completed. The family may select a Service Coordination Agency to support the applicant and/or legal representative to ensure processing without delay or may complete the application packet on their own.
4. The Service Coordinator/Case Manager or Parent/Guardian takes the child and the Annual Medical Evaluation [DD2A/CDCSP (for ICF/MR Level of Care)] or the Medical Evaluation [DD-2B/CDCSP (for acute hospital/nursing home level of care)] form to a physician.
    i. Physician completes assessment documenting on the DD2A or DD2B form. The assessment must indicate that child requires **one** of the institutional levels of care to allow for review to determine medical eligibility to be established and returns it to the Service Coordinator/Case Manager or Parent. **Only one** institutional level of care is to be selected.
    ii. Other pertinent information may also be obtained and submitted for review.
5. The Service Coordinator/Case Manager or Parent completes or may provide the following:
    - DD-6/CDCSP, "Cost Estimate Sheet"
    - DD-4/CDCSP, "Social History"
    - Obtains the Individualized Education Plan (IEP) for school-age children
    - Obtains the West Virginia Birth to Three, Individual Family Service Plan (IFSP), for children three and below
    - Obtains the DD-2A/CDCSP or DD-2B/CDCSP, "Medical Evaluation"
    - DD-3/CDCSP, "Psychological Evaluation" (for ICF/MR Level of Care only)
    - Other documentation if required and/or pertinent to apply for the institutional level of care the individual is seeking

- The packet of information is to be submitted directly to the contracted agency (vendor), dated and logged. Applications will be reviewed in the order received.

Applications should be addressed to Attention: CDCSP, Psychological Consultation and Assessment (contractual agency), 202 Glass Drive, Cross Lanes, West Virginia 25313.

6. The Bureau for Medical Services (BMS) or its agent reviews the documentation to determine medical eligibility. Additional information may be requested to support application.
   - If the documentation does not support medical or cost eligibility, BMS informs the Service Coordinator/Case Manager, or parent and the local DHHR office. The parent/applicant is notified of the appeals process.
   - If the documentation substantiates medical eligibility, the local DHHR office, Service Coordinator/Case Manager or parent, is informed.

8. The parent applies at the local Department of Health and Human Resources (DHHR) office to determine financial eligibility after medical eligibility has been determined.
   - If child is financially ineligible - Child has income and/or resources in excess of limits. Parents are informed of ineligibility and appeals decisions.
   - If child is financially eligible – the Medicaid card will be provided.
9. Medical and financial eligibility must be re-established annually, following the same guidelines.

526.5 MEDICAL ELIGIBILITY FOR ACUTE CARE HOSPITAL LEVEL OF CARE

Hospital level of care is appropriate for children who require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent, continuous, or prolonged hospitalizations. This level of care is highly skilled, provided by professionals, and is not normally available in a skilled nursing facility, but available only in an inpatient hospital setting. This level of care is appropriate when a child requires throughout the day an extensive array of services furnished either directly by, or under the direct supervision of, a physician. This daily skilled medical treatment is more complex than nursing facility level of care due to an unstable medical condition.

526.5.1 Medical Necessity for Acute Care Hospital Level of Care

The child meets hospital level of care when:

1. Skilled assessment and intervention multiple times during a 24 hour period, on a daily basis, is required to maintain stability and prevent deterioration including:
   - Medical monitoring, assessment, and intensive medication administration for the medical condition;
   - Monitoring changes in the child's condition that require prompt interventions to avert complications;

- Provision of physician-supervised, hands-on, comprehensive medical interventions and treatments;
- Modifications of treatment plans throughout the day based on the child's condition;
- The child requires comprehensive medical treatments and skilled services on a daily basis; AND

2. As a practical matter, the daily comprehensive medical services can be provided only on an
   inpatient basis in a hospital setting; AND
3. The child requires acute care services that must be performed by, or under the supervision of, professional or technical personnel and directed by a physician and directed by a treatment plan; AND
4. The treatment of the child's illness substantially interferes with the ability to engage in everyday age appropriate activities of daily living at home and in the community, including but not limited to bathing, dressing, toileting, feeding, and walking/mobility; AND
5. The child's daily routine is substantially altered by the need to complete these specialized, complex and time consuming treatments and medical interventions or self-care activities; AND
6. The child requires specialized professional training and monitoring beyond those ordinarily expected of parents; AND
7. The child's condition meets criteria for an inpatient level of care. Hospital level of care must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of an individual's illness or injury and must be consistent with the nature and severity of the child's illness or injury, his/her particular medical needs and accepted standards of medical practice.

526.5.2 Documentation Evidence Required for Acute Care Hospital Level of Care

- DD1/ CDCSP Cover Sheet
- DD2B/CDCSP Medical Evaluation
- DD4/ CDCSP Social History
- DD6/CDCSP Cost Estimate
- Evidence of Physician directed medical care
- History of recurrent emergency room visits for acute episodes over the last year **AND** history of recurrent hospitalizations over the last year
- Ongoing visits with specialists in an effort to prevent an acute episode
- Medical condition is not stabilized, requiring frequent interventions
- Substantial impairment of daily living activities within the child's developmental level for age due to recurrent acute illnesses requiring hospitalization
- Documentation of frequent need to stabilize in an inpatient setting using medication, surgery, and/or other procedures.

526.5.3 Factors Not Considered Medically Necessary for Acute Hospital Level of Care

A hospital setting is not considered medically necessary when ANY ONE of the following is present:

- Services do not meet the medically necessary criteria above; OR

- The child's condition has changed such that hospital care is no longer needed; OR
- Medical monitoring, assessment, frequent medical intervention, comprehensive medical treatment and intensive medication regimen is no longer required and there is no improvement in the level of functioning within a reasonable period of time; OR
- Services that are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition that is resolved or stable; OR
- The child or his/her family refuses to participate in the recommended treatment plan; OR
- The care has become custodial; OR
- The services are provided by a family member or another non-medical person; OR
- When a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse; OR
- The service cannot be regarded as an acute hospital service.

526.6 MEDICAL ELIGIBILITY FOR ICF/MR LEVEL OF CARE

In order to be eligible to receive ICF/MR Level of Care, an applicant must meet the following medical eligibility criteria:

526.6.1 Diagnostic

- Have a diagnosis of mental retardation and/or a related condition.
- Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.
    - Level of care (medical eligibility) is based on the Annual Medical Evaluation (DD-2A/CDCSP), the Psychological Evaluation (DD-3/CDCSP) and verification if not indicated in the DD-2B/CDCSPand DD-3/CDCSP, that documents that the mental retardation and/or related conditions with associated concurrent adaptive deficits, are severe, and are likely to continue indefinitely. Other documents, if applicable and available, that can be utilized include the Social History, IEP for school age children and Birth to Three assessments.

The evaluations must demonstrate that an applicant has a diagnosis of mental retardation and/or a related developmental condition, which constitutes a severe and chronic disability. For this program individuals must meet the diagnostic criteria for medical eligibility not only by relevant test scores, but also be supported by the narrative descriptions contained in the documentation.

- Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
- Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits. Examples of related conditions which, if severe and chronic in nature, may make an individual eligible for the CDCSP (ICF/MR Level of Care) include, but are not limited to, the following:

- Autism
- Traumatic brain injury
- Cerebral Palsy
- Spina Bifida
- Tuberous Sclerosis

- Any condition, other than mental illness, found to be closely related to mental retardation that results in an impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation. Additionally, mental retardation and/or related conditions with associated concurrent adaptive deficits that are likely to continue indefinitely.

- Must result in the presence of a least three (3) substantial deficits as that term is defined in Title 42, Chapter IV, Part 435.1010 of the Code of Federal Regulations (CFR). Substantial deficits associated with a diagnosis other than mental retardation or a related condition do not meet eligibility criteria. Additionally, any individual needing only personal care services does not meet the eligibility criteria for ICF/MR level of care

526.6.2 Functionality

Substantially limited functioning in three (3) or more of the following major life areas; ("substantially limited" is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than (1) one percentile when derived from non MR normative populations (when mental retardation has not been diagnosed) or in the average range or equal to or below the seventy-fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported by not only the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, narrative descriptions, etc.)

- **Self-care** refers to such basic activities such as age appropriate grooming, dressing, toileting, feeding, bathing, and simple meal preparation.
- **Receptive or expressive language** (communication) refers to the age appropriate ability to communicate by any means whether verbal, nonverbal/gestures, or with assistive devices.
- **Functional Learning** (age appropriate functional academics)
- **Mobility (motor skills)** refers to the age appropriate ability to move one's person from one place to another with or without mechanical aids.
- **Self-direction** refers to the age appropriate ability to make choices and initiate activities, the ability to choose an active lifestyle or remain passive, and the ability to engage in or demonstrate an interest in preferred activities.
- **Capacity for independent living** encompasses sub-components that are age appropriate for home living, socialization, leisure skills, community use and health and safety.

526.6.3 Active Treatment

The applicant would benefit from continuous active treatment typically provided by a facility whose primary purpose is to furnish health and habilitation services to persons with mental retardation or related conditions.

526.6.4 Child Determined Medically Eligible for Title XIX Home and Community Based Waiver

If the child has been determined medically eligible for the Title MR/DD XIX Home and Community Based Waiver program and is on the wait list, the medical eligibility will be accepted for the CDCSP. An updated CDCSP Cover Sheet (DD-1/CDCSP), an updated social history (DD- 4/CDCSP) that is signed and dated, and the Cost Estimate (DD-6/CDCSP) will need to be submitted for review.

526.7 MEDICAL ELIGIBILITY FOR NURSING FACILTY LEVEL OF CARE

Nursing facility level of care is appropriate for children who do not require acute hospital care, but who, on a regular basis, require skilled nursing services, complex rehabilitation services, and other health-related services ordinarily provided in an institution.

Skilled nursing services are provided to children living at home who have significant medical needs and require complex nursing treatments, personal care, specialized therapy, and medical equipment to enhance or sustain their lives. The child's daily routine is substantially altered by the need to complete specialized, complex, and time consuming treatments.

A nursing facility level of care is appropriate when the child requires complex skilled nursing care or comprehensive rehabilitative interventions throughout the day including **ALL** of the following:

1. The child requires skilled nursing or skilled rehabilitation services that must be performed by, or under the supervision of professional or technical personnel; AND
2. The child requires specialized professional training and monitoring beyond the capability of, and those ordinarily expected of parents; AND
3. The child requires skilled observation and assessment several times daily due to significant health needs; AND
4. The child requires these skilled services on a daily basis; AND
5. A skilled nursing facility setting must be furnished pursuant to a physician's order and be reasonable and necessary for the treatment of a child's illness or injury (i.e.,, be consistent with the nature and severity of the individual's injury or illness, his particular medical needs and accepted standards of medical practice); AND
6. The child has unstable health, functional limitations, complicating conditions, or is medically fragile such that there is a need for active care management; AND
7. The child's impairment substantially interferes with the ability to engage in everyday activities of daily living at home and in the community, including but not limited to bathing, dressing, toileting, feeding, and walking/mobility; AND
8. The child's daily routine is substantially altered by the need to complete these specialized, complex and time consuming treatments and medical interventions or self-care activities; AND

9. The child needs complex care management and/or hands on care that substantially exceeds age appropriate assistance; AND
10. The child needs complex restorative, rehabilitative and other special treatment of a chronic nature that can be provided only in a skilled nursing facility. In other words, institutionalization in a nursing facility would be necessary in the absence of these services provided in the community setting; AND
11. In addition to the general requirements above, the child's condition must require one or more of the following defined settings below on a daily basis:

    - Observation, assessment and monitoring of a complicated or unstable condition; OR
    - Complex teaching services to the child and/or family requiring 24-hour skilled nursing facility (SNF) setting vs. intermittent home health setting; OR
    - Complex medication regimen other than oral medication or medication otherwise deemed self administered, such as insulin or growth hormone; OR
    - *Initiation* of tube feedings; OR
    - Active weaning of ventilator dependent children requiring changing and monitoring of ventilator setting; OR
    - Wound care (including decubitus ulcers) requiring more than just superficial dressing changes, i.e. packing, debridement, etc.

526.7.1 Documentation - Evidence Required for Nursing Level of Care

Documentation required:

- DD1/ CDCSP Cover Sheet
- DD2B/CDCSP Medical Evaluation
- DD4/CDCSP Social History
- DD6/CSCSP Cost Estimate
- Evidence that Complex rehabilitative services (therapies), wound care, and other intense skilled nursing care of a chronic nature is medically necessary
- The medical condition is stabilized
- Substantial impairment of daily living activities which are not within the child's developmental level for age
- Care is ordered and delegated by the physician to an RN or LPN and/or RN or LPN oversight according to a plan of treatment with short and long term goals
- Medical care can be managed in setting that is less than a acute care setting
- Skilled nursing care is medically necessary.

526.7.2 Factors Not Considered Medically Necessary for Nursing Facility Level of Care

A skilled nursing facility setting is considered not medically necessary when ANY ONE of the following is present:

- Services do not meet the medically necessary criteria above; OR
- The child's condition has changed such that skilled medical or rehabilitative care is no longer needed; OR
- Physical medicine therapy or rehabilitation services that will not result in improvement in the level of functioning within a reasonable period of time; OR

- Services that are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition that is resolved or stable; OR
- The child and or family refuses to participate in the recommended treatment plan; OR
- The care has become custodial; OR
- The services are provided by a family member or another non-medical person. When a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled service.

526.7.2.1 Examples of Services Not Medically Necessary for Nursing Facility Level of Care

- Routine or maintenance medication administration, including oral medication and other agents deemed by CMS to be 'self-administered drugs'
- Routine enteral feedings
- Medically stable ventilator care that can be safely provided in an alternative setting
- Monitoring of home oxygen therapy
- Routine tracheostomy care
- Routine gastrostomy, jejunostomy or ileostomy care
- CPAP or BiPAP administration or monitoring
- Inhalation care. **The need for respiratory therapy, either by a nurse or by a respiratory therapist, DOES not alone qualify a child for skilled nursing facility care.**
- Personal care services such as bathing.

526.8 CASE MANAGEMENT/SERVICE COORDINATOR FOR THOSE APPLYING FOR ICF/MR LEVEL OF CARE--RECERTIFICATION

The Case Management/Service Coordinator Agency, if utilized, must:

- o Accept referrals of children who are included in the disability group(s) which the agency serves;
- o Ensure that the parents or legal representative establish or re-establish their child's financial eligibility at the county DHHR office on an annual basis and report any changes in the child's finances to the county DHHR office;
- o Ensure that the child has completed all assessments necessary for initial certification and annually thereafter for recertification; Coordinate and obtain appropriate assessments and evaluations (this should include a discharge plan if the child has been recently discharged from a medical facility) to be used in development of the Individual Program Plan (IPP).
- o Convene an Interdisciplinary Team (IDT), consisting of the child, family or legal representative, service providers, advocate, professionals, paraprofessionals and other stakeholders needed to ensure the delivery of the necessary level of services and care, to develop an annual comprehensive IPP in accordance with Medicaid and Office of Health Facility Licensure and Certification (OHFLAC) policies;
- o Complete the Cost Estimate Worksheet (DD-6/CDCSP) on an annual basis;

- Monitor the implementation of the IPP to assure the quality of services and to ensure that the services are delivered in accordance with the relevant State Medicaid manual (e.g., Targeted Case Management, Personal Care, and Clinic Services Manuals) and policies;
- Communicate with the family via home visits, telephone calls and letters to monitor its satisfaction with and the effectiveness of services. The frequency of home visits and other contacts will be determined by the IDT;
- Monitor the service cost to ensure that the community service costs do not exceed the comparable institutional cost and notify the county DHHR office and BMS if the community service costs exceed the comparable institutional cost;
- Ensure that all providers of service and the parent are made aware of the cost effective nature of the program and that all community service providers must participate in the development of the IPP and be part of the cost estimate for services;
- Review and update the IPP as required by Medicaid and OHFLAC policies, to ensure the quality, appropriateness and cost effectiveness of the community services. Substantial changes in the IPP and DD-6/CDCSP will require submission of a new DD-6/CDCSP to BMS.
- Maintain the required documentation for Medicaid services in the child's record, and provide State level staff with necessary information to establish or maintain eligibility and meet reporting requirements.

526.9 RE-DETERMINATION OF MEDICAL ELIGIBILITY

Re-determination of medical eligibility must be completed annually for each member, pursuant to federal law. An individual must qualify for recertification at least annually. Eligibility determination must be made on current eligibility criteria, not on past CDCSP eligibility. The fact that a recipient had previously received CDCSP services shall have no bearing on continued eligibility for this program. The date of the member's medical re-eligibility is the date the annual medical evaluation (DD 2A or DD-2B/CDCSP) was signed.

526.10 SERVICES

Covered Medicaid Services that are appropriate and medically necessary for the individual.

526.11 SERVICE LIMITATIONS

Services are restricted by limits as set in the Medicaid State Plan/policies/procedures. Services do not include Waiver program services.

526.12 RIGHT TO APPEAL

If an applicant/member is determined not to be medically eligible by BMS, a Notice of Decision and a Request for Hearing form will be issued to the applicant/member. The decision/denial may be appealed directly through the fair hearing process.

526.13 MOUNTAIN HEALTH TRUST—MANAGED CARE

Recipients eligible for this program are not eligible for enrollment in a managed care organization.

526.14 MOUNTAIN HEALTH CHOICES

Recipients eligible for this program are not eligible to participate in Mountain Health Choices.

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX A

FINANCIAL LIMITATIONS

APPENDIX A

FINANCIAL LIMITATIONS:

Services in a community setting must be cost-effective when compared to the cost of facility-based care.	
FACILITY	**COST**
Hospital	$3,951 per stay
Nursing Facility	$4,934/month
ICF/MR Facility	$9,696/month

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX B

CDCSP INFORMATION SHEET

DD1

PAGE 1 OF 2

CDCSP INFORMATION SHEET

□ **Initial** □ **Annual Renewal**

□ **ICF/MR** □ **Acute Care Hospital** □ **Nursing Facility**

NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

SSN: _____

MEDICAID #: _____

PARENTS' NAMES: _____

TELEPHONE (s)#: _____

E-MAIL ADDRESS:_____

COUNTY: (CHILD RESIDES) _____

CASE MANAGER / SERVICE COORDINATOR (if applicable):

NAME: _____

AGENCY: _____

ADDRESS: _____

_____

TELEPHONE #:_____

DATE COMPLETED: _____ **COMPLETED BY:** _____

Revised September 2008

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX C

MEDICAL EVALUATION (ICF/MR LEVEL OF CARE)

DD2A

West Virginia Department of Health and Human Resources
CDCSP Level of Care Evaluation

□ **Initial** □ **Annual Renewal**
□ **ICF/MR Facility**

Service Coordination Agency: _____
Address: _____
Service Coordinator: _____
Contact Person: _____
Date: _____

I. DEMOGRAPHIC INFORMATION (MAY BE COMPLETED BY SERVICE COORDINATOR OR FAMILY MEMBER)

1. Individual's Full Name	2. Sex: ☐ F ☐ M	3. Medicaid # (Required)
4. Address (including Street/Box, City, State & Zip) _____ _____ Phone: ( )		

5. County	6. Social Security #	7. Birthday (MM/DD/YY)	8. Age	9. Phone

10. Parents' Name	11. Children with Special Needs #

12. List Current Medications

Name of Medication	**Dosage**	**Frequency**

13. Living Arrangement □ Natural Family □ Adoptive Family

14. Private Insurance □ Yes □ No
Name of Company _____

15. Significant Health history – (include recent hospitalization(s) and/or surgery(ies) with dates, history of infectious disease)

II. MEDICAL ASSESSMENT (MUST BE COMPLETED BY PHYSICIAN)

NAME: _____

DATE: _____

16. Height	Weight	BP	P	R	T
17. Allergies:					

CODE: √ **= NORMAL** **N** = **NOT DONE** (PLEASE EXPLAIN WHY) **NA = NOT APPLICABLE** **X = ABNORMAL** (PLEASE DESCRIBE**)**

SKIN		
EYES/VISION		
NOSE		
THROAT		
MOUTH		
SWALLOWING		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMETIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MANUAL VAGINAL		
VISION		
DENTAL		
HEARING		
NEUROLOGICAL		
ALERTNESS		
COHERENCE		
ATTENTION SPAN		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		

NAME _____ DATE _____

II . MEDICAL ASSESSMENT (CONTINUED)

Problems requiring Special Care (check all appropriate blanks)

MOBILITY		CONTINENCE STATUS		MEAL TIMES	
Ambulatory	_____	Continent	_____	Eats independently	_____
Ambulatory w/human help	_____	Incontinent	_____	Needs Assistance	_____
Ambul. w/mechanical help	_____	Not Toilet trained	_____	Needs to be fed	_____
Wheelchair self propelled	_____	Catheter	_____	Gastric/J tube	_____
Wheelchair w/assistance	_____	Ileostomy	_____	Special Diet	_____
Transfer w/assistance	_____	Colostomy	_____		
Immobile	_____				

PERSONAL HYGIENE/SELF CARE		MENTAL/BEHAVIORAL DIFFICULTIES		COMMUNICATION	
Independent	_____	Alert	_____	Communicates verbally	_____
Needs assistance	_____	Confused/Disoriented	_____	Communicates with sign	_____
Needs total care	_____	Irrational behavior	_____	Communicates/assistive device	_____
		Needs close supervision	_____	Communicates/hearing aid	_____
		Self-injurious behavior	_____	Communicates/gestures	_____
		EPS/Tardive Dyskinesia	_____	Limited communication	_____

CURRENT THERAPEUTIC MODALITIES

VISION THERAPY	_____	TRACTION, CASTS	_____	SOAKS, DRESSINGS	_____
SPEECH THERAPY	_____	OXYGEN THERAPY	_____	IV FLUIDS	_____
OCCUPATIONAL THERAPY	_____	SUCTIONING	_____	VENTILATOR	_____
PHYSICAL THERAPY	_____	TRACHEOSTOMY	_____	DIAGNOSTIC SERVICES	_____

ADD ADDITIONAL SHEET IF NECESSARY.

PLEASE COMPLETE ALL SECTIONS BELOW TO ENSURE CERTIFICATION FOR THE PROGRAM

DIAGNOSTIC SECTION:

AXIS I: (List all Emotional and/or Psychiatric conditions)

AXIS II: (List all Cognitive, Developmental conditions and Personality disorders)

AXIS III: (List all Medical conditions)

PROGNOSIS AND RECOMMENDATIONS FOR FURTHER CARE:

I CERTIFY THAT THIS INDIVIDUAL'S DEVELOPMENTAL DISABILITY, MEDICAL CONDITION AND/OR RELATED HEALTH NEEDS ARE AS DOCUMENTED ABOVE AND HE/SHE REQUIRES THE LEVEL OF CARE PROVIDED IN AN ICF/MR.

AS AN ALTERNATIVE, THIS CHILD CAN BE SERVED BY:
CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM _____ Yes _____ No

_____ _____ _____

DATE **PHYSICIAN'S SIGNATURE** **LICENSE #**

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for Children with Disabilities Community Services Program _____ Yes _____ No
Name of Reviewer: _____ Date:_____

DD-2A CDCSP – Revised September 2008

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX D

MEDICAL EVALUATION (ACUTE HOSPITAL/NURSING HOME LEVEL OF CARE)

DD2B

PAGE 1 OF 6

INSTRUCTIONS:

- Initial Application –must be completed by the physician within ninety (90) days of submission.
- Re-determination Application – must be completed by the physician ninety (90) days of submission.
- Physician completes assessment documenting on the DD-2B/CDCSP form. (must indicate that child requires **one** of the institutional levels of care to allow medical eligibility to be established) and returns it to the Service Coordinator/Case Manager or Parent. **Only one** institutional level of care can be selected. The capabilities of the children will be compared to other children his/her own age. Note: the recommendation that the child requires one of the institutional levels of care is only one piece of information that will be taken into consideration. The process of defining the institutional level of care takes into account all pieces of information submitted in the packet.

West Virginia Department of Health and Human Resources

MEDICAL EVALUATION

Children With Disabilities Community Services Program (CDCSP)

I. DEMOGRAPHIC INFORMATION (can be completed by Parent/Guardian or Case Manager)

1. Individual's Full Name (Last, First, Middle)	2. Sex		3. Medicaid Number	4. Medicare Number
	F	M	□ Yes (give number) □ No	□ Yes (give number) □ no
5. Address (Including Street/Box, City, State & Zip)				6. Private Insurance □ Yes (give information including policy number) □ No
7. County	8. Social Security Number	9. Birth date (M/D/YY)	10. Age	11. Phone Number(s)
12. Parent/Guardian Name:		13. Address (If different from above)		

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)_____

_____

15. Name and Address of Provider, if applicable_____

_____

16. Medicaid Waiver Wait List A. □ Yes B. □ No

17. Has the option of Medicaid Waiver been explained to the applicant? A. □ Yes B. □ No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative.

_____ / _____ / _____

SIGNATURE – Parent or Legal Guardian for Applicant Relationship Date

19. Check if Applicant has any of the following:

a. □ **Guardian**
b. □ **Committee**
c. □ **Medical Power of Attorney**
d. □ **Power of Attorney**
e. □ **Durable Power of Attorney**
f. □ **Living Will**
g. □ **Other** _____

Name and Address of the Representative_____

_____

Phone: (_____) _____ - _____

Name of Person completing the form **Telephone number of person completing form**

_____ _____

DATE: _____

NAME: _____

II. MEDICAL ASSESSMENT

DIAGNOSIS:	
Primary Diagnosis	**Secondary Diagnosis**

NORMAL VITAL SIGNS FOR THE INDIVIDUAL:					
a. Height	**b. Weight**	**c. Blood Pressure**	**d. Temperature**	**e. Pulse**	**f. Respiratory Rate**

PHYSICAL EXAMINATION:

RESULTS: √ **=**Normal **NC =** Not completed (explain) **N/A =**not applicable **X =**Abnormal (explain)

AREA	RESULTS	EXPLANATION
Eyes/Vision		
Nose		
Throat		
Mouth		
Swallowing		
Lymph Nodes		
Thyroid		
Heart		
Lungs		
Breast		
Abdomen		
Extremities		
Spine		
Genitalia		
Rectal		
Prostrate (Males)		
Bi-Manual Vaginal		
Vision		
Dental		
Hearing		
NEUROLOGICAL		
Alertness		
Coherence		
Attention Span		
Speech		
Sensation		
Coordination		
Gait		
Muscle Tone		
Reflexes		

DATE: _____

NAME: _____

AREAS REQUIRING SPECIAL CARE

RESULTS: √ = within developmental limits AD= Age Appropriate Dependent X =Problems Requiring Special Care (Explain below)

AREA	RESULTS	PLEASE PROVIDE A DESCRIPTIVE – SPECIFIC EXPLANATION
Grooming / Hygiene		
Dressing		
Bathing		
Toileting		
Eating/ Feeding		
Simple Meal Preparation		
Communication (communication) refers to the age appropriate ability to communicate by any means whether verbal, nonverbal/gestures, or with assistive devices.		
Mobility – Motor Skills refers to the age appropriate ability to move one's person from one place to another with or without mechanical aids.		–
Self Direction: refers to the age appropriate ability to make choices and initiate activities, the ability to choose an active life style or remain passive, and the ability to engage in or demonstrate an interest in preferred activities.		
Household Skills (cleaning laundry, dishes, etc)		
Health and safety		

CURRENT TREATMENT		
	EXAMPLES	PLEASE PROVIDE A DESCRIPTIVE- SPECIFIC EXPLANATION OF TREATMENT
Nutrition	Tube feeding, N/G Tube, IV use, Medications, Special diets, etc.	
Bowel	Colostomy	
Urogential	Dialysis in the home, Ostomy, Catheterization	
Cardiopulmonary	CPAP/Bi-PAP, CP Monitor, Home Vent, Tracheostomy, Inhalation Therapy, Continuous Oxygen, Suctioning	
Integument System	Sterile Dressing, Decubiti, Bedridden, Special Skin Care	
Neurological Status	Seizures, Paralysis	
Other		

MEDICATION(s) INDIVIDUAL IS CURRENTLY BEING PRESCRIBED				
Medication	**Dosage/Route**	**Frequency**	**Reason Prescribed**	**Diagnosis**

III. HOSPITAL LEVEL OF CARE ASSESSMENT **(only required for Hospital Level of Care)**

Skilled Assessment (ONLY REQUIRED FOR HOSPITAL LEVEL OF CARE) (See Section IV)		
		Specific Description and frequency of intervention
The individual requires acute care services that must be performed by, or under the supervision of professional or technical personnel and directed by a physician.	□ Yes (explain) □ No	
The individual requires specialized professional training and monitoring beyond those ordinarily expected of parents.	□ Yes (explain) □ No	
Individual has a history of recurrent emergency room visits for acute episodes over the last year AND/OR history of recurrent hospitalizations over the last year	□ Yes (explain) □ No	
Individual has had ongoing visits with specialists in an effort to prevent an acute episode	□ Yes (explain) □ No	
The Individuals' medical condition is not stabilized, requiring frequent interventions	□ Yes (explain) □ No	
Individual has had a history in the past year of a need to frequently stabilize in an inpatient setting using medication, surgery, and/or other procedures	□ Yes (explain) □ No	

IV. NURSING FACILITY LEVEL OF CARE ASSESSMENT (only required for Nursing Facility Level of Care)

Skilled Assessment (ONLY REQUIRED FOR HOSPITAL LEVEL OF CARE) (See Section IV)		
		Specific Description and frequency of intervention
The individual requires rehabilitative services (therapies), wound care, and other intense nursing care of a chronic nature that is medically necessary and must be performed by, or under the supervision of professional or technical personnel.	□ Yes (explain) □ No	
The individual requires specialized professional training and monitoring beyond the capability of, and those ordinarily expected of parents.		
The individual's medical condition is stabilized.	□ Yes (explain) □ No	
The individual's care is order and delegated by the physician to an RN or LPN and/or RN or LPN oversight according to a plan to treatment with sort and long term goals.	□ Yes (explain) □ No	
The individual's medical care can be managed in a setting that is less than an acute care setting.	□ Yes (explain) □ No	

DATE: _____
NAME: _____

IV. PHYSICIAN RECOMMENDATION (recommendation by physician necessary)

Recommendation for the following level of Care for the Children with Disabilities Community Services Program **(only one can be checked).**

- Acute Care Hospital: A child with a high need for medical services and/or nursing services who is at risk of hospitalization in an acute care hospital setting. Inpatient services are defined as services ordinarily furnished in a hospital for care and treatment of inpatients and are furnished under the direction of a physician. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in a hospital, and who, without these services, would require frequent hospitalizations. This level of care is highly skilled and provided by professionals in amounts not normally available in a skilled nursing facility but available in a hospital.
- Intermediate Care Facility for Individuals with Mental Retardation and/or Related Conditions (ICF/MR): A child with *mental retardation and/or related conditions* (e.g., cerebral palsy, autism, traumatic brain injury) and ***substantial*** deficits in self-care (age appropriate grooming, dressing, toileting, feeding, bathing, and simple meal preparation), receptive or expressive language functional learning (age appropriate functional academics), mobility (motor skills—age appropriate ability to move one's person from one place to another with or without mechanical aids, self-direction (age appropriate ability to make choices and initiate activities, the ability to choose an active life style or remain passive, and the ability to engage in or demonstrate an interest in preferred activities), and capacity for independent living (age appropriate for home living, socialization, leisure skills, community use and health and safety); and who is at risk of being placed in an ICF/MR facility An ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and habilitation services to persons with mental retardation or related conditions.
- Nursing facility (NF): A child with a high need for medical services and/or nursing services who is at risk of hospitalization or placement in nursing facility. Nursing facility services are services that are needed on a daily basis that must be provided on an inpatient basis and that ordered by and provided under the direction of a physician. Nursing level of care is appropriate for individuals who do not require acute hospital care, but, on a regular basis, require licensed nursing services, or other health-related services ordinarily provided in an institution. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

I RECOMMEND THAT THIS INDIVIDUAL'S DEVELOPMENTAL DISABILITY, MEDICAL CONDITION AND/OR RELATED HEALTH NEEDS ARE AS DOCUMENTED ABOVE AND HE/SHE REQUIRES THE LEVEL OF CARE PROVIDED IN ONE OF THE ABOVE CHECKED FACILITIES:	
_____ **Physician's Signature** **MD/DO** _____ **Physician's License Number** _____ **Date This Assessment Completed**	**TYPE OR PRINT Physician's name/address below:** _____ _____ _____ _____ _____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX E

COMPREHENSIVE PSYCHOLOGICAL EVALUATION

DD3

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INSTRUCTIONS:

- Initial Application –must be completed by the psychologist within ninety (90) days of submission.
- Re-determination Application – must be completed by the psychologist within ninety (90) days of submission.
- MR/DD Waiver Wait List – will accept verification of established medical eligibility for the MR/DD Waiver Program for ICF/MR Level of Care

West Virginia Department of Health and Human Resources

Comprehensive Psychological Evaluation

Name: _____

Evaluation Date: _____/_____/_____

Birth Date:_____/_____/_____

Agency/Facility: _____

Reason for Evaluation:

_____

_____

_____

I. Relevant History:

A. Prior Hospitalization/Institutionalization:

B. Prior Psychological Testing:

C. Behavioral History:

II. Current Status:

A. Physical/Sensory Deficits:

B. Medications (type, frequency and dosage):

C. Current Behaviors:

1. Psychomotor:
2. Self-help:
3. Language:
4. Affective:
5. Mental Status:
6. Other (social interaction, use of time, leisure activities)

III. Current Evaluation:

A. Intellectual/Cognitive
   1. Instruments used:
   2. Results:
   3. Discussion:

B. Adaptive Behavior
   1. Instruments used: ABS I & II Other (list)
   2. Results:
   3. Discussion

C. Other
   1. Instruments used:
   2. Results:
   3. Discussion

D. Indicate the individual's level of acquisition of these skills commonly associate with needs for active treatment.
   1. Able to take care of most personal care needs Yes_____No_____
   2. Able to understand simple commands Yes_____No_____
   3. Able to communicate basic needs and wants Yes_____No_____
   4. Able to be employed at a productive wage level without systematic long-term supervision or support Yes_____No_____
   5. Able to learn new skills without aggression and consistent training Yes_____No_____
   6. Able to apply skills learned in a training situation to other environments or setting without aggressive and consistent training Yes_____No_____
   7. Able to demonstrate behavior appropriate to the time, situation or place without direct supervision Yes_____No_____
   8. Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety Yes_____No_____
   9. Able to make decisions requiring informed consent without extreme difficulty Yes_____No_____
   10. Identify other skill deficits or specialized training needs which necessitates the availability of trained NR personnel, 24 hours per day, to teach the person to learn functional skills Yes_____No_____

E. Developmental Findings/Conclusions:

IV. Recommendations:

A. Training:
B. Activities:
C. Therapy/Counseling/Behavioral Intervention:

V. Diagnosis:

VI. Prognosis:

VII. Placement Recommendations:

_____
Signature of Supervised Psychologist Date

_____
Title

_____
Signature of Licensed Psychologist Date

_____
License#/Title

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX F

SOCIAL HISTORY

DD4

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The Social History is the DD-4/CDCSP. It is not necessary for a social worker to complete the social history if the family is completing the application without the assistance of the case management service coordinator. The family may complete the social history.

West Virginia Department of Health and Human Resources

Social History

Participant Name: _____ Date: _____

I. <u>Developmental History:</u> Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if developmental is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman Numeral and Letter.

a. Physical

b. Social

c. Emotional

II. <u>Family:</u> List parents, spouse, children, siblings, significant other, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socioeconomic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. Education/Training: Describe education and training experiences. Identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. Functional Status: Describe levels of functioning relevant to the activities of daily living and self-care skills. Indicate level of care recommendations.

V. Recreation/Leisure Activities: Identify and describe recreational and leisure time activities, frequencies, accessibility and degree of involvement.

VI. Hospitalizations: List all hospitalization dates and reason for admissions.

VII. Family Medical History (identify relationship to the participant):

_____	MR/DD	_____	Heart Disease	_____	Cerebral Palsy
_____	Autism	_____	Diabetes	_____	Tuberculosis
_____	Hepatitis	_____	Mental Illness	_____	Kidney Disease
_____	Cancer	_____	Hypertension	_____	Metabolic Disease
_____	Allergies	_____	Thyroid Disease	_____	Muscular Dystrophy
_____	Epilepsy	_____	Other	_____	Other

Deceased Siblings (cause of death):

_____

_____

VIII. Legal Status: (guardianship, committee, custody)

IX. Other Relevant Information: (family medical history; religious preference or significant events or circumstances not covered in other sections)

_____	_____
Date	Date
_____	_____
Signature of Temporary LSW	Signature/Co-Sign of Degree/LSW
_____	_____
License #/Degree	License #/Degree
_____	_____
Parent Signature	Date

CHAPTER 526

CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

(CDCSP)

JULY 1, 2008

APPENDIX G

COST ESTIMATE WORKSHEET INSTRUCTIONS

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All medical costs [billed charges] the child incurred in the twelve [12] months prior to application are less than the costs that would have been incurred in/out of the institution for the distinct level of care during the same period. The child's proposed costs for the forthcoming year are also compared to the costs in/out of the institution and may not exceed the 'ceiling' for the specific level of care.

Cost Estimate Worksheet Instructions

1. **COMPLETE DEMOGRAPHIC INFORMATION.**

2. **INDICATE THE SPECIFIC PERIOD OF TIME: FROM _____ TO _____.**

3. **LIST ALL SERVICES THE CHILD HAS RECEIVED IN THE TWELVE (12) MONTHS PRIOR TO SUBMISSION OF THE PACKET. ON THE FORM "HISTORY OF MEDICALTREATMENT PRIOR TO SUBMISSION OF THE PACKET". COMPLETE ALL INFORMATION REQUESTED INCLUDING BILLED CHARGES**.**

   a. **Out-patient Services Include: physician, dental, behavioral health, specialized tests, lab work, Children with Special Health Care Needs services, home health, private duty nursing, therapies, etc.**

   b. **In-hospital Services Include: all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.**

   c. **School-Based Services: provided by the school system, e.g., physical, occupational, speech, aide, transportation, monthly case management, etc.**

   d. **Birth to Three Services: provided by the Birth to Three Program**

   e. **Pharmacy Includes: medications that have been dispensed by a pharmacist***, prescribed nutritional supplements, etc.**

   f. **Durable Medical Equipment Includes: diapers, assistive technology, wheelchairs, orthotics, dressings, etc.**

4. **ON The FORM "SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE UPCOMING TWELVE (12) MONTHS" LIST ALL SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE NEXT TWELVE (12) MONTHS. SEE ABOVE CATEGORIES.**

* IF YOUR CHILD HAS PRIVATE INSURANCE IN LIEU OF THE ABOVE LISTING, PROVIDE COPIES OF THE EXPLANATION OF BENEFITS (EOBs) FROM YOUR INSURANCE COMPANY. ASSURE THAT ALL ABOVE CATEGORIES ARE INCLUDED.
** BILLED CHARGES ARE THE CHARGES THE PROVIDER CHARGES NOT WHAT YOU HAVE PAID OUT OF POCKET.
*** A PRINT-OUT FROM THE PHARMACY SHOULD INCLUDE TOTAL BILLED CHARGES.

□ **Initial** □ **Annual Review**

(check only one) □ **ICF-MR** □ **Nursing Facility Hospital** □ **Acute Care Hospital**

`HISTORY OF MEDICAL TREATMENT PRIOR TO SUBMISSION OF THE PACKET

(can be completed by Parent/Guardian, Nurse and/or Case Manager)

West Virginia Department of Health and Human Resources

BUREAU FOR MEDICAL SERVICES- CHILDREN WITH DISABILITIES COMMUNITY SERVICES PROGRAM

COST ESTIMATE WORKSHEET

Demographic Information (may be completed by Service Coordinator or family member)

Individual's Full Name:

12 Month Period from _____ to _____

PHYSICIAN AND INPATIENT VISITS DURING THE PAST YEAR

Admission and/or Date seen	**Discharge Date** (if applicable)	**Name of Medical Facility and/or Physician**	**Type of Visit** Outpatient (OP) Inpatient (I P)	**Purpose of Medical Treatment**	**BILLED CHARGES (EOB)**

SCHOOL BASED SERVICES - BIRTH TO THREE SERVICES (if applicable)		
SERVICE	FREQUENCY	BILLED CHARGES
PHARMACY		
MEDICATION	COST OF MEDICATION	
DURABLE MEDICAL EQUIPMENT / SUPPLIES		
MEDICATION	BILLED CHARGES	

SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE UPCOMING TWELVE (12) MONTHS			
TYPE OF SERVICES	**ANTICIPATED SERVICE (s)**	**ANTICIPATED FREQUENCY OF SERVICE**	**ESTIMATED COST**
Out-patient Services Include: *physician, dental, behavioral health,, specialized tests, lab work, Children with Special Health Care Needs services, home health, private duty nursing, ,therapies, etc.*			
In-hospital Services Include: *all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.*			
School-Based Services: provided by the school system, *e.g., physical, occupational, speech, aide, transportation, monthly case management, etc.*			
School-Based Services: *e.g., physical, occupational, speech, case management, etc.*			

Durable Medical Equipment Includes: *diapers, assistive technology, wheelchairs, orthotics, dressings, etc*			
Pharmacy Includes: *medications that have been dispensed by a pharmacist***, prescribed nutritional supplements, etc.*			
TOTAL ESTIMATED COST FOR THE YEAR:			

The estimated cost for the upcoming year is accurate to the best of my knowledge:

Signature: _____

NOTE: REMEMBER TO INCLUDE EXPLANATION OF BENEFITS (EOBs)

CHAPTER 527 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MOUNTAIN HEALTH CHOICES

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CHAPTER 527 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MOUNTAIN HEALTH CHOICES

CHAPTER 527 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MOUNTAIN HEALTH CHOICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

The Mountain Health Choices (MHC) program is offered by West Virginia Medicaid for certain eligibility categories. It includes a choice of benefit packages and primary care provider, encourages personal responsibility, and provides care coordination for its members through the member's medical home. MHC provides all federal and state mandated services. The goal of Mountain Health Choices is to promote health and reward Medicaid members who choose to be personally responsible for their own healthcare and choose to adopt healthier lifestyles.

The policies and procedures set forth herein are promulgated as regulations governing the Mountain Health Choices program as administered by the Bureau for Medical Services, West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act, Chapter 9 of the West Virginia Code, and the Deficit Reduction Act of 2005.

527.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to the Provider Manual, Chapter 200, Definitions. In addition, the following definitions apply and/or relate to the Mountain Health Choices Program.

Basic Benefit Package or Plan – The group of services available to Medicaid members covered by Mountain Health Choices who choose not to sign the member agreement and potentially develop a Health Improvement Plan.

Benefit Package or Plan – The group of services which make up a plan or set of benefits covered by Medicaid.

Enhanced Benefit Package or Plan – The package of services available to members enrolled in Mountain Health Choices who choose to sign the member responsibility agreement and potentially develop a Health Improvement Plan.

Traditional Benefit Package or Plan – The group of services available to Medicaid members who are not currently eligible for the Mountain Health Choices benefit package.

Health Improvement Plan – A plan developed by the member and his/her primary care/medical home provider to improve or maintain their current health.

Member Agreement – An agreement executed by the member and his/her primary care medical provider when they have met and discussed rights and responsibilities for receiving services that are available for the member or his/her child(ren).

Medical Home – A team approach to providing health care and care management, which includes the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, provision of follow-up and support for achieving the identified outcomes. The medical home maintains a centralized, comprehensive record of all health related services that promotes and provides continuity of care.

Mountain Health Choices – The name of West Virginia Medicaid's Program where members have a choice of benefit packages. This program promotes member choice, member responsibility and health improvement. This program was developed as a result of the Deficit Reduction Act 2005 and allows for the tailoring of benefit packages to meet the needs of certain populations. This program is a part of the redesign of Medicaid to promote wellness and to prevent and/or manage the progression of chronic diseases by encouraging healthier lifestyles for Medicaid members.

Mountain Health Trust – The name of West Virginia Medicaid's Managed Care Program that consists of the Physician Assured Access System (PAAS) and the Medicaid Managed Care Organizations (MCOs).

Notification of Change in Benefit – A notification mailed to each Medicaid member when their benefit package has changed from the Traditional benefit package or plan to the Mountain Health Choices Program, which offers a choice of a Basic or Enhanced benefit package or plan. This notification is provided 30 days in advance of the redetermination month, or 60 days before their redetermination date. All members will be notified no less than 13 days before their benefit package or plan changes.

Primary Care Provider – A practitioner associated with the medical home that is the primary contact for provision and coordination of a member's health care services or needs.

Redetermination Date – The date on which a current Medicaid member's eligibility is reviewed for continued eligibility.

527.2 MEDICAL NECESSITY

All services must be medically necessary and appropriate to the member's needs to be eligible for payment. The medical records of all members receiving services must contain documentation that establishes the medical necessity for the service.

Important: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service, nor does it mean that the member is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are rendered.

527.3 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive reimbursement from BMS, providers must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located.
- Have a valid signed provider enrollment application/agreement on file.
- Meet and maintain all Bureau provider enrollment requirements.

Refer to Chapter 300 for additional information related to West Virginia Medicaid Provider enrollment.

527.4 MOUNTAIN HEALTH CHOICES OVERVIEW

The Mountain Health Choices program is offered by West Virginia Medicaid for certain eligibility categories. It includes a choice of benefit package and primary care provider, encourages personal responsibility, and provides care coordination for its members through the member's medical home. This program provides all federally and state mandated services. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS). The goal of Mountain Health Choices is to promote health and reward Medicaid members who choose to be personally responsible for their own healthcare and to adopt healthier lifestyles.

527.4.1 MEMBER ELIGIBILITY

Members will be enrolled in Mountain Health Choices based upon eligibility categories, which include all Aid to Families and Dependent Children (AFDC) and AFDC-related eligibility groups, by county of residence, and by redetermination date. The first phase of Mountain Health Choices, effective March 2007, began in Clay, Upshur and Lincoln counties. Beginning in September of 2007, additional counties were phased into the program in counties with MCOs.

Refer to Appendix 1 for the AFDC/AFDC-related groups, which are the only groups eligible to be enrolled in the MHC program.

Providers can view the member's benefit plan designation on the member's Medicaid card, call the provider eligibility telephone line or utilize the Medicaid Management Information System (MMIS) vendor web portal to determine member eligibility and benefit package. Refer to Chapter 100, General Information, for additional information related to the MMIS vendor. The following will be noted on the member's card to identify the benefit plan in which the member is enrolled:

- "TR" Traditional Medicaid Benefit Package
- "BA" Basic Adult Benefit Package
- "EA" Enhanced Adult Benefit Package
- "BC" Basic Child Benefit Package
- "EC" Enhanced Child Benefit Package.

Those Medicaid members who are not eligible for Mountain Health Choices include those in the following categories:

- MR/DD Waiver (Mental Retardation and Developmental Disabilities)
- Aged and Disabled Waiver
- Pregnant Women
- SSI/Deemed SSI
- Long-term care placement
- Foster Care
- CDCSP (Children with Disabilities Community Services Program)
- Spend Down
- Medicare Primary.

527.4.2 PROMOTING MEMBER CHOICE AND RESPONSIBILITY

Existing Medicaid members eligible for Mountain Health Choices will be notified by mail of their change in benefits 30 days before the month of their re-determination, or 60 days before their eligibility is re-determined. They will transition to MHC on the first day of the month of scheduled re-determination. The Mountain Health Choice program offers a choice of two benefit packages, Enhanced and Basic, both for adults and children. Members should make an appointment with their Medical Home for a preventive office visit within 90 days of their re-determination date or upon the notification of change in benefit, for development of a health improvement plan and to discuss the Member Agreement with their primary care provider. Adults are required to select a benefit plan for their Medicaid eligible child(ren). If a benefit plan is not selected, the member will remain in the Basic Plan.

An explanation of the member agreement (Appendix 2), options and benefits of the Basic and Enhanced Plans will be provided by the Medical Home personnel. The Medicaid member will have the opportunity to choose their plan. By electing to sign the Member Agreement, the member becomes qualified for the Enhanced Plan. If the member chooses not to sign the member agreement, they will remain in the Basic Benefit Plan for the following year. During the preventive visit, it is anticipated that the provider will develop a Health Improvement Plan (Appendix 3) with the member. The Plan will guide the member as to what they will need to do as it relates to their healthcare for the next year to improve health or for early detection or prevention of problems. These goals are agreed upon by both the member and the primary care provider.

During the transition from the traditional program, current Medicaid members have 5 months to determine which benefit plan is best for them before being locked-in. Newly eligible Medicaid members will be placed in the Basic Plan upon approved Medicaid eligibility and will have 3 months to make the determination before being locked-in. Members who choose to remain in the Basic Plan will be able to enroll in the Enhanced Plan after one year and at the time of their eligibility redetermination.

Traditional Medicaid coverage is no longer available or an option for the AFDC/AFDC related eligibility groups upon enrollment in MHC or Medicaid eligibility.

527.5 PROMOTION OF PREVENTIVE CARE FOR MEMBERS

Mountain Health Choices is designed to promote preventive health practices by providing members access to services that will assist in developing healthier lifestyles and prevent the occurrence or progression of chronic disease. Through the health improvement plan that is developed between the member and their provider, preventive care becomes the guide for services the member should obtain within the next year.

West Virginia Medicaid covers well child, preventive medicine examinations for children up to 20 years of age based on the recommended frequency established by the American Pediatric Association and adopted by the West Virginia Medicaid Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT). For adult members, West Virginia Medicaid covers annual physical examinations and other preventive and diagnostic services. The annual examination must be reported with a preventive medicine code reflective of the member's age. The annual physical examination is separate and distinct from treatment or diagnosis for a specific illness, symptom, complaint, or injury. Clinical laboratory services, radiology procedures, and other diagnostic services must be reported and billed separately.

West Virginia Medicaid does not cover the following types of physical examinations:

- Sport physicals
- Camp physicals
- Physicals required by third parties, such as insurance companies, government agencies, and businesses as a condition of employment
- Daycare physicals.

Eligibility examinations requested by the county DHHR office are not annual physicals. See Chapter 519, Practitioner Services, for related coverage information for eligibility exams.

527.6 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. (West Virginia Medicaid EPSDT coverage is through the month in which the member turns 21 years of age.) These services target early detection of disease and illness and provide referral of members for necessary diagnostic and treatment services.

The health improvement plan for all children should include all aspects of an EPSDT exam. Per the American Academy of Pediatrics' guidelines, these include the physical exam, developmental screening, vision screening, hearing screening, and a dental screening. If these services cannot be provided by the child's primary care provider, a referral to an appropriate provider is necessary for the member to meet the requirements of the health improvement plan.

If the Medicaid member is a member of the Physician Assured Access System (PAAS) Program, a referral from the primary care physician (PCP) must be obtained prior to performing an EPSDT exam if the provider administering the exam is not the member's PAAS PCP; no reimbursement will be provided if there is no

referral from the PCP. If the Medicaid member is a member of a MCO, the MCO is responsible for reimbursement for the services when the MCO's requirements have been met.

For children enrolled in the Basic Benefit Plan and **require** a service beyond the benefit package limitations, the provider must document the medical necessity for the service during the EPSDT exam. Any specialist providing services should coordinate service needs with the primary care provider. Providers must make reasonable efforts to identify if members under 21 years of age are visiting their office as a result of an EPSDT exam by their PCP by asking the referring provider, clinic, or member. To obtain service reimbursement for services that have been identified as a result of the EPSDT exam that are not covered in the benefit package, or for service limitations that have been previously met, the PCP must provide the medical documentation for the service requested and fax those requirements to the attention of BMS' EPSDT Program at 304-558-1509. This process only applies to those enrolled in the Basic Benefit Plan who are not enrolled in an MCO. For those enrolled in an MCO, the respective member's MCO must be contacted.

527.7 OTHER PREVENTIVE CARE SERVICES

Other preventive care services are covered by West Virginia Medicaid regardless of the member's benefit package. Although the following preventive care services covered by Medicaid may be utilized in a health improvement plan developed between the member and the medical home, it is not an all-inclusive list of preventive services covered by Medicaid. Other preventive care services required by the member may be recommended by the medical home to improve the health of the member.

Refer to Chapter 519, Practitioner Services, for coverage, prior authorization requirements, and additional information.

527.7.1 CANCER SCREENING

West Virginia Medicaid covers various types of cancer screening that include, but aren't limited to:

A. COLORECTAL CANCER SCREENING

West Virginia Medicaid covers colorectal cancer screening tests for high risk members and for members aged 50 and over.

Refer to Chapter 519, Practitioner Services, for coverage, prior authorization requirements, and additional information.

B. PROSTATE CANCER SCREENING

West Virginia Medicaid covers yearly digital rectal examination of the prostate for cancer screening, but makes no separate payment for this exam, as it is included as part of the E&M service. PSA (prostate specific antigen testing) is covered for susceptible populations.

C. BREAST AND CERVICAL CANCER SCREENING

The West Virginia Medicaid program covers yearly Pap smears for cervical cancer screening in susceptible populations. A separate reimbursement for obtaining the Pap smear is not allowed, as this is considered part of the E&M service and examination. Billing for a Pap smear with a laboratory (80000) code is only paid to the pathology facility actually reading the smear. In addition, a separate specimen handling charge is not covered.

The Breast and Cervical Cancer Screening Program (BCCSP), administered by the West Virginia Department for Health and Human Resources' Bureau for Public Health, provides statewide screening services free of charge or at a minimal fee to low income and uninsured or underinsured women. Women at or below 200 percent of the Federal Poverty Level qualify for services. The BCCSP offers screening mammography and diagnostic services for breast abnormalities to women age 50 and older. Diagnostic services for breast abnormalities are available for women under the age of 50. Cervical cancer screening services are available for women 25 and older. Cervical cancer screening services are also available for women under age 25 with Pap test results of High Grade Squamous Intraepithelial Lesion (HGSIL).

Diagnostic and screening mammography services are a covered service if medically necessary. A screening mammography is limited to one per year.

All facilities providing these services are required to have FDA certification under the Mammography Quality Standards Act (MQSA) of 1992. The Food and Drug Administration has the responsibility for implementing and enforcing MQSA, which requires that all mammography facilities in the United States meet certain stringent quality standards, be accredited by an FDA-approved accreditation body, and be inspected annually.

527.8 BONE DENSITY TESTING

West Virginia Medicaid covers bone density scans in order to prevent the morbidity associated with osteoporosis and osteoporotic fracture. The bone density test is not to be routinely performed for dialysis members. Routine screening of individuals without symptoms or risk factors is not covered. Symptoms or disorders associated with the loss of bone density is the criterion. The following applies:

- The bone density test is limited to one every two years. More frequent requests will require prior authorization with documentation of the medical necessity.
- Only axial testing is allowed for monitoring osteoporosis therapy. Photo-densitometry of a peripheral bone and ultrasound bone densitometry are not allowed as part of this monitoring.

Only one scan can be billed regardless of how many sites are tested during the session. For those providers who are also the treating physician, a separate written interpretation of the scan must be included in the member's chart as the codes include interpretation and report.

Refer to Chapter 519, Practitioner Services Manual, for more information regarding bone density testing.

527.9 PROVIDER BILLING FOR THE HEALTH IMPROVEMENT PLAN

In addition to the office visit, providers may also bill for developing a health improvement plan, which includes an initial discussion with the member regarding the member agreement and the member's health improvement goals. The information provided and the goals developed on the health improvement plan will guide the member and provider on health improvement activities for the next year. This reimbursement includes the time spent with the member and submission of the required forms. It is not dependent upon the member's decision to participate in the program. For Physicians and Nurse Practitioners billing on a CMS 1500, reimbursement is made through the use of CPT 99420 (Health Risk Assessment Test). This service may be reimbursed in addition to other medical services provided on the same date of service. Reimbursement for these services is limited to once every 7 months per member based on the last date of service billed for the Health Improvement Plan. This timeframe also allows the member to see their primary care provider and make a choice between benefit packages at the time of their next redetermination date or renewal.

For RHC/FQHC's billing on a UB04, reimbursement is made through the use of CPT 99420 (Health Risk Assessment Test) billed with Revenue Code 52X. This should only be billed when a preventive visit is also billed utilizing the standard encounter (T1015) and the correlating Evaluation & Management (E&M) code. The member should always have a preventive service encounter, and never should the 99420 be billed as the sole service.

If the Medicaid member is enrolled with an MCO, the MCO is responsible for reimbursing for CPT 99420.

527.10 BASIC/ENHANCED BENEFIT PACKAGE BENEFITS AND SERVICE LIMITATIONS

An overview of benefits related to the Basic and Enhanced packages can be found in Appendix 4. All Medicaid policy and procedure manuals apply unless specifically addressed in this manual or in the particular manual related to the benefit.

The member is provided the option of choosing between the Basic and Enhanced Benefit Plan.

Basic Benefit Package

If the member chooses not to see their primary care provider, sign the member agreement, and potentially initiate a health improvement plan, they will remain in the Basic Plan. The member will be automatically placed in the Basic Benefit Package because there are no other requirements necessitated for this level of service.

The group of services provided by the Basic Plan provides a comprehensive set of medical and behavioral health services.

Enhanced Benefit Package

Eligibility for the Enhanced Benefit Package is based upon the member's willingness to schedule an appointment with his/her primary care physician, sign the member agreement, discuss their health care needs, and mutually develop a health improvement plan.

Members who sign the member agreement after visiting their primary care provider to receive a preventive exam will receive the Enhanced Benefit Package regardless of whether they initiate a Health Improvement Plan with their provider. The Enhanced Benefit Package will allow them access to services that may or may not have been traditionally available through the Medicaid Program. The enhanced services provided in this benefit package will support the member's effort to improve his/her health status.

527.11 SERVICE COVERAGE REGARDLESS OF BENEFIT PLAN

The following service categories are covered regardless of benefit package unless coverage limitations are identified by benefit package.

527.11.1 INPATIENT HOSPITAL SERVICES

Inpatient acute care services are covered services for all benefit plans. See Chapter 510, Hospital Services Manual, for coverage, prior authorization requirements, and additional information.

527.11.2 INPATIENT REHABILITATION SERVICES

Services covered in this setting relate to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals under the age of 21.

The services provided by these facilities are not covered for adults in the Basic, Enhanced, or Traditional benefit packages. Inpatient rehabilitation services are only covered for adults during an acute care hospital stay and reimbursed as part of the diagnostic related group (DRG) reimbursement.

See Chapter 510, Hospital Services, for coverage, prior authorization requirements, and additional information.

527.11.3 INPATIENT PSYCHIATRIC HOSPITAL SERVICES

527.11.3.1 Adult Benefit Packages

A. Basic Benefit Package Service Limitations

For those adults enrolled in the Basic Benefit package, there is no coverage for inpatient psychiatric services in the distinct part psychiatric units of an acute care hospital. However, inpatient psychiatric services are covered in acute care general hospitals when such individuals are admitted following review and admission certification by BMS' utilization management contractor. The services rendered in the acute care, general hospital setting are subject to DRG reimbursement under the acute care hospital provider number.

B. Enhanced Benefit Package Service Limitations

For those adults enrolled in the Enhanced Benefit package, coverage is limited to 30 days per year in the distinct part psychiatric unit of an acute care hospital. These services are subject to medical necessity review and admission certification by the utilization management contractor.

Once the 30-day per rolling year limit is reached, inpatient services are covered in acute care general hospitals when such individuals are admitted following medical necessity review and admission certification by BMS' utilization management contractor. The services rendered in the acute care general hospital setting is subject to DRG reimbursement.

Members who are admitted to distinct part psychiatric units must have an admission diagnosis of a mental illness. If however, during the course of the stay, treatment changes from psychiatric care to physical care, the hospital shall bill the appropriate acute care service. Admissions to distinct part psychiatric units are subject to audit and cost settlement.

C. Traditional Benefit Service Limitations

Medicaid program coverage for inpatient psychiatric services rendered to adults is limited to Medicaid eligible individuals in a distinct part psychiatric unit or an acute care general hospital when such individuals are admitted following review and admission certification by BMS's utilization management contractor

See Chapter 510, Hospital Services, for coverage, prior authorization requirements, and additional information.

527.11.3.2 Children's Benefit Package (under the age of 21)

See Chapter 510, Hospital Services, for coverage, prior authorization requirements, and additional information. The same requirements apply for Mountain Health Choices' members.

A. Inpatient Psychiatric Facility

Services rendered in an inpatient psychiatric facility include inpatient acute care psychiatric services for individuals under 21 years of age. Professional services rendered to members who would be admitted to a "psych under 21 facility" must be billed separately by the practitioner. Those charges are not included in the facility's reimbursement. Such facilities may also render all of the outpatient services for which they meet applicable federal and state regulatory requirements. Outpatient services are reimbursed on a procedure specific fee for service utilizing appropriate HCPCS and CPT codes just as for outpatient services rendered in any other approved settings and may be limited based on benefit package. Services rendered in the outpatient setting may also include partial hospitalization services in Medicaid approved Partial Hospitalization Programs, as further defined in Chapter 510, Hospital Services Manual.

Psychiatric services rendered to Medicaid members enrolled in an MCO are not the responsibility of the MCO and must be billed to Medicaid. If the Medicaid member is enrolled in the PAAS Program, PAAS PCP referrals are not required.

B. Inpatient Psychiatric Residential Treatment Facility

Services rendered in an inpatient psychiatric residential treatment facility (PRTF) are available only to Medicaid eligible individuals under age 21. PRTFs may only render inpatient services, which are inclusive of any medical, pharmaceutical or psychiatric professional services rendered in the facility. PRTFs are not authorized to render outpatient hospital services.

Because it is considered long-term care, residents of a Psychiatric Residential Treatment Facility are excluded from coverage in Mountain Health Trust or Mountain Health Choices. Any PRTF resident will be disenrolled from either or both of these programs at the time they become a resident of the PRTF. A PRTF resident will be placed in the Traditional Medicaid Benefit Plan at the first of the following month after their placement if it occurs before approximately the 20th of the month, but no later than the first of the second month following their placement. Services will be covered upon placement. At such time that the resident is discharged from the PRTF, he/she will again become eligible for enrollment in Mountain Health Trust and/or Mountain Health Choices if his/her eligibility category is appropriate.

Services rendered to Medicaid members enrolled in an MCO are not the responsibility of the MCO and must be billed to Medicaid. If the Medicaid member is enrolled in the PAAS Program, PAAS PCP referrals are not required.

The following limitations apply by benefit package:

1. Basic Benefit Package Service Limitations

Services provided for children in an inpatient psychiatric facility are limited to 30 days. Once the child is admitted, the facility must appropriately provide discharge planning on the first day of the inpatient stay. Under no circumstances should the 30 day limit be reached and then appropriate placement attempted. If the child is placed in a PRTF (long term care), the child is no longer eligible for Mountain Health Choices; the child will be exempted and placed in the Traditional Benefit Package.

2. Enhanced Benefit Package Service Limitations

Services provided for children in an inpatient psychiatric facility have no maximum service limits. However, once the child is admitted, the facility must appropriately provide discharge planning on the first day of the inpatient stay. Continued stay must be authorized. If the child is placed in a PRTF (long term care), the child is no longer eligible for Mountain Health Choices, and the child will be exempted and placed in the Traditional Benefit Package.

3. Traditional Benefit Package Service Limitations

See Chapter 510, Hospital Services, for coverage, prior authorization requirements, and additional information.

527.12 OUTPATIENT SURGERIES AND SERVICES

Medical services provided in outpatient settings are covered for all benefit plans. Prior authorization is required for certain services.

Refer to Chapter 519, Practitioner Services, for coverage, prior authorization requirements, and additional information.

527.12.1 DIAGNOSTIC RADIOLOGY

Diagnostic radiology services are covered for all benefit plans. Prior authorization is required for certain services.

Refer to Chapter 512, Laboratory and Radiology Services, for coverage, prior authorization requirements, and additional information.

527.12.2 PRIMARY CARE OFFICE VISITS

Primary provider office visits are covered for all benefit plans.

Refer to Chapter 519, Practitioner Services, for coverage, prior authorization requirements, and additional information.

527.12.3 SPECIALTY CARE SERVICES

A. Physicians

Office visits with physicians who are specialists are covered for all benefit plans.

Physicians who are not psychiatrists cannot be reimbursed for psychiatric service codes; reimbursement for psychiatric codes are restricted to mental health providers.

Refer to Chapter 519, Practitioner Services, for coverage, prior authorization requirements, and additional information.

B. Behavioral Health Providers

Behavioral health provider office visits are covered under specialty services when provided by private psychiatrists, psychologists, psychiatric nurse practitioners, or licensed behavioral health centers.

1. Psychologists

Regardless of benefit package, psychological services are covered. Refer to Chapter 521, Psychological Services Manual, for coverage, prior authorization requirements, and additional information.

2. Psychiatrists

Regardless of benefit package, psychiatric services are covered. Refer to Chapter 519, Practitioner Services, for coverage, prior authorization requirements, and additional information. Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Licensed Social Worker, or Master's Level Licensed Professional Counselor in the psychiatrist's or licensed behavioral health center's employ must also be registered and assigned an authorization number by the

contracted agent.

3. Psychiatric Nurse Practitioners

Regardless of benefit package, psychiatric services provided by a psychiatric nurse practitioner are covered. The following codes may be billed by those psychiatric nurse practitioners enrolled with the Medicaid program.

Certified Psychiatric Advanced Nurse Practitioner Service Codes

CPT Code	Description Certification in Psychiatric Medicine is Required
90801	Psychiatric diagnostic examination
90804	Individual psychotherapy, insight oriented 20 – 30 min
90805	with medical evaluation and management
90806	Individual psychotherapy, insight oriented 45 – 50 min
90807	with medical evaluation and management
90847	Family psychotherapy with member present
90853	Group psychotherapy
90862	Pharmacologic management, including Rx

Refer to Chapter 519, Practitioner Services, for provider enrollment, coverage, prior authorization requirements, and additional information.

4. Licensed Behavioral Health Centers

The Licensed Behavioral Health Centers (LBHC) must follow the requirements outlined in this manual for psychological services rendered to Medicaid members enrolled in the Basic Benefit package. Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient behavioral health services must be provided by a psychiatrist, a psychologist, a Master's Level Licensed Social Worker, a Psychiatric Nurse Practitioner, or a Master's Level Licensed Professional Counselor in the employ of the Licensed Behavioral Health Center.

Services rendered by a Master's Level Licensed Social Worker or a Master's Level Licensed Professional Counselor under the direction of the psychiatrist must also be registered and assigned an authorization number by the contracted agent billed by the psychiatrist or psychologist and paid to the LBHC.

527.13 OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH THERAPY

Occupational, physical, and speech therapy are covered for all benefit plans. Speech therapy requires prior authorization with the first visit after the initial evaluation. For all benefit packages and for Medicaid payment purposes, prior authorization is not required for members who need no more than 20 physical/occupational therapy visits during a year, in addition to the evaluation and re-evaluation. One visit may include any combination of occupational/physical/speech therapy procedures performed on the same day, excluding the evaluation and re-evaluation codes.

Prior authorization (PA) is required when service limits exceed the defined Medicaid limit. If a Medicaid member is a member of an MCO, occupational, speech and physical services must be prior authorized in accordance with the particular MCO's prior authorization requirements. If the member is a member of the PAAS Program, the service must be authorized by the member's PCP. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met.

If provided during an inpatient stay covered by a DRG, the limits do not apply.

Refer to Chapter 515, Occupational/Physical Therapy Services for coverage, prior authorization requirements, and additional information.

The following service limitations by benefit package apply:

Basic Benefit Package

For those enrolled in the Basic Benefit Plan, services are limited to 20 visits total for all therapies combined. This benefit is for each member, per rolling member year.

Enhanced Benefit Package

For those enrolled in the Enhanced Benefit Plan, there are no service limitations; prior authorization is required after 20 visits. This benefit is for each member, per rolling member year.

Traditional Benefit Package

For those enrolled in the Traditional Benefit Plan, there are no service limitations; prior authorization is required after 20 visits. This benefit is for each member, per calendar year.

527.14 HOME HEALTH

527.14.1 Home Health Services

Home health services are covered in all benefit plans pursuant to a physician's written order detailing the member-specific plan of care and provided by a Medicare certified/Medicaid enrolled home health agency.

CHAPTER 527 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MOUNTAIN HEALTH CHOICES

Skilled nursing, physical therapy, occupational therapy, and speech-language pathology provided in the home must be reasonable and necessary for the diagnosis and treatment of the illness or injury within the context of the member's unique medical condition. Documentation must clearly indicate why the services are reasonable and necessary and why the individual cannot go to a health care provider for the treatment. The documentation must be clear, specific and measurable. For homebound status, the medical record must indicate exactly why it is a considerable and taxing effort for the individual to leave the home. The lack of transportation is not evidence that the individual is homebound. An individual who is physically and mentally capable of driving a car is not considered homebound.

To determine if the services are reasonable and necessary, the following items will be considered:

- The diagnosis is never to be the sole factor in determining medical necessity.
- The determination of medical necessity of the services should be based upon the member's unique condition, whether it is acute, chronic, terminal, or expected to continue over a long period of time, and in some cases if the condition is stable.
- The services are intermittent.
- Documentation must support the establishment of medical necessity and should clearly define the member's unique circumstance that justifies provision of these services.

Skilled nursing visits for observation are medically necessary when the likelihood of change in a member's condition requires the skills of a registered nurse to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures. When documentation indicates a reasonable potential for a complication or further acute episode, skilled registered nurse visits for observation and assessment will be covered for a maximum of three weeks from the start of care. Visits may be covered longer if there remains a reasonable potential for such a complication or acute episode. Documentation in the medical record must clearly indicate a change in the health status such as fluctuation of vital signs for observation and assessment to continue as a skilled service.

Teaching and training activities by a skilled nurse are covered when it is necessary to teach a member, family member or care giver how to manage the treatment regimen and the skill being taught is reasonable and necessary for the treatment of the illness, injury or functional loss. If a member or family is unable to learn and manage care, in all cases, documentation of the member's mental status must clearly indicate why the individual cannot be educated to provide the skilled care. Additionally, if there are others in the household who might be able to provide care, documentation must indicate why these individuals cannot provide the care.

Infants and toddlers are not automatically considered homebound. Newborn home health care will not be covered unless there is a diagnosis and/or condition that requires intermittent skilled nursing services. Infants discharged from a neonatal intensive care unit may receive skilled nurse visits for observation and education if their condition upon discharge requires additional skilled services and is medically necessary. Documentation must clearly indicate the need for these visits.

For children, the focus is to mainstream the physically challenged individuals as much as possible. Home health services may be provided to a child who would be homebound if the services were not provided or the normal care giver is unavailable to provide the care for a short period of time. The home health visits may not duplicate services received from other sources.

A member with a psychiatric disorder is considered homebound if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended, even if he/she has no physical limitations. The diagnosis and rationale for homebound status must be made by a psychiatrist. The following conditions support the homebound determination:

- Agoraphobia, paranoia, or panic disorder;
- Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the member's judgment and decision making and therefore the member's safety;
- Acute depression with severe vegetative symptoms; and
- Psychiatric problems associated with medical problems that render the member homebound.

The services of a skilled psychiatric nurse must be required to provide the necessary care, including counseling services. Many members who require the services of a skilled psychiatric nurse also require skilled nursing care related to a physical illness. Therefore, the psychiatric nurse must also have medical and surgical nursing experience to ensure that all the member's home care needs are met. These services should not be duplicative, and concurrent counseling or psychotherapy services by multiple providers are not medically necessary.

Benefit Plan Limitations

The total visits include any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), or home health aide (HHA). The services of a home health aide will only be reimbursed when a skilled nurse or physical therapist's care is required. Home health services will not be reimbursed when duplicative services are provided through another program.

Basic Benefit Plan

For both children and adults enrolled in the Basic Benefit Plan, services are limited to 25 visits per rolling year. If services are required beyond the 25 visits, all services must be prior authorized.

Enhanced Benefit Plan

For both children and adults enrolled in the Enhanced Benefit Plan, there are no service limits and services must be prior authorized after 60 visits have been provided.

Traditional Benefit Plan

For both children and adults enrolled in the traditional benefit plan, there are no service limits and services must be prior authorized after 60 visits have been provided.
For service limitations governing the provision of all West Virginia Medicaid services, refer to Chapter 300, Provider Participation Requirements, Chapter 800, General Administration, and Chapter 508, Home Health Services for coverage, and additional information.

527.14.2. Private Duty Nursing

Private duty nursing (PDN) services are medically necessary and continuous in-home nursing care services provided to members who are under the age of 21. In accordance with a physician's orders, continuous nursing services are provided through a Medicare approved and Medicaid enrolled home health agency by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN) under the direction of a Registered Nurse. The LPN must maintain documentation that identifies the agency supervisory nurse. Supervisory nurse visits rendered must be signed by the RN. The medical record must be complete enough to allow another professional to reconstruct what has transpired during the supervisory visit.

All services must be provided according to a plan of care, which documents the member's specific health-related need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such as "monitor health needs" are not considered sufficient documentation for the service.

PDN is not covered when rendered in a hospital, nursing facility, including an ICF/MR, or is provided by a RN or LPN that is the member's spouse, legal guardian, legally responsible relative, adoptive parent or foster parent. PDN must be prior authorized.

Benefit Plan Limitations

Basic Benefit Plan

For those children enrolled in the Basic Benefit Plan, PDN is not a covered service. For those children in the basic plan that require short term nursing care in the home, the home health skilled nursing benefit may be utilized. Refer to the Home Health Section of this manual. For further information on prior authorization and policy information, refer to Chapter 508, Home Health.

Enhanced Benefit Plan

Private duty nursing is continuous nursing care in the home for complex medical needs of infants and children. As parents or other caretakers begin the process of learning how to care for the child's acute or chronic care needs, private duty nursing services should decrease over time. Therefore, for children enrolled in the enhanced benefit plan, services are limited to 180 days per rolling year.

527.15 DURABLE MEDICAL EQUIPMENT

For both the Medicaid Traditional and Enhanced Benefit Packages, service coverage, prior authorization requirements, service limitations and all policy information must be followed as outlined in Chapter 506, Durable Medical Equipment, for all benefit plans.

For those members enrolled in the Basic Benefit Plan, there are service limitations specifically related to the Basic benefit package. Although the same policy requirements must be followed outlined in Chapter 506, for those members who have chosen the Basic benefit package, prior authorization is required for every request

above the $1,000 limit once exceeded if the $1,000 limit has been exceeded in previous paid claims for durable medical equipment. All other prior authorization and service limitations apply.

527.16 NON-EMERGENT TRANSPORTATION

Refer to Chapter 524, Transportation Services Manual for service coverage, service limitations, and policy information.

For both children and adults who are enrolled in either the Enhanced or Traditional Benefit Plan, there are no service limitations other than those outlined in Chapter 524, Transportation Services Manual.

For adults and children enrolled in the Basic Benefit Plan, trips are limited to five round trips, or 10 trips per year. At this time, these limitations apply to modes of transportation reimbursed directly through the Medicaid claims payment system.

527.17 AMBULANCE

Emergent ambulance transports are covered for all plans. Refer to Chapter 524, Transportation Services, manual.

527.18 HOSPICE

Hospice services are covered for all benefit plans. Refer to provider manual, Chapter 509, Hospice Services, for service coverage, service limitations, and policy information.

527.19 DENTAL

Dental coverage for adults and children is outlined in provider manual Chapter 505, Dental Services for service coverage, service limitations, and policy information for children and adults.

527.20 ORTHOTICS AND PROSTHETICS

These services are covered in all benefit plans. Refer to provider manual Chapter 516, Orthotics and Prosthetics for service coverage, service limitations, and policy information for children and adults.

527.21 FAMILY PLANNING

Family planning services are covered for children and adults for all benefit plans. Refer to provider manual Chapter 519, Practitioner Services, for service coverage, service limitations, and policy information.

527.22 CHIROPRACTIC SERVICES

For both the Medicaid Traditional and Enhanced adult benefit packages, service coverage, prior authorization requirements, service limitations and all policy information must be followed as outlined in Chapter 504, Chiropractic Services. Chiropractic services are not covered for children in the Basic or Enhanced Benefit

Plans.

527.23 PODIATRY

For both the Medicaid Traditional and Enhanced benefit packages, service coverage, prior authorization requirements, service limitations and all policy information must be followed as outlined in Chapter 520, Podiatry Services.

Podiatric services are not covered for those members enrolled in the Basic Plan when the services could be provided, generally, by the PCP or other PCP type.

527.24 NURSING HOME SERVICES

Nursing home services are covered for the Traditional, Basic and Enhanced adult benefit packages with appropriate prior authorization and approval requirements. Service coverage, prior authorization requirements, service limitations and all policy information that must be followed as outlined in Chapter 514, Nursing Facility Services.

Once a member is placed in a nursing facility, the member is removed from MHC and placed in the traditional program at the first of the following month after their placement if it occurs before approximately the 20th of the month, but no later than the first of the second month following their placement because it is considered long-term care. Services will be covered upon placement if the member meets all program and eligibility requirements. Inpatient rehabilitation services provided in nursing homes are not covered for all adult benefit plans.

If a member is placed prior to Medicaid's knowledge of the placement, please contact the Office of Facility and Residential Services for assistance at 304-558-1700. Services will be covered at the time of placement.

527.25 HEARING SERVICES/AID/SUPPLIES

These services are covered for all plans. Service coverage, prior authorization requirements, service limitations and all policy information must be followed as outlined in Chapter 506, DME/Medical Supplies.

527.26 PHARMACY SERVICES

Pharmacy services are covered for all benefit plans. All existing rules regarding prior authorization, the Preferred Drug List and quantity limits for medications covered by the Outpatient Pharmacy Program apply to the pharmacy benefit for the Mountain Health Choices Program. Refer to Chapter 518, Pharmacy Services for service coverage, limitations, and policy information.

Mountain Health Choices members who choose the Enhanced Benefit Package will not have a limit on the number of prescriptions obtained for a 34-day period. All rules and edits pertaining to prior authorization and the Preferred Drug List apply to the pharmacy benefit for this program.

Members in the MHC Basic Benefit Package or Plan will be limited to 4 prescriptions per 34 day period.

Certain categories of drugs will not be included in the 4 prescription limit for members who choose the Basic Benefit Package. Drugs in the following therapeutic classes will not count toward the prescription limit for **children** with the Basic Benefit Package, which will be indicated by "BC" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Medications used for the treatment of seizures
c. Certain antibiotics-cephalosporins, macrolides, penicillins, and sulfonamides
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

The following therapeutic classes will not count toward the 4-prescription limit for **adults** with the Basic Benefit Package, which will be indicated by "BA" on their Medicaid Identification Card:

a. Diabetes supplies and all insulins
b. Atypical antipsychotics
c. Antidepressants (all therapeutic classes)
d. Drugs used for the treatment of HIV/AIDS
e. Birth Control

When the 4-prescription limit is exceeded, a call may be made to the Rational Drug Therapy Program Help Desk (1-800-847-3859) for a medication review. These requests will be considered on a case-by-case basis after review of the member's medication profile.

527.27 VISION SERVICES

West Virginia Medicaid covers vision care services for the examination, diagnosis, treatment, and management of ocular and adnexal pathology. This includes diagnostic testing, treatment of eye disease or infection, specialist consultation and referral, comprehensive ophthalmologic evaluations, and eye surgery that is not cosmetic in nature. Visual examinations to determine the need for eyeglasses are covered for children only.

Full vision care benefits are available for Medicaid members under 21 years of age regardless of benefit plan. Limited vision care benefits are available for members 21 years and older. There is no coverage for cosmetic purposes.

All covered services for members under 21 years must be started before the 21st birthday. Vision care services provided on or after the birth date are not covered even if eligibility extends to the end of the month in which the birth date occurs.

Refer to Chapter 525, Vision Services, for service coverage, prior authorization requirements, service limitations and policy information.

527.27.1 COMPREHENSIVE EYE EXAMINATIONS

Comprehensive eye exams are covered services for all benefit plans for children under the age of 21 years regardless of benefit package. One comprehensive ophthalmologic examination per year is covered for members under 21 years of age without prior authorization. If a member needs an additional service related to the eye, the provider may bill other appropriate service codes.

West Virginia Medicaid does not reimburse for both an evaluation and management visit and a comprehensive or intermediate ophthalmologic eye exam on the same day for the same member.

For additional information regarding vision services, eyeglasses, repairs, etc., please see Chapter 525, Visions Services Manual.

527.27.2 EYEGLASSES

Regardless of benefit package, eyeglasses are covered for all members under the age of 21 years.

One of the following criteria must be met for West Virginia Medicaid to cover eyeglasses for members who are under 21 years of age and have never worn eyeglasses previously.

- There is a .50 diopter sphere and/or cylinder and the beneficiary's visual acuity is decreased more than 20/25 and will improve to 20/20 with eyeglasses
- Bifocals are required
- Eyeglasses give at least one line improvement on standard visual acuity chart.

West Virginia Medicaid covers the first pair of eyeglasses and a visual examination after cataract surgery for adults age 21 years and older regardless of benefit package.

A participating ophthalmologist or an optometrist must prescribe eyeglasses. Both the prescribing and the supplying provider must keep a copy of the prescription in the member's medical record.

NOTE: Sometimes an eye appliance may not be dispensed on the prescribing date. In situations where Medicaid coverage ends before the appliance can be dispensed, the provider should use the prescribing date to bill for the appliance. In all cases, a claim should not be submitted until the complete service has been provided.

Reimbursement for an eye appliance is based on West Virginia Medicaid's fee schedule.

527.27.3 CONTACT LENSES

Contact lenses (hard, soft, and gas-permeable) may be considered for reimbursement when they enable better vision than can be achieved with spectacle lenses for those in the Enhanced Children's Benefit Plan. Contact lenses are only covered for members under the age of 21 years who have the Enhanced Benefit Package. West Virginia Medicaid does not provide reimbursement for contact lenses for cosmetic purposes or for those children in the Basic Benefit Package.

A participating ophthalmologist or an optometrist must prescribe contact lenses. Both the prescribing and supplying providers must retain a copy of the prescription in the member's medical record. Reimbursement for contact lenses covers all professional services, follow-up visits, contact lenses, and required care kits. Separate payment is available for contact lens fittings. In all cases, claims for payment should not be submitted until vision care services have been completed.

For members in the Enhanced Benefit Package, both eyeglasses and contact lenses may be provided if medically necessary for vision correction.

527.27.4 ORTHOPTICS – VISUAL TRAINING

Orthoptics or visual training is only covered for those members enrolled in the Enhanced Benefit Plan or the Traditional Plan when the prognosis is for substantial improvement or correction of a member's ocular or visual condition.

527.28 PSYCHIATRIC SERVICES

Mental health services provided by a private practitioner or licensed behavioral health center that has opted to provide services as a specialty provider are unlimited. Refer to Chapter 519, Practitioner Services, and Chapter 521, Psychological Services for coverage limitations and policy information.

Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Licensed Social Worker, or Master's Level Licensed Professional Counselor in their employ must also be registered and assigned an authorization number by the contracted agent. Telephone numbers for this agent are located in Chapter 100, General Information, Section 153, Behavioral Health Services are not the responsibility of the managed care organization, nor do they require PAAS approval prior to rendering services. Claims must be billed to Medicaid for reimbursement.

527.29 CHEMICAL DEPENDENCE/MENTAL HEALTH

I. Services

A. Private Practitioners/Licensed Behavioral Health Center Specialty Care Providers

Mental health services provided by a private practitioner or licensed behavioral health center that has opted to provide services as a specialty provider are unlimited in all plans. Refer to Chapter 519, Practitioner Services, and/or Chapter 521, Psychological Services, for coverage limitations and policy information.

Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Licensed Social Worker, or Master's Level Licensed Professional Counselor in their employ must also be registered and assigned an authorization number by the contracted agent. Telephone numbers for this agent are located in Chapter 100, General Information, Section 153, Behavioral Health Services are not the

responsibility of the managed care organization, nor do they require PAAS approval prior to rendering services. Claims must be billed to Medicaid for reimbursement.

Services provided by a LBHC Specialty Services Provider, i.e., psychiatrist, physician, psychologist, or the psychiatric nurse practitioner, may bill for services independently. All other services rendered by other licensed practitioners must be provided under the direct supervision of the psychiatrist/psychologist and must be billed by the psychiatrist/psychologist in accordance with the level of service provided.

B. Behavioral Health Clinic Services

Behavioral health clinic services are services provided on an outpatient basis under the direction of a physician. Clinic Services are typically provided by Licensed Behavioral Health Centers and provided at the clinic.

Individuals who require this level of service typically demonstrate assessed needs that are best met through a combination of intensive behavioral health treatment modalities. The combination of services range from targeted case management, day treatment services, and crisis stabilization, to name a few, which may be individualized to the member. Private practitioners and LBHC Specialty providers cannot be reimbursed for the array of services provided at the Clinic Services level of care. LBHC's who are also Specialty providers cannot concurrently bill a clinic service code and the specialty code; duplicative billings will be recouped.

Clinic services provide treatment planning whereby a treatment team identifies the needs of a member and a treatment plan is developed and implemented, which is dissimilar from the lower level service utilization provided by private practitioners/LBHC specialty providers who detail member interventions.

Refer to provider manuals, Chapter 502, Behavioral Health Clinic, for service coverage, prior authorization requirements, service limitations and policy information.

C. Behavioral Health Rehabilitation Services

Behavioral health rehabilitation services are of short term duration and recommended by a physician or licensed psychologist for the purpose of reducing a mental disability and restoring a member to his/her highest level of functioning. Behavioral health rehabilitation services may be provided to members in a variety of settings including the home, community, or residential program.

Refer to Chapter 503, Behavioral Health Rehabilitation, for service coverage, prior authorization requirements, service limitations and policy information.

D. Partial Hospitalization Services

Partial hospitalization services are outpatient hospital services rendered in a treatment setting where an interdisciplinary program of medical therapeutic services is provided for the treatment of psychiatric and substance abuse disorders.

Refer to Chapter 510, Hospital Services Manual, for coverage, prior authorization requirements, and additional

information.

II. Benefit Plans and Limitations

For the MHC benefit plans, service limitations for "Chemical Dependence/Mental Health" relate to the behavioral health clinic, rehabilitation, and partial hospitalization services. For all plans, there are no maximum service limitations provided by specialty care unless service codes are limited. Prior authorization is required as indicated in current policy manuals.

Basic Benefit Plan – Adults and Children

Medicaid covers up to 26 visits per year under the children's Basic Benefit Plan. All services provided during the visit equate to one visit. Case management services are not included in the per visit limit. For adults enrolled in the Basic Adult Benefit Plan, clinic, rehabilitation, and partial hospitalization service codes are not covered. There are no service limits for the specialty visits to psychiatrist, psychologists, and the specialty care rendered at LBHCs.

Enhanced Benefit Plan – Adults and Children

Medicaid covers up to 20 visits/year for service codes related to clinic, rehabilitation, and partial hospitalization services for those adults enrolled in the Enhanced Benefit Plan; case management services are not included in the visit limit. Specialty care visits are unlimited. For those receiving services under the Enhanced Plan, services may be rendered and billed under the center's clinic and rehabilitation numbers as services apply. For those enrolled in the Enhanced Children's Plan, there are no service limits unless the service codes themselves are limited.

Refer to the appropriate manuals for services, prior authorization requirements, service limitations and policy information.

Refer to provider manuals, Chapter 502, Behavioral Health Clinic, Chapter 503, Behavioral Health Rehabilitation, and Chapter 510, Hospital Services Manual, for service coverage, prior authorization requirements, service limitations and policy information.

Traditional Benefit Plan Coverage

For those enrolled in the traditional benefit plan, refer to present service manuals for service coverage, prior authorization requirements, service limitations and policy information.

527.30 ENHANCED PLAN SERVICE PROVISION, SERVICE COVERAGE, AND POLICY INFORMATION

Members who enrolled in the Mountain Health Choices Enhanced Benefit Plan will have access to services that are preventive in nature, services that may maintain health at the member's highest function, or services which have not been previously covered by West Virginia Medicaid. These services include: weight

management, cardiac rehabilitation, pulmonary rehabilitation, and exercise and nutrition management services and are described in further detail below.

527.30.1 TOBACCO CESSATION PROGRAM

West Virginia Medicaid covers tobacco cessation for members in the Traditional and Enhanced Benefit Package and all childrens' benefit packages. Medicaid no longer covers tobacco cessation programs for those enrolled in the Basic Adult Benefit Package. The West Virginia Division of Tobacco Prevention, administered through the West Virginia Department for Health and Human Resources' Bureau for Public Health, may also assist in providing services for those who are uninsured or under-insured.

West Virginia Medicaid operates a tobacco cessation program to assist members to discontinue use of tobacco products. In order for members to have access to drugs and other tobacco cessation services, they are required to see their primary care provider and enroll in the program. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are also available through the program. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate. Refer to Chapter 518, Pharmacy Services, for covered tobacco cessation drug products.

Additional information regarding the tobacco cessation program can be accessed through www.wvdtp.com or www.wvquitline.com.

If a Medicaid member is enrolled in a managed care organization (MCO), please contact the member's MCO for service limitations and all other requirements related to this benefit.

527.30.2 CARDIAC REHABILITATION

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. Members who use tobacco must be referred to the tobacco cessation program. Refer to Section 527.30.1.

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.

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.

Cardiac rehabilitation programs are regulated exercise programs which are effective in the physiological and psychological rehabilitation of many members with cardiac conditions. 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)
- 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.

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 them 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.

Program Description for High Risk Members:

- 36 sessions (e.g., 3x/week for 12 weeks) of supervised exercise.
- Educational program for risk factor/stress reduction
- Create an individual out-patient 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. A routine cardiac rehabilitation session usually consists of an exercise training session lasting 20-60 minutes and at least one of the following services;

- A continuous ECG/EKG monitoring during exercise
- ECG/EKG rhythm strip with interpretation and physician's revision of the exercise program, or
- Limited physician follow-up to adjust medication or other treatment(s) related to the program.

Additional cardiac rehabilitation services may be medically necessary based on the above listed criteria when the member has any of the following conditions:

- Another documented myocardial infarction or extension of initial infarction, or
- Another cardiovascular surgery or angioplasty; or
- New evidence of ischemia or an exercise test, including thallium scan, or
- New clinically significant coronary lesions documented by cardiac catheterization.

The following codes must be utilized for billing cardiac rehabilitation services:

93798 Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

93797 Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session). This code is only to be utilized after it is determined that no clinically significant arrhythmia is documented during the first three weeks of the program and the provider recommends that the member complete the remaining portion without telemetry monitoring.

If a Medicaid member is enrolled in a managed care organization (MCO), please contact the member's MCO for service limitations and all other requirements related to this benefit.

527.30.3 PULMONARY REHABILITATION

Pulmonary Rehabilitation (PR) is an individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease. PR offers members a chance to reduce hospitalizations, increase their knowledge about pulmonary disease and its management, the ability to control and alleviate the symptoms of pulmonary disease, and the ability to carry out activities of daily living with less shortness of breath. Pulmonary rehabilitation programs include exercise training, psychosocial support, and education, which are intended to improve the member's functioning and quality of life.

A PR program should include these components:

- A team assessment, which typically includes input from a physician, a respiratory care practitioner, a nurse, a psychologist, and a nutritionist;
- Member training, which includes breathing retraining, bronchial hygiene, medication education and proper nutrition;
- Psychosocial intervention addressing the member's emotional support systems, anxiety and dependency issues;
- Exercise training, which includes strengthening and conditioning which may include stair climbing, inspiratory muscle training, treadmill walking, cycle training; and,
- Member follow-up, which includes a structured and ongoing home pulmonary rehabilitation program.

The goal of PR is to:

- Restore the member to the highest possible level of independent function
- Educate the member and significant others about the disease, treatment options and strategies
- Reduce and control breathing difficulties and symptom
- Maintain healthy behaviors such as good nutrition and exercise
- Encourage members to be actively involved in their own healthcare.

527.30.3.1 Criteria and Coverage

Pulmonary Rehabilitation (PR) is considered medically necessary in select members with chronic respiratory impairment who, despite optimal medical management, are experiencing disabling dyspnea associated with a restriction in ordinary activities and significantly impaired quality of life. Candidates must also be motivated to participate in a pulmonary rehabilitation program.

West Virginia Medicaid considers medically supervised outpatient pulmonary rehabilitation programs when ***all*** of the following criteria are met:

- Member is enrolled in the Enhanced Benefit Package; and
- Member has chronic pulmonary disease (asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing

alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barre syndrome or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

- Member has a reduction of exercise tolerance which restricts the ability to perform activities of daily living; and
- Member does not have a recent history of smoking or has quit smoking for at least 3 months; and
- Member has a moderate to moderately severe functional pulmonary disability as evidenced by *either* of the following

  - Pulmonary function tests showing that either the FEV1, FVC, FEV1/FVC, or Dlco is < 60% of that predicted; or
  - A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO2max) equal to or < 20ml/kg/min, or about 5 metabolic equivalents (METS); and
  - Member does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last 6 months, dysrhythmia, active joint disease, claudication, malignancy).

527.30.3.2 Billing Information

The focus of therapy is to educate and establish a program of adaptive changes to a chronic medical illness. West Virginia Medicaid will cover outpatient pulmonary rehabilitation 2 times per week for 10 weeks and not to exceed 20 sessions.
The following code must be utilized when billing:

G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, per 15 minutes (including monitoring)
G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (including monitoring).

Revenue codes 0948/948, Other Therapeutic Services (also see 094x), Pulmonary Rehabilitation, must be billed with the HCPCS code in order for payment to be made. The member must also have the benefit. A denial will be issued when the revenue code is not billed with the HCPCS code**.**

Repeat pulmonary rehabilitation programs are considered not medically necessary since there is no current evidence that repeat pulmonary rehabilitation programs result in additive long-term benefits in terms of dyspnea, exercise tolerance, or health related quality of life measures. Maintenance exercise programs are not eligible for reimbursement.

West Virginia Medicaid continues to cover the following services separately from those billed for pulmonary rehabilitation regardless of member's benefit package:

- 94375 Respiratory flow volume loop

- 94642 Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
- 94664 Demonstration and/or evaluation of member utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device.

Separate payment for the following service codes is only made when the services are medically necessary and there are no other covered services provided on the same date by the same provider. They are not reimbursed on the same day as PR services are provided.

- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94720 Carbon monoxide diffusing capacity (e.g., single breath, steady state)
- 94770 Carbon Dioxide, expired gas determined by infrared analyzer
- 94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determination e.g., during exercise.

If a Medicaid member is enrolled in a managed care organization (MCO), please contact the member's MCO for services related to this benefit.

527.30.4 DIABETES DISEASE STATE MANAGEMENT

The concept of the Medicaid Diabetes Disease State Management Program is based upon the premise that eligible Medicaid members will benefit from a member-centered health care approach that is responsive to the unique needs and conditions of people living with diabetes.

Medicaid members with diabetes will benefit from a member-centered health care approach that is responsive to their unique needs and conditions. Because the care is member centered, the most effective treatment options can be implemented that will ultimately prove cost-effective with outcomes and results that are quantifiable and measurable. The evaluation form to be used for initial and ongoing screening for members is the Diabetes Managing Provider Care Tool, which is included with the instructions for this program, and provides for the ADA Guidelines for appropriate treatment of members with diabetes. This form, which is to be completed by the member's Managing Provider, will define the health care and health related support needs of the member.

The program provides for a coordinated approach to the treatment of Medicaid members who have been diagnosed with Type 1, Type 2, or gestational diabetes mellitus. The essential program components of Medicaid's disease management program have been developed from the American Diabetes Association Guidelines (ADA), which aim to prevent the development of serious complications from diabetes. Not only will the member's PCP or provider (physician, nurse practitioner) agree to manage the member's medical treatment, but will also ensure that self-management skills and diabetes educational needs are met. Practitioners will provide diabetes education or refer individuals with diabetes to a Certified Diabetes Educator

who is enrolled in the Diabetes Disease Management Program. This policy does not change the requirement for PAAS primary care referral.

The components of Diabetes Disease State Management are:

- Evaluation and education, which includes a comprehensive assessment of the member's clinical status, including health care needs, risks, hygiene, and diet, etc.
- A drug therapy evaluation of the member's oral or injectable medication requirements and their ability to self-monitor blood glucose, to recognize emergency conditions, etc.
- Diet management/education including education on diet restrictions, eating patterns, diet and medication interactions, etc.
- Referral to other providers to meet identified health care needs, such as skin and/or wound care, eye or renal care, etc.
- Comprehensive diabetes assessment using a Diabetes Managing Provider Care Tool. (See Chapter 519, Practitioner Services Manual, for additional information).

527.30.4.1 Requirements for Becoming a Diabetes Management Provider:

Managing providers may be any of the following licensed practitioners:

- Physicians (MD, D.O.)
- Medicaid Enrolled Nurse Practitioners
- Certified Diabetic Educators

In order to be reimbursed for diabetes management extended visits and for comprehensive educational services, Medicaid providers are required to meet the following criteria:

- enroll as a Medicaid provider
- Certified Diabetes Educators may only enroll with West Virginia Medicaid for the provision of diabetes education and self-management skills. Along with the provider enrollment information found in Chapter 300, the CDE must submit a copy of credentials showing current, unrestricted certification as a Certified Diabetes Educator issued by the National Certification Board for Diabetes Educators.
- Demonstrate successful completion of the six hours of web-based training provided by the Bureau for Medical Services and the Diabetes Prevention and Control Program by submitting the provider's Medicaid number via the web upon completion of the training program. This will provide the documentation necessary for BMS to enroll the provider as a provider of diabetes disease management and will allow reimbursement for diabetes disease management service codes. Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification.
- Document care utilizing the tools provided
- Submit documents for outcome monitoring as required by BMS
- Demonstrate a capacity to provide all core elements of disease state management services, which includes:

- Comprehensive client assessment and service plan development
- Assisting the client to access needed services, i.e., assuring that services are appropriate for the client's needs and that they are not duplicative or overlapping.
- Monitoring and periodically reassessing the client's status and needs.

527.30.4.2 System Process

The following are directions for completing the on-line course for "Diabetes Education for Primary Care Providers":

Begin by accessing the course at www.camcinstitute.org/professional/diabetes/camc.htm. On the course "opening page", click the button labeled "*Click here to begin program*". Fill in your 10-digit Medicaid number, (Physician Assistants will use their employing physician's Medicaid number and personal 4-digit identifier). These number(s) will track your participation. When you access this course the first time, you will be asked to submit your personal demographic information. This information will be retained for you. If necessary, you may edit the information at a later time. Provide valid credit card information for a one-time Credit Processing fee of $30.00 for six hour of continuing education credit. Complete and submit the program pre-test. From the Program Menu Page, you will find a listing of the six module titles. Complete the modules in any sequence you choose.

When all modules have been completed, a link will become available at the bottom of the Program Menu Page for a post course evaluation form and Certificate of Completion processing. Complete Post Course Evaluation form and submit. At this point, a Certificate of Completion is displayed and an automated email is sent to West Virginia Medicaid advising them that you have successfully completed the course. Another automated email is sent to the email address you provided in your demographic information. You may print the Certificate of Completion for your personal records. The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate. Providers will receive a written notice from Unisys stating the provider file has been updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

CD's of this program will be available for those who do not have broadband Internet access. However, to use CD version of the course, the computer you use must have dial-up access to the Internet. CDs will be provided upon request, at no charge by contacting CAMC Health Education and Research Institute at 304-388-9960.

527.30.4.3 Reimbursement

Medical care that is covered by Medicaid and provided will be reimbursed at the Medicaid fee schedule. Diabetes disease management service codes are only reimbursable if the requirements previously noted for becoming a diabetes disease management provider have been met. In addition, reimbursement for the managing provider's extended office visit is a billable service based on the completion of the Diabetes Managing Provider Care Tool. This service is reimbursable, separate from, and in addition to, the evaluation and management services rendered on the same date of service. Modifier 25 must be used to indicate that a significant separately identifiable EM service was required by the same provider on the same day of a procedure or other service. Reimbursement for diabetes education and self-management training is a

separate service from the extended office visit, and payable to either managing providers or Certified Diabetes Educators. Billing should be submitted on the CMS-1500 claim form or through electronic transmission. Claims which exceed the service limits spelled out in this program instruction will not be reimbursed.

If a Diabetes Managing Provider determines that a member may benefit from diabetes education beyond extended office visits, a referral may be made to a Certified Diabetes Educator or provided by the practitioner. Certified Diabetes Educators and Diabetes Managing Providers who choose to provide diabetes education must define the educational support needs and develop an educational plan of care. Certified Diabetes Educators must develop and implement a plan of care and supply a copy of this plan to the member's Diabetes Managing Provider, as well as maintaining documentation for services rendered and billed to Medicaid for audit purposes. For your convenience, a Diabetes Educational Provider Care Tool is included with this manual. The provider of diabetes education and self-management training will monitor and re-assess the member periodically. It is the responsibility of those submitting claims to inquire whether these services have been previously received from other entities, so that service limits are not exceeded. The member may not be held liable for payment of claims which are not reimbursed by Medicaid.

Disease State Management services are reimbursed on a fee-for-service basis with limitations as follows:

Code	Description
S0315	Disease management program; Managing Provider Extended Office Visit Limits - 2 visits per year
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes replaces Certified Diabetes Educator Contact Visit and Certified Diabetes Educator Brief Visit (1 unit = 30 minutes) Combination of G0108 and G0109 Limits - 8.5 hours per year (17 units)
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes replaces Certified Diabetes Educator Group Service. (1unit = 30 minutes) Combination of G0108 and GO109 Limits - 8.5 hours per year (17 units)
S0316	Follow-Up/reassessment replaces Certified Diabetes Educator Follow-Up Visit; Limits - 2 visits per year

Provider reimbursement of these codes for members enrolled in the Basic Adult Benefit Package is not available. Primary Care Providers should highly recommend and promote enrollment in the Enhanced Benefit Package to maximize services available to the diabetic member.

527.30.5 WEIGHT MANAGEMENT PROGRAM

For those enrolled in the Enhanced Benefit Plan only, weight management services are available for those members who are pre-diabetic and have co-morbid conditions due to obesity and whose medical conditions can be improved by weight loss and improved nutrition. Weight management services include preventive

medicine counseling, individual and group exercise classes with nutritional counseling, and bariatric surgery. The goal of these services is to assist the client who is pre-diabetic and has co-morbid conditions to implement lifestyle changes and further and maintain health status improvements.

527.30.5.1 EXERCISE and NUTRITION PROGRAMS

Exercise programs, coupled with nutritional programs, may assist members in making lifestyle changes that will reduce the incidence of obesity, diabetes, heart disease and other risk factors, while improving overall health status.

The emphasis for this service is on assisting the member to establish an exercise and nutritional regimen that meets their personal fitness and nutrition needs, provides a supportive place in which to exercise, assists the member in understanding the importance of exercise in a healthy life, and transitioning them to maintain an ongoing exercise program in their home or community.

527.30.5.1.1 Provider Participation Requirements

In addition to requirements established in Chapter 300, exercise facilities must meet the specific requirements below in order to participate in and receive payment from BMS:

- The facility must provide the following personnel and provide appropriate documentation that the required personnel are licensed/credentialed:
    - Exercise physiologist
    - Certified trainer (ACSM = American College of Sports Medicine or ACE=American Council on Exercise)
    - Registered and licensed dieticians

Facilities will enroll with BMS. Because the personnel may not practice as individual practitioners, each service provider will be provided a Medicaid number as staff of the facility for identification purposes when billing. This individual number cannot be used independently and must be billed with the facility's number.

Services may be delivered through a single site or between two sites with a formal agreement between the two parties. Appropriately credentialed staff may be shared and services provided via telehealth. See section 527.30.5.1.4 for billing telehealth services.

527.30.5.1.2 Eligibility

Adults

Adult members who are enrolled in the Enhanced Benefit Plan who have a BMI > or = to 25 with co-morbid conditions (heart disease, diabetes, hypertension, sleep apnea) OR persons with a BMI > or = 30 and are pre-diabetic will be eligible for fundamental exercise and nutritional services. The member must be referred by the primary care provider (medical home).

Children

Children who are enrolled in the Enhanced Benefit Plan who are defined as overweight or defined as at risk of being overweight with complications, will be eligible for exercise and nutrition programs. For the purposes of this policy, complications are defined as: hypertension, dyslipidemia, orthopedic disorders, sleep disorders, gall bladder disease and insulin resistance. No distinction is made between levels of service for children. It is expected that the provider will work with parents or caretakers based upon age appropriateness and family dynamics. Members must be referred by the primary care provider (medical home).

527.30.5.1.3 Fundamental Requirements of the Program

The following are requirements of the program:

- A pre-activity risk screening must be performed utilizing a pre-activity screening tool
- The tool must be interpreted by qualified staff and results documented
- Members must be referred by their primary care provider
- The exercise program must be developed by the exercise physiologist or ACE or ACSM certified trainer
- The program may only be altered and monitored by the exercise physiologist or ACE or ACSM certified trainer
- The facility must have written policies and procedures for an emergency response system
- All staff must be certified in basic first aid, CPR, and public access defibrillation program
- All staff must have appropriate training, licensure, and certifications in order for reimbursement to be made by Medicaid
- The facility must perform criminal background checks
- The facility must have an incident reporting system
- Equipment must be maintained and safety checked in accordance with state and local regulations and within the guidelines of equipment maintenance; safety checks must be documented.

The facility is subject to review by the Medicaid Survey and Utilization Review staff. If deficiencies are found, the facility may be disenrolled from Medicaid participation. If found that inappropriately credentialed staff are providing services, all reimbursements will be recovered.

Service Requirements and Limitations

Services must be provided by an exercise physiologist, or ACE or ACSM certified trainer. Programs must be individualized to meet the member's needs and reviewed every 4-6 weeks. All members must be referred by their primary care provider.

For adults, a comprehensive, weight management program must include at a minimum:

- Minimum of one evaluation session with an exercise physiologist and follow-up sessions as part of an ongoing monitoring/educational program provided according to the individual's need. These sessions are to be provided one-on-one.

- Minimum of one evaluation session with a registered dietician and follow-up sessions as part of an ongoing monitoring/educational program provided according to the individual's need. These sessions are to be provided one-on-one.
- Instruction by a certified trainer following the individualized exercise plan developed by the exercise physiologist, which may include, as appropriate, classes for a maximum of 12 weeks guided by an ACE or ACSM certified trainer based upon the individual's exercise prescription for a minimum of two, and maximum 3, 1-hour sessions per week.

For children, the weight management program must have MD or DO supervision and shall offer at a minimum:

- One evaluation session and three follow-up sessions, as needed, with a registered dietician, involving the parents or caretakers and the child; with up to 2 more sessions subsequent to the review and recommendations of the child's primary care provider. Sessions are to be provided one-on-one.
- One evaluation with an exercise physiologist and two follow-up sessions as needed, provided one-on-one.
- 12 weeks in an enrolled facility inclusive of sessions with an ACE or ACSM certified trainer with a weekly minimum of two, maximum of three, one hour sessions.

The member will exercise at the facility to the maximum allowed or until:

- Goals are achieved
- Member begins maintenance program, or,
- Member's non-compliance is determined.

Member reports must be provided to the primary care provider regarding progress and participation by the member.

Continued programs will only be approved if documentation is shown that the member has been compliant and continues to lose weight and improve his/her health status.

Weight loss camps or other similar camps will not be covered.

If a Medicaid member is enrolled in a managed care organization (MCO), please contact the member's MCO for services related to this benefit and for other weight loss programs that may be offered

527.30.5.1.4 Billing Information

Claims are to be billed on a CMS 1500 claim form utilizing the appropriate billing code as defined below with diagnosis code 278.00.

The appropriately credentialed provider who provides the service must bill as the provider of service with reimbursement to the facility. Service providers cannot bill as independent providers.

All billings are subsequent to service delivery.

The following codes must be utilized for billing services:

For in-office dietician services:

97802 Medical nutrition therapy; initial assessment and intervention, individual, face to face with the member; each 15 minutes for a maximum of 4 units or 1 hour.
97803 Medical nutrition therapy; re-assessment and intervention, face to face with the member; each 15 minutes for a maximum of 12 units, or 3 hours.

For in-office exercise physiologists:

S9449 Weight management classes, non-physician provider, per session, for a maximum of 3 sessions for both adults and children.

For facility based fitness centers/certified trainer services:

S9451 Exercise classes, non-physician provider, per session for a maximum of 36 sessions. A session is considered to be 1 hour.

Telehealth Services

Because not all facilities have exercise physiologists and dieticians available on a daily basis, a single site model will not always present a feasible option. For example, rural clinics have fitness facilities and the medical and ancillary staff for oversight, but they lack a dietician or exercise physiologist. Rural clinics may partner with a single site provider to utilize their professional services in a coordinated effort to provide the services necessary. Scheduled appointments are then set up and video teleconferencing is used to deliver services to the member with at minimum a nurse present with the member during the consultation.

Q3014 originating site facility fee can be used with Modifier GT to be used for interactive audio and video telecommunications can be used. However, comparable services may be rendered through the use of telehealth technology and /or a hybrid of “hands-on” and telehealth services.

Refer to Chapter 519, Practitioner Services, for additional policy information

527.30.6 BARIATRIC SURGICAL PROCEDURES

The West Virginia Medicaid Program covers bariatric surgery procedures for those who have enrolled in the Enhanced Plan, who are in the appropriate eligibility categories for MHC, and subject to the following conditions.

527.30.6.1 MEDICAL NECESSITY REVIEW AND PRIOR AUTHORIZATION

The member’s primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request to BMS’’s Utilization Management Contractor (UMC), along with all

the required information. A review of the submitted documentation will be performed and prior authorized based upon the following criteria:

- A Body Mass Index (BMI) greater than 40 must be present and documented for at least the past 5 years. Submitted documentation must include height and weight.
- The obesity has incapacitated the member from normal activity, or rendered the individual disabled. Physician submitted documentation must substantiate inability to perform activities of daily living without considerable taxing effort, as evidenced by needing to use a walker or wheelchair to leave residence.
- Must be between the ages of 18 and 65. (Special considerations apply if the individual is not in this age group. If the individual is below the age of 18, submitted documentation must substantiate completion of bone growth.)
- The member must have a documented diagnosis of diabetes that is being actively treated with oral agents, insulin, or diet modification.
- The member must have documented failure at two attempts of physician supervised weight loss, attempts each lasting six months or longer. These attempts at weight loss must be within the past two years, as documented in the member medical record, including a description of why the attempts failed.
- The member must have had a preoperative psychological and/or psychiatric evaluation within the six months prior to the surgery. This evaluation must be performed by a psychiatrist or psychologist, independent of any association with the bariatric surgery facility, and must be specifically targeted to address issues relative to the proposed surgery. A diagnosis of active psychosis; hypochondriasis; obvious inability to comply with a post operative regimen; bulimia; and active alcoholism or chemical abuse will preclude approval.
- The member must demonstrate ability to comply with dietary, behavioral and lifestyle changes necessary to facilitate successful weight loss and maintenance of weight loss. Evidence of adequate family participation to support the member with the necessary lifelong lifestyle changes is required.
- Member must be tobacco free for a minimum of six months prior to the request.
- Documentation of a current evaluation for medical clearance of this surgery performed by a cardiologist or pulmonologist, must be submitted to ensure the member can withstand the stress of the surgery from a medical standpoint.

527.30.6.2 PHYSICIAN CREDENTIALING REQUIREMENTS

In order to be eligible for reimbursement for bariatric surgery procedures, physicians must submit the following to the provider enrollment unit:

Evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.

- Documentation that the physician is working within an integrated program for the care of the morbidly obese that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training and psychological/psychiatric assistance as needed.
- Assurances that surgeons performing these procedures will follow the guidelines established by the American Society for Bariatric Surgery including:
  - Credentials to perform open and laparoscopic bariatric surgery
  - Document at least 25 open and/or laparoscopic bariatric surgeries within the last three years.

527.30.6.3 PHYSICIAN PROFESSIONAL SERVICES

Professional services which will be required of the physician performing bariatric surgery include the surgical procedure, the 90-day global post-operative follow-up, and a 12 month assessment period which includes the following:

- medical management of the member's bariatric care,
- nutritional and personal lifestyle counseling, and a
- written report at the end of the 12 month period consisting of: an assessment of the member's weight loss to date, current health status and prognosis, and recommendations for continuing treatment. The 12 month assessment report must be submitted to the member's primary care physician/medical home.

While the bariatric surgeon's association with the member may end following the required 12 month follow-up, the member's continuing care should be managed by the primary care or attending physician throughout the member's lifetime.

527.30.6.4 REIMBURSEMENT

The physician performing the bariatric surgery procedure will be reimbursed through the existing RBRVS payment methodology for the surgical procedure. Reimbursement includes a post-operative follow-up for the global period of 90 days. For the remainder of the required 12 month follow-up period and assessment, the bariatric surgeon may submit claims using the appropriate evaluation and management procedure code. After completion of the required 12 month evaluation period, the member may be followed-up and medically managed either by the surgeon or primary care physician utilizing appropriate E & M procedure codes.

Bariatric procedures are not covered for members enrolled in the Basic Plan.

527.30.6.5 COVERED BARIATRIC PROCEDURES

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical- banded gastroplasty.

43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty.

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy.

43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption.

43848 Revision of gastric restrictive procedure for morbid obesity (separate procedure). (This is only for correction of serious complications caused by the procedure within the first 6 months postoperatively, and is not meant to indicate that a member can have a second procedure due to failure to lose weight from a prior procedure.)

Note: Only one procedure will be covered per lifetime. Those failing to lose weight from a prior procedure will not be approved for a second one.

527.30.6.6 NON-COVERED BARIATRIC PROCEDURES

The following procedures will not be covered by West Virginia Medicaid Program:

- Mini-gastric bypass surgery
- Gastric balloon for treatment of obesity
- Laparoscopic adjustable gastric banding

Refer to Chapter 519, Practitioner Services, for service coverage, service limitations, and policy information.

527.31 MANAGED CARE

If the individual is a member of a Managed Care Organization (MCO), the providers must follow the MCO's prior authorization requirements and applicable rules related to MCO covered services and bill the MCO.

If the individual is a Physician Assured Access System (PAAS) member, authorization/referral is required from the Primary Care Provider (PCP) for reimbursement of services. Medicaid will not reimburse for services provided when requirements of the MCO/PAAS Program are not followed.

CHAPTER 527
MOUNTAIN HEALTH CHOICES

APPENDIX 1

ELIGIBILITY CATEGORIES FOR MHC ENROLLMENT
1 OF 2

MEDICAID REDESIGN ELIGIBILITY GROUPS

CHILDRENS COVERAGE GROUP

	FPL
Income Based on child No deeming	Less than 1 – 150% Continuously eligible newborns 12,279 (CEN) 1 to 6 – 133% 6 to 19 – 100% Members (133,569)
Asset **Test - None** **Can Have Other Insurance Coverage**	
12 Month Continuous Eligibility	

These groups will be enrolled into the Basic Package upon initial application or re-determination, phased in county by county as the infrastructure is developed. Advanced notification will be provided to members as they are enrolled in the Basic Benefit Plan. It is anticipated initially, that Clay, Upshur and Lincoln Counties will be started on July 1, 2006. Expansion of the program will occur over the next year as provider networks are developed. Once developed, the program will be expanded county by county until it is statewide.

MEDICAID REDESIGN ELIGIBILITY GROUPS
ADULTS WITH CHILDREN COVERAGE GROUP

Eligibility Categories	FPL
AFDC Medicaid **AFDC Related-Medicaid (MMN)** **(Pregnant Women excluded)**	
Income Income Test No deeming	July 16, 1996 AFDC payment levels
Asset Test	Asset Test - $1,000 1 - $149 2. - $201 3 - $253 4. - $312
Transitional Medicaid **(Up to 12 Months)**	Members 3,212 Loses Medicaid due to earnings
Extended Medicaid **Child Support** **(4 Months)**	Members 294 Ineligible due to Child Support amount received

These groups will be enrolled into the Basic Package upon initial application or re-determination, phased in county by county as the infrastructure is developed. Advanced notification will be provided to members as they are enrolled in the Basic Benefit Plan. It is anticipated initially, that Clay, Upshur and Lincoln Counties will be started on July 1, 2006. Expansion of the program will occur over the next year as provider networks are developed. Once developed, the program will be expanded county by county until it is statewide.

CHAPTER 527
MOUNTAIN HEALTH CHOICES

APPENDIX 2

MEMBER AGREEMENT
PAGE 1 OF 2

West Virginia Medicaid Member Agreement

This Agreement outlines your Rights and Responsibilities as a person in the West Virginia Medicaid Program. It also is about ways you can work with your doctor and other health care providers to become healthier.

MEMBER RESPONSIBILITES

1. I will follow the requirements of the West Virginia Medicaid program.

2. I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.

3. I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.

   - I will go to my medical home when I am sick.
   - I will take my children to their medical home when they are sick.
   - I will go to my medical home for check-ups.
   - I will take my children to their medical home for check-ups.
   - I will take the medicines my health care provider prescribes for me.
   - I will show up on time when I have my appointments.
   - I will bring my children to their appointments on time.
   - I will call the medical home to let them know if I cannot keep my appointments or those for my children.
   - I will let my medical home know when there has been a change in my address or phone number for myself or my children.

4. I will use the hospital emergency room only for emergencies.

MEMBER RIGHTS

1. I have the right to pick my medical home. This is where I go for check-ups or when I am sick and where my health care records will be.

2. I have a right to decide things about my health care and the health care of my children. I have a right to see my medical records. I have the right to ask questions about my health care and the health care of my children.

3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the Medicaid Program.

4. I have a right to know about all laws and rules of the Medicaid Program.

5. I can contact Medicaid or my health plan with any questions about my health care.

6. I have a right to be sent a written notice when West Virginia Medicaid decides to deny or limit my Medicaid eligibility. I have a right to appeal a decision about my eligibility.

7. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

MEMBER ACKNOWLEDGEMENT

The information in this paper has been explained to me and I agree to follow this Medicaid Member Agreement.

_____ _____

West Virginia Medicaid Member Signature Date

_____

Witness: Title:

Location: _____

Date

CHAPTER 527
MOUNTAIN HEALTH CHOICES

APPENDIX 3
HEALTH IMPROVEMENT PLAN
FOR ADULTS AND CHILDREN
PAGE 1 OF 2

Patient/Clinician Health Improvement Plan for Enhanced Medicaid Benefits
Adult

Patient's Name: _____ Medicaid ID Number: _____

Date of Birth: _____ Medicaid Home: _____

1. Please indicate how often you and this patient have agreed that he/she will be seen at the health center (medical home) this year **(choose** one):

   O One visit to the primary care provider this year

   O Two visits to the primary care provider this year

   O Three visits to the primary care provider this year (approximately every 4 months)

   O Quarterly visits to the primary care provider this year (approximately every 3 months)

   O Monthly visits with the primary care provider this year

2. Please mark at least two of the following preventive and/or chronic illness care tests/procedures that you would recommend for this patient **in the next 12 months:**

() Colonoscopy	() Pneumococcal vaccination	() Tetanus vaccination
() Mammogram	() Influenza vaccination	() Lipid screening
() Pap Test	() Blood Pressure	() Glucose level
() Prostate Exam	() Other_____	_____

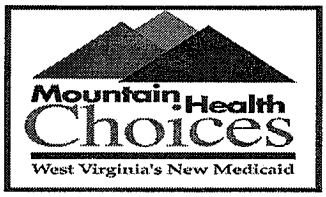
3. Health Education Classes. Please place a check mark in the appropriate box indicating if this patient needs education on any/all of the listed topics:

Nutritional Education ( )	Weight Management ( )	Diabetes Education ( )	Tobacco Cessation Education ( )

( ) I do not wish to sign the Member Agreement or to work with my medical home to develop a health improvement plan.

Signature _____ Date _____

Witness _____ Date _____



Patient/Clinician Health Improvement Plan for Enhanced Medicaid Benefits
Child/Adolescent

Patient's Name: _____ Medicaid ID Number: _____

Date of Birth: _____ Medicaid Home: _____

1. Please indicate how often you and this patient have agreed that he/she will be seen at health center (medical home) this year **(choose one):**

   O One visit to the primary care provider this year

   O Three visits to the primary care provider this year (approximately every 4 months)

   O Quarterly visits to the primary care provider this year (approximately every 3 months)

   O Monthly visits to the primary care provider this year

   O Other as per EPSDT periodicity schedule #_____ visits

2. Please mark any of following preventive and/or chronic illness care tests/procedures you would recommend for this patient **in the next 12 months:**

   () Age appropriate immunizations () Lipid screening

   () Lead Screening () Glucose level

   () Other _____ () Dental Check-ups

3. Health Education Classes. Please place a check mark in the appropriate box indicating if this patient needs education on any/all of the listed topics:

Nutritional Education ( )	Weight Management ( )	Diabetes Education ( )	Tobacco Cessation Education ( )

( ) I do not wish to sign the Member Agreement or to work with my medical home to develop a health improvement plan.

Signature _____ Date _____
(Parent or Guardian)

Witness _____ Date _____

CHAPTER 527
MOUNTAIN HEALTH CHOICES

APPENDIX 4
BENEFITS AT A GLANCE
FOR
ADULTS AND CHILDREN
1 OF 2

Mountain Health Choice
Plan A - Adults

Medicaid Benefits at a Glance		
Benefit Description	**Basic (Adult)**	**Enhanced (Adult)**
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Not Covered	Not Covered
Inpatient Hospital Psychiatric Services	Not Covered	Prior Auth Required - maximum benefit of 30-days/year
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered
Physician Office Visits - specialty care*	Covered	Covered
Occupational/Speech/Physical Therapy	Covered - maximum benefit of 20/year Prior Auth Required *(Total allowed for all therapies combined)*	Covered Prior Auth Required
Weight Management	Not Covered	Covered New
Home Health Services	Covered - maximum benefit of 25/year (Prior Auth Required)	Covered (Prior Auth Required)
Durable Medical Equipment	Covered - limited to $1000 per year with Prior Auth required if limits exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Non-emergency Medical Transportation	Covered - maximum benefit of 10/year (5 round trips)	Covered
Ambulance Services	Emergent Only	Covered
Prescriptions	Limited - 4/month	Covered
Hospice	Covered	Covered
Emergency Dental Services	Covered	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Tobacco Cessation Programs	Not Covered	Covered
Family Planning	Covered	Covered
Cardiac Rehabilitation	Not Covered	Covered New (Prior Auth Required)
Pulmonary Rehabilitation	Not Covered	Covered New (Prior Auth Required)
Chiropractic Services	Not Covered	Covered (Prior Auth Required)
Podiatry Services	Not Covered	Covered
Chemical Dependency/Mental Health Services* (limited)	Not Covered	Covered - maximum benefit of 20 visits/year
Diabetes Education/Nutritional Counseling	Not Covered	Covered New
Nutritional Educational Services	Not Covered	Covered New
Nursing Home Services	Covered (Prior Auth Required)	Covered (Prior Auth Required)

*Psychiatrist/Psychologist Services covered under Specialty Care

Original 7/25/06; revised 10/30/06, Revised 1/12/07,Revised 1/26/07

Mountain Health Choices
Plan C - Children

Medicaid Benefits at a Glance		
Benefit Description	**Basic (Children)**	**Enhanced (Children)**
Well Child Visits (EPSDT Services)	Covered	Covered
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Prior Auth Required	Prior Auth Required
Inpatient Hospital Psychiatric Services	Prior Auth Required - maximum benefit of 30 days/year	Prior Auth Required
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered
Physician Office Visits - Specialty Care	Covered	Covered
Birth to Three Services	Covered	Covered
Occupational/Speech/Physical Therapy	Covered - maximum benefit of 20/year (total allowed for all therapies combined) (Prior Auth Required)	Covered (Prior Auth Required)
Weight Management	Not Covered	Covered New
Home Health Services	Covered - maximum benefit of 25/year	Covered
Durable Medical Equipment	Covered - limited to $1000 per year with Prior Auth required if limit exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Non-emergency Medical Transportation	Covered - 10/year (5 round trips)	Covered
Ambulance Services	Covered	Covered
Prescriptions	Limited - 4 per month	Covered
Hospice	Covered	Covered
Vision Services	Comprehensive eye exam, glasses - maximum benefit of $750/year	Comprehensive eye exam, glasses, contact lenses, vision training New
Emergency Dental Services	Covered	Covered
Dental Exams (dental check-ups)	Covered - 2/year	Covered
Hearing Services/Aids/Supplies	Annual exam and hearing aids when medically necessary	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Tobacco Cessation Programs	Covered	Covered
Family Planning	Covered	Covered
Cardiac Rehabilitation	Covered (Prior Auth Required)	Covered New (Prior Auth Required)
Pulmonary Rehabilitation	Covered (Prior Auth Required)	Covered New (Prior Auth Required)
Chiropractic Services	Not Covered	Not Covered
Podiatry Services	Not Covered	Covered
Chemical Dependency/Mental Health Services (limited)	Covered - maximum benefit of 26/year (Prior Auth Required)	Covered (Prior Auth Required)
Diabetes Education/Nutritional Counseling	Covered	Covered New
Nutritional Education Services	Not Covered	Covered New
Skilled Nursing Care (Private Duty Nursing)	Not Covered	Covered (Limited to 180 days/yr --Prior Auth Required)

Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)) and identified by an EPSDT (early and periodic screening, diagnostic and treatment services) screen will be provided either at the medical home or referred to an appropriate provider.

CHAPTER– 528 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR RADIOLOGY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Manual	Entire Manual	December 1, 2009	January 1, 2010

CHAPTER 528–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR RADIOLOGY SERVICES

TABLE OF CONTENTS

CHAPTER 528–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR RADIOLOGY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally define parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

Radiological covered services available to Medicaid members may be provided in a hospital, Independent Diagnostic Testing Facility (IDTF), office, or clinic setting in accordance with State regulations. The Health Care Authority (HCA) must provide Certificate of Need (CON) approval in many cases (e.g., Cardiac CT). Specific covered diagnostic radiology services may be provided by enrolled Portable X-ray Providers when it is medically necessary.

Certain radiological services may require prior authorization. A request from the referring provider must be submitted to BMS' Utilization Management Contractor (UMC) with the appropriate medical documentation prior to services being rendered. Prior authorization is required regardless of the place of service unless the service is medically necessary during a documented emergent visit at an emergency room.

528.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services shall apply pursuant to the Provider Manual, *Chapter 200, Definitions*. In addition, the following definitions apply and/or relate to radiology services.

Computed Tomography (CT) - A diagnostic technology that combines x-ray equipment with a computer and cathode ray tube display to produce images of cross sections of the human body.

Contrast Material - A substance that is opaque to x-rays; when administered it allows the radiologist to examine an organ or tissue.

General Supervision – When the radiological procedure is furnished under the physicians overall direction, but the physician's presence is not required.

Independent Diagnostic Testing Facility (IDTF) - A facility in which diagnostic tests are performed by licensed and certified non-physician personnel under the appropriate physician supervision.

Magnetic Resonance Angiography (MRA) - An application of magnetic resonance imaging (MRI) that provides visualization of blood flow, as well as images of normal and diseased blood vessels.

Magnetic Resonance Imaging (MRI) – The performance of medical imaging using radio waves, magnetic fields and a computer to produce images of the body tissues.

Mammogram - A radiographic image of the breast.

Mammography - A radiograph of the breast, which may utilize specialized diagnostic procedures including computer analyzed digitalization or digital mammography.

Nuclear Medicine - A diagnostic and treatment imaging process that uses special cameras and radioactive materials to form images of the body.

Portable X-ray Provider – A provider of radiological procedures that utilizes hand-carried or mobile radiological systems or components in the member's residence.

Positron Emission Tomography (PET) Scan - A diagnostic technology that involves the acquisition of physiologic images based on the detection of positrons. Positrons are tiny particles emitted from a radioactive substance administered to the patient. The subsequent views of the human body developed by this technique are used to evaluate the patient for the presence of a variety of diseases.

Radiopharmaceutical - A radioactive compound used in radiotherapy or diagnosis.

Ultrasonography - A diagnostic technology that produces a visual image from the application of high frequency sound waves.

Utilization Management Contractor (UMC) - The UMC is authorized to grant prior authorization for radiology services provided to West Virginia Medicaid members. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by BMS for medical necessity reviews.

528.2 PROVIDER PARTICIPATION

To participate in the West Virginia Medicaid Program and receive reimbursement from BMS, providers must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located: [Note: When the license and/or certification(s) are not current, the provider shall not participate in Medicaid until such time the BMS' Provider Enrollment Unit receives the copy of current license(s) and/or certification(s). When current license and/or certification(s) are not on file, reimbursement cannot be provided.
- Have a valid signed provider enrollment application/agreement on file.
- Meet and maintain all BMS provider enrollment requirements.

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid provider enrollment.

In addition to the above, to be eligible for payment for radiology, or diagnostic services, the provider must:

- Indicate the location of the installation/equipment and provide its registration number on the enrollment application. The equipment installation and personnel must comply with any applicable federal, state, and local laws as well as federal and state Medicaid rules and regulations.
- Provide a copy of Board Certification in Radiology to provider enrollment, or be Board eligible or Board certified in a medical specialty in which they are qualified by experience and training in the use of x-rays for diagnostic purposes. Radiological services must be performed by, or provided under the supervision of, a licensed provider who is qualified by advanced training and experience in the use of x-rays for diagnostic and therapeutic purposes.

528.3 PORTABLE X-RAY PROVIDER

Specific diagnostic radiology services provided by portable x-ray providers are considered for payment when it is deemed medically necessary by the member's provider for the service to be rendered in a Nursing Facility or the member's home. These services shall only be performed where there is true medical necessity and when the member cannot access or otherwise be examined on fixed conventional radiology equipment.

Portable x-rays are not to be performed for "routine" purposes or for reasons of convenience. Portable x-ray services provided in the member's home are subject to prior authorization.

Covered radiology services limited to portable x-ray providers are defined as:

- Skeletal films involving the extremities, pelvis, vertebral column, or skull
- Chest and abdominal films that do not involve the use of contrast media
- Diagnostic mammograms if the approved portable x-ray provider, as defined in 42 CFR part 486, subpart C, meets the certification requirements of section 354 of the Public Health Services Act, as implemented by 21 CFR part 900, subpart B. FDA certification under the Mammography Quality Standards Act (MQSA) is required.

Transportation of portable x-ray equipment is reimbursable only when the equipment used is transported to the location where the x-ray services are provided. West Virginia Medicaid will not reimburse for transportation of portable x-ray equipment when the x-ray equipment is stored at the facility for use as needed.

Reimbursement for transportation of equipment and personnel to provide radiological services, (R0070), is limited to one unit of service, per location, per day when one West Virginia Medicaid member is seen.

If more than one Medicaid member is x-rayed at the same place of service, R0075 (transportation of portable x-ray equipment and personnel, more than one member seen), is to be reported with the appropriate modifier. The appropriate modifiers are:

- R0070 One member served
- R0075 - UN Two members served
- R0075 - UP Three members served
- R0075 - UQ Four members served
- R0075 - UR Five members served
- R0075 - US Six members or more served (paper claim must be submitted indicating the number of members served).

Setup of portable x-ray equipment at the site of service, and transportation and/or set up charges for portable EKG services are not reimbursable.

528.3.1 ENROLLMENT (PORTABLE X-RAY PROVIDER)

The portable x-ray provider must meet the Centers for Medicare and Medicaid Services' (CMS) enrollment requirements (see 42 CFR §486.100-110) as a portable x-ray provider in order to be reimbursed for services provided to West Virginia Medicaid members. Portable x-ray services must be provided under the general supervision of one or more licensed physicians qualified by advanced training and experienced in the use of diagnostic x-rays. The supervising physician is responsible for the ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of non-physician personnel that use the equipment. Any non-physician personnel utilized by the portable x-ray provider to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidenced by licensure or certification.

All entities wishing to enroll as a portable x-ray provider with the West Virginia Medicaid Program must provide Provider Enrollment with the following:

- A copy of the Medicare approval that certifies them by CMS as a Portable X-ray Provider
- Completed West Virginia Medicaid enrollment application
- Registration/certification of radiological equipment
- List of procedure codes provider is approved by CMS to provide

- Name and copy of current license of each supervising radiologist, including any medical specialty certifications
- Mammography Certification issued by Mammography Quality Standards Act of 1992 (MQSA). (Only if mammograms are performed)
- Certificate of Need

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid Provider Enrollment.

528.4 INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)

Certain diagnostic services provided by an IDTF are considered for payment if medically necessary. An IDTF may be a fixed location, a mobile facility, or an individual non-physician provider, but must be independent of a hospital. An IDTF must have one or more supervising physicians with experience in each type of diagnostic procedure performed by the IDTF. The supervising physician is responsible for the ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualifications of non-physician personnel that use the equipment. Any non-physician personnel utilized by the IDTF to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidenced by licensure or certification.

Any procedures performed by an IDTF must be ordered by the provider who is treating the member, that is, the provider who is furnishing the consultation or treating a member for a specific medical problem and uses the results in the management of the member's medical problem. The supervising physician for the IDTF shall not order tests performed by the IDTF and the IDTF shall not add any procedures based on internal protocols without an order from the treating provider. An exception to this rule is if the supervising physician is the members treating provider. In this situation, the supervising physician would have been treating the member for a specific medical diagnosis prior to the testing.

An IDTF must comply with all applicable laws of any state in which it operates. Exceptions for diagnostic x-rays and other diagnostic tests that are not required to be furnished in accordance with IDTF criteria can be referenced in 42 CFR 410.33.

528.4.1 ENROLLMENT (IDTF)

An IDTF must meet CMS's enrollment requirements (see 42 CFR §410.32 and 410.33) as an IDTF in order to be reimbursed for services provided to West Virginia Medicaid members. All entities wishing to enroll as an IDTF with the West Virginia Medicaid Program shall provide Provider Enrollment with the following:

- A copy of the Medicare approval that certifies them by the Centers for Medicare and Medicaid Services (CMS) as an IDTF Medicare provider
- Completed West Virginia Medicaid enrollment application
- Registration/certification/location of radiological equipment
- List of procedure codes provider is approved by CMS to provide

- Name and copy of current license of each supervising radiologist, including any medical specialty certifications
- Mammography Certification issued by Mammography Quality Standards Act of 1992 (MQSA). (Only if mammograms are performed)
- Certificate of Need

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid Provider Enrollment.

528.5 COVERED SERVICES

Radiology services provided by Medicaid enrolled providers are considered for reimbursement by West Virginia Medicaid when the services are determined medically necessary to meet the healthcare needs of the member. If the radiology service is a covered service and requires prior approval, the prior authorization is required prior to the service being rendered regardless of the place of service unless medically necessary during an emergent visit at an emergency room. A referring/treating provider must order all covered services. The treating provider is the provider responsible for the management of the member's specific medical problems.

Services must be performed under the supervision of a licensed physician or other authorized, licensed provider within the scope of his or her licensure and must be medically necessary. Generally accepted professional standards of care must be followed by all personnel.

Radiology services eligible for coverage include, but are not limited to:

- Diagnostic x-ray tests and therapeutic procedures
- CT, MRI, MRA and PET Scans
- Radiation oncology/Interventional Radiology
- Bone Density Tests
- Nuclear medicine services [Note: Nuclear medicine equipment must be registered with or licensed by the Nuclear Regulatory Commission (NRC)]
- Ultrasound services provided by radiologists and certain medical specialists qualified by advanced training and experience in the use of diagnostic ultrasound procedures
- Radiopharmaceutical and contrast materials: A list with billing guidelines can be found on the WVDHHR webpage:

http://www.wvdhhr.org/bms/sPharmacy/PractitionerOutpatient/NDC_DrugCodeList.pdf

- One interpretation/report per radiology procedure

528.5.1 MAMMOGRAPHY

Diagnostic and screening mammography services are a covered service if medically necessary. A screening mammography is limited to one per year. All facilities providing these services are required to have FDA certification under the Mammography Quality Standards Act (MQSA) of 1992. MQSA requires that all mammography facilities in the United States meet certain

stringent quality standards, be accredited by an FDA-approved accreditation body, and be inspected annually.

Physicians providing an interpretation/report for mammographies performed in MQSA approved facilities may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the member, in accordance with 42 CFR 410.32.

528.6 NON-COVERED SERVICES

Non-covered radiology services include, but are not limited to:

- Experimental, investigational, clinical trials or services for research purposes
- Radiology services for which a required prior authorization has been denied or not obtained
- Radiology services rendered by providers and facilities not properly licensed, certified, or enrolled with West Virginia Medicaid
- Mass screenings or examination of members at nursing facilities, schools, or other institutional or public settings
- Non-compliant MQSA mammograms
- Diagnostic services ordered by a provider who is not the member's attending/treating provider. (Exception: FDA regulated mammograms)
- Interpretation of x-rays for quality assurance/confirmation
- Radiology services provided to persons who are not Medicaid eligible on the date of service
- Reports requested by BMS or its designee
- Review of x-ray without providing a written report
- Set up of portable x-ray/EKG equipment are considered included in the procedure itself
- A second interpretation/report of a radiology procedure. Payment for initial report is considered payment in full and includes any additional reports that may be submitted.

528.7 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES

For radiology services requiring prior authorization for medical necessity by the Utilization Management Contractor (UMC), the referring/treating provider must submit the appropriate CPT code with clinical documentation and any other pertinent information to be used for clinical justification of services by the UMC. The information must be provided to the UMC, and the prior authorization granted, prior to services being rendered. Prior authorization requests for radiological services must be submitted within the timeframe required by the UMC.

The UMC reviews all requests for services requiring prior authorization. When the medical documentation does not meet medical necessity criteria or additional information is not received a denial letter is sent to the member or their legal representative, the requesting provider and facility. This denial letter notes the reason for the denial and includes information regarding the member's right to a fair hearing and a Request for Hearing Form for completion. In addition, the

letter sent to the provider contains information regarding their right to a reconsideration of the denial. To obtain a copy of the prior authorization form and a list of radiological procedures requiring prior authorization refer to www.wvdhhr.org.

If services are provided before the prior authorization is confirmed, the provider and/or facility shall not be reimbursed. Prior authorization does not guarantee payment. Prior authorization is required regardless of the place of service unless the service is medically necessary during a documented emergent visit at an emergency room.

Nationally recognized medical appropriateness criteria, or other criterion that has been approved by BMS may be utilized for medical necessity reviews of radiology services requiring prior authorization.

Retrospective authorization is available (1) for West Virginia Medicaid covered services denied by the member's primary payer (2) retroactive Medicaid eligibility; and, (3) the next business day following a medically necessary emergency procedure occurring on weekends, holidays, or at times when the UMC is unavailable. A request for consideration of retrospective authorization does not guarantee approval or payment.

528.8 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in *Common Chapter 300 Provider Participation Requirements, Section 320.5 Document and Retain Records*, providers and facilities submitting claims for Medicaid reimbursement must maintain complete, individual, accurate and legible records. Records must include documentation of services provided to Medicaid members and billed to West Virginia Medicaid.

Radiological services require a written order which includes the original signature of the member's treating provider, date test was ordered, member's diagnosis, and the specific test or procedure requested. These records must be made available upon request to the Bureau for Medical Services, Federal/State Auditors and Investigators, or BMS contracted agencies.

528.9 BILLING

West Virginia Medicaid utilizes Current Procedure Terminology (CPT) and/or Healthcare Procedure Coding System (HCPCS) codes for billing of services provided to Medicaid members. These codes are recommended by CMS and can be found in procedure code books published by the American Medical Association. Some services are not assigned a CPT or HCPCS code; therefore, an unlisted code may be available for the service provided. The appropriate unlisted code with the documentation describing the service performed must be submitted on a paper claim for payment consideration. Use of an unlisted code when a national CPT code is available is not reimbursable. In addition, coding modifiers may be required to accurately and completely report any service provided to the member.

Specific procedure/service codes are bundled into other codes to reflect the complexity of the service provided and West Virginia Medicaid requires the use of the correct code for service

provided. West Virginia Medicaid utilizes clinical auditing bundling software for prepayment review of claims, which prevents overpayments from occurring when services are unbundled.

West Virginia Medicaid requires providers and facilities to be enrolled with West Virginia Medicaid to be eligible for reimbursement of services rendered. Providing services prior to enrollment, with the exception of emergency room services provided by an Out of Network hospital is not reimbursable.

Radiology services generally include a technical and professional component that together equals the total procedure. The professional component is the interpretation of the x-ray and the written report. The technical component includes the use of equipment, personnel and materials. The date of service the technical component is performed is the appropriate date of service for both the professional and technical components. The professional or technical components are billed with the appropriate modifier in addition to the CPT/HCPCS code for payment consideration:

- Facilities, including IDTF's and Portable X-ray Providers, bill the technical component only of the procedure code.
- Practitioners bill the professional component of the procedure for their services when only an interpretation/report is done.
- Practitioners who own radiology equipment and interpret the x-ray may bill for the total procedure.
- Practitioners who own radiology equipment but choose to send to another practitioner for interpretation would bill the technical component only and the practitioner who reads the x-ray would bill for the interpretation/report.

The professional, technical, or total components of radiology services provided by providers are billed on the CMS 1500 paper claim or ASCX12N837P electronic format with the appropriate modifier when applicable. The technical component of radiology services provided by IDTFs is billed this way as well. Hospitals bill the technical component of radiology services with the appropriate modifier on a UB04 or ASCX12N837I electronic format. Claims must be submitted to the BMS Fiscal Agent within 12 months of the date of service. Please refer to *Chapter 800, General Administration*, for more information on timely filing.

Medicaid is the payer of last resort. Third-Party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. Please see *Chapter 600, Reimbursement Methodologies*, for further information regarding TPL.

528.9.1 REIMBURSEMENT METHODOLOGY

Physicians, Outpatient Hospitals Facilities/Services, IDTFs, Portable X-ray Providers, Rural Health Clinics and Federally Qualified Health Center's are reimbursed for radiology services based on the Resource-Based Relative Value Scale (RBRVS) or the lesser of the established fees or the providers usual customary charge to the public. Refer to *Chapter 600, Reimbursement Methodologies*, for further information on RBRVS. Radiology services for Critical Access Hospital's are reimbursed at a percent of billed charges.

528.10 MANAGED CARE

Unless otherwise noted in this manual or appendices, these services are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a West Virginia MCO, MCO requirements must be met for reimbursement. If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for all benefits/services ordered prior to rendering the service. Medicaid shall not reimburse for services provided when MCO or PAAS requirements are not met.

528.11 MOUNTAIN HEALTH CHOICES

Mountain Health Choices (MHC) is the name of West Virginia Medicaid's Program where members have a choice of benefit packages. This program promotes member choice, member responsibility and health improvement. This program was developed as a result of the Deficit Reduction Act 2005 and allows for the tailoring of benefit packages to meet the needs of certain populations. This program is a part of the redesign of Medicaid to promote wellness and to prevent and/or manage the progression of chronic diseases by encouraging healthier lifestyles for Medicaid members.

The services outlined in this manual are covered for children and adults in both the Basic and Enhanced Benefit packages. Diagnostic radiology services are covered for all benefit plans. Prior authorization is required for certain services.

CHAPTER– 529 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR LABORATORY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Manual	Entire Manual	December 1, 2009	January 1, 2010

CHAPTER 529-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR LABORATORY SERVICES

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CHAPTER 529–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR LABORATORY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally define parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

Covered laboratory services available to Medicaid members may be provided in an office, clinic, hospital setting, or clinical laboratory, which is in compliance with Clinical Laboratory Improvement Amendments (CLIA) requirements and state regulations. Certain laboratory services may require prior authorization. Appropriate medical documentation shall be submitted to the Utilization Management Contractor (UMC) or Rational Drug Therapy Program (RDTP), by the referring provider prior to services being rendered. Prior authorization is required regardless of the place of service.

This chapter describes West Virginia Medicaid's coverage policies for laboratory services. See *Chapter 510, Hospital Services Manual*, for information regarding hospital laboratory services.

529.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services shall apply pursuant to the Provider Manual, *Chapter 200, Definitions*. In addition, the following definitions apply and/or relate to laboratory services.

CLIA Certificate - Any of the following types of certificates issued by Centers for Medicare and Medicaid Services (CMS):

- **Certificate of Accreditation (COA)** - A certificate issued to a laboratory that is CLIA approved to perform tests categorized as waived, Provider Performed Microscopy Procedures (PPMP), and moderate and/or high complexity testing. These labs must meet the standards of a private non-profit accreditation program approved by CMS.
- **Certificate of Compliance (COC)** - A certificate issued to a laboratory that is proven to be in compliance with applicable CLIA requirements. Laboratories with a COC can perform tests categorized as waived, PPMP and moderate and/or high complexity tests.
- **Certificate of Provider Performed Microscopy Procedures (PPMP)** - A certificate issued to a laboratory in which a physician or midlevel practitioner performs no tests other than PPMP procedures, and if desired, waived tests.
- **Certificate of Registration (COR)** - A certificate issued to a laboratory that applies for a COC or a COA. This enables the laboratory to conduct waived, PPMP and moderate and/or high complexity testing while achieving their CLIA certification.
- **Certificate of Waiver (COW)** - A certificate that permits a laboratory to perform only waived tests.

Clinical Laboratory – Any facility or place, however named, for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of human beings.

Clinical Laboratory Improvement Amendments (CLIA) - An established standard for laboratories to ensure the accuracy, reliability, and timeliness of patients' test results regardless of where the test is performed. Congress passed CLIA in 1988 establishing quality standards for all laboratory testing performed on humans (clinical) to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. The regulations are based on the complexity of the test method.

Exempt Tests - Laboratory testing that is not regulated by nor certified by CLIA.

Laboratory Services - Services ordered by or under the direction of a licensed practitioner of the healing arts within the scope of his or her practice as defined by state law and must be in compliance with the rules implementing CLIA.

Moderate/High Complexity Testing - Testing subject to regulations setting minimum qualifications for all persons performing or supervising these tests, along with corresponding responsibilities for each position in the lab. These laboratories must also participate successfully in approved proficiency testing programs, which provide an external evaluation of the accuracy of the laboratory's test results. Moderate and high complexity laboratories must have systems and processes for monitoring testing

equipment, procedures to ensure proper test performance and accurate results and an overall plan to monitor the quality of all aspects of the laboratory's operation ongoing.

Reference Lab - Any lab performing clinical laboratory diagnostic tests (or the interpretation/report of such tests, or both) without a face-to-face encounter between the member and the lab billing for the test and/or interpretation/report.

Utilization Management Contractor (UMC) - The BMS Utilization Management Contractor authorized to grant prior authorizations.

Waived Tests - Simple laboratory examinations and procedures that employ methodologies that are as simple and accurate as to render the likelihood of erroneous results negligible and/or pose no reasonable risk of harm to the patient if the test is performed incorrectly.

529.2 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

To participate in the West Virginia Medicaid Program and receive reimbursement from BMS, providers must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located: (Note: When the license and/or certification(s) are not current, the provider shall not participate in Medicaid until such time the BMS' Provider Enrollment Unit receives the copy of current license(s) and/or certification(s). When current license and/or certification(s) are not on file, reimbursement cannot be provided.)
- Have a valid signed provider enrollment application/agreement on file
- Meet and maintain all BMS provider enrollment requirements.

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid Provider enrollment.

In addition to the above, to be eligible for payment for laboratory services, a clinical laboratory must be certified by CMS to perform the specialties or subspecialties of tests billed to Medicaid as of the date the tests are performed. Reimbursement for clinical laboratory services is paid only to laboratories certified under CLIA or as amended. Providers billing CLIA regulated laboratory tests must have CLIA certification or registration certification. A copy of any current certifications must be on file with the West Virginia Medicaid enrollment department.

529.3 COVERED SERVICES

Laboratory services provided by Medicaid enrolled providers are considered for reimbursement by West Virginia Medicaid when the services are determined medically necessary to meet the specific healthcare needs of the member. Covered laboratory services include, but are not limited to, diagnostic and therapeutic laboratory and

pathology procedures. Laboratory services are limited to those tests identified by CMS for which the individual provider is CLIA certified. A list of laboratory codes with their proper certifications can be found on the CMS website at http://www.cms.hhs.gov/. Refer to the West Virginia Medicaid website, http://www.wvdhhr.org/bms/, the Clinical Lab Fee Schedule, for a list of covered and non-covered laboratory services.

Laboratory services require a written practitioner's order which includes the original signature of the member's treating provider, date ordered, member's diagnosis, and the specific test or procedure requested.

529.3.1 PATHOLOGY SERVICES

West Virginia Medicaid covers various pathology services for Medicaid members. These may be subject to medical necessity review, appropriateness criteria, and any prior authorization requirements.

Pathology services must be requested by a treating provider regarding an abnormal condition which results in a written report by a pathologist. A Pathologist will be reimbursed for the professional component of pathology services. The professional component is paid according to the RBRVS fee schedule, and appropriate modifiers must be billed. The total component is eligible for reimbursement to a laboratory which employs the pathologist.

529.3.1.2 SPECIMEN COLLECTION

West Virginia Medicaid covers the collection of specimens either through routine venipuncture, finger, heel or ear stick, and catheterization (urine collection), etc. A specimen collection fee is not separately reimbursable when the same provider is collecting the specimen and processing the specimen. The collection of the specimen is considered an inherent part of processing the specimen. A specimen collection fee is separately reimbursable to the collecting provider when the specimen is collected in the collecting provider's office or laboratory but is processed elsewhere.

When a specimen is drawn and sent to a reference lab for processing, West Virginia Medicaid will reimburse the referring provider for the specimen collection and the reference lab for processing the specimen. The reference lab must enroll for reimbursement for services rendered.

Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each member encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

For information regarding specimen collection of homebound members please refer to *Chapter 508, Home Health Services*.

529.4 NON-COVERED SERVICES

West Virginia Medicaid shall not reimburse an independent laboratory for a test ordered by a provider who has, or whose family has, an ownership or financial interest in the facility or who receives any form of compensation, fee or gratuity for requesting laboratory services from that facility.

Non-Covered laboratory services include, but are not limited to:

- Blood tests required for marriage, employment, paternity determination, etc.
- Drug screenings which are:
    - Done routinely as a result of a provider's/facility's procedure and/or policy
    - Not based on medical necessity
    - Work related
- Fertility services such as embryo/sperm collections and banking
- Experimental/research/investigational/trial examinations, testing, or screening
- Services not ordered by the member's treating provider
- Services that are provided to members who are not eligible to receive them on the date provided
- Reports to providers of service
- Reports requested by BMS or its authorized representative
- Mass screenings or examinations of members at nursing facilities, schools or other institutional or public settings
- Lab tests performed for quality assurance/confirmation
- Repeated tests due to provider error
- Routine reflex testing. (Reflex testing occurs when initial test results are positive or outside normal parameters and indicate that a second related test is medically appropriate. This is covered only when specifically ordered by the provider as medically necessary.)
- Specimen collection when same provider provides specimen analysis
- More than one specimen collection for each member per encounter
- Specimen collection for throat cultures or pap smear, as these services are included in the evaluation and management visit
- Autopsies and/or supervisory pathology services
- Handling and/or conveyance of specimens for transfer from one site to another
- Any lab service the facility is not CLIA certified to provide.

529.5 PRIOR AUTHORIZATION

For laboratory services requiring prior authorization for medical necessity by the Utilization Management Contractor (UMC), the referring/treating provider must submit the appropriate CPT code with clinical documentation and any other pertinent information to be used for clinical justification of services, prior to services being

rendered to the UMC. Some laboratory tests may require prior authorization by and/or coordinated with Rational Drug Therapy Program (RDTP). Refer to www.wvdhhr.org for a list of services requiring prior authorization.

The UMC and/or RDTP review all requests for services requiring prior authorization. When the medical documentation does not meet medical necessity criteria or additional information is not received, a denial letter is sent to the member or their legal representative, the requesting provider and facility. This denial letter notes the reason for the denial and includes information regarding the member's right to a fair hearing and a Request for Hearing Form for completion. In addition, the letter sent to the provider contains information regarding their right to a reconsideration of the denial.

Prior authorization does not guarantee payment. Prior authorization is required regardless of place of service. Nationally recognized medical appropriateness criteria, or other criterion that has been approved by BMS, may be utilized for medical necessity reviews of laboratory services requiring prior authorization.

Retrospective authorization is available (1) for West Virginia Medicaid covered services denied by the member's primary payer, (2) retroactive Medicaid eligibility, and (3) the next business day following a medically necessary emergency procedure occurring on weekends, holidays, or at times when the UMC is unavailable. A request for consideration of retrospective authorization does not guarantee approval or payment.

529.6 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in *Common Chapter 300, Provider Participation Requirements, 320.5 Document and Retain Records*, providers and facilities submitting claims for Medicaid reimbursement must maintain complete, individual, accurate and legible records. Records must include documentation of services provided to Medicaid members and billed to West Virginia Medicaid.

Laboratory services require a written order which includes the original signature of the member's treating provider, date test was ordered, member's diagnosis, and the specific test or procedure requested. The written order, along with the results of the laboratory services, must be kept on file at least five years with the billing facility and have a copy in the members' medical record. These records must be made available upon request to the Bureau for Medical Services, Federal/State Auditors and Investigators, or BMS contracted agencies.

The laboratory must maintain records that indicate the daily accession of specimens. At a minimum, these records must contain the following information:

- Member identification: Name, address, birth date, Medicaid Identification Number
- Specimen identification if other than by member name
- Written order from requesting provider
- Name of provider submitting specimen

- Date of specimen collection
- Date specimen received
- Type of specimen
- Tests requested and performed
- Date test performed
- Test results and date reported to provider
- Specimens and test requests referred to other laboratories, and the name and location of the reference laboratory.

529.7 BILLING

West Virginia Medicaid utilizes Current Procedure Terminology (CPT) and/or Healthcare Procedure Coding System (HCPCS) codes for billing of services provided to Medicaid members. These codes are recommended by CMS and can be found in procedure code books published by the American Medical Association. Some services are not assigned a CPT or HCPCS code; therefore, an unlisted code may be available for the service provided. The appropriate unlisted code with the documentation describing the service performed must be submitted on a paper claim for payment consideration. Use of an unlisted code when a national CPT code is available is not reimbursable.

There are laboratory tests that are frequently performed as a group (profile) on automated equipment. For any combination of these tests, the provider shall use the code which correctly designates the number of tests included in the profile. The provider shall not "unbundle" and bill separately for tests included as part of a group, profile or panel. West Virginia Medicaid utilizes clinical auditing bundling software for prepayment review of claims. Unbundling of codes is not eligible for reimbursement. When all individual component tests that make up a particular panel are ordered and performed, West Virginia Medicaid rebundles all components into the panel. Furthermore, when components of one panel are duplicated in another panel, only one panel code may be billed. Individual tests not included in the panel may be billed separately.

The clinical laboratory that provides covered services must perform both the technical and professional components of the service. The technical component is the test procedure. The professional component is the report that interprets the test results and identifies those that are outside the normal range. The date of service the technical component is performed is the appropriate date of service for both the professional and technical components.

Laboratories will only be reimbursed for the tests the CLIA certification authorizes. CLIA Waived tests that require a modifier must be billed with the appropriate modifier in order to be eligible for payment. Claims must be submitted to the BMS Fiscal Agent within 12 months of the date of service. Refer to *Chapter 800, General Administration*, for more information on timely filing.

Practitioners not in a group practice shall bill laboratory services with their individual National Provider Identification (NPI). Practitioners affiliated with groups shall bill with

their individual NPI and group NPI. The laboratory CLIA number that has been submitted to enrollment will be appropriately applied.

Medicaid is the payer of last resort. Third-party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. Refer to *Chapter 600, Reimbursement Methodologies*, for further information regarding TPL.

529.7.1 REIMBURSEMENT METHODOLOGY

West Virginia Medicaid pays the lesser of 90 percent of the Medicare Clinical Laboratory Fee Schedule or the provider's usual and customary fee for laboratory services. Refer to Chapter 600, Reimbursement Methodologies, for further information. A pathologist, when billing separately, will be reimbursed for the professional component of pathology services. The professional component is paid according to the Resource-Based Relative Value Scale (RBRVS) fee schedule, and appropriate modifiers must be billed.

529.8 MANAGED CARE ORGANIZATION

Unless otherwise noted in this manual or appendices, these services are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a West Virginia MCO, MCO requirements must be met for reimbursement. Medicaid will not reimburse for services provided when MCO or PAAS requirements are not met. Medicaid members enrolled in the PAAS Program do not require the primary care provider's referral for lab services.

529.9 MOUNTAIN HEALTH CHOICES

Mountain Health Choices (MHC) is the name of West Virginia Medicaid's Program where members have a choice of benefit packages. This program promotes member choice, member responsibility and health improvement. This program was developed as a result of the Deficit Reduction Act 2005 and allows for the tailoring of benefit packages to meet the needs of certain populations. This program is a part of the redesign of Medicaid to promote wellness and to prevent and/or manage the progression of chronic diseases by encouraging healthier lifestyles for Medicaid members.

The services outlined in this manual are covered for children and adults in both the Basic and Enhanced Benefit packages.

CHAPTER 530–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	October 26, 2011	January 1, 2012

Chapter 530–Covered Services, Limitations, and Exclusions for Speech-Language Pathology and Audiology Services
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CHAPTER 530–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item or situation not discussed in this chapter must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical, dental, and mental services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

The Center for Medicare and Medicaid Services (CMS) require that all services provided to Medicaid members be medically necessary, cost effective, and provided in the appropriate setting by enrolled providers. As such, covered services are subject to nationally accredited, evidence based medical necessity guidelines, including but not limited to the medical necessity criteria utilized by the BMS' Utilization Management Contractor (UMC).

The National Correct Coding Initiative (NCCI) is used by West Virginia Medicaid as coding standards for procedures/services provided to Medicaid members. These standards, recommended by CMS and compiled by the American Medical Association (AMA), apply to Current Procedural Terminology (CPT numeric codes) and the Healthcare Common Procedure Coding System (HCPCS alpha-numeric codes). Services may also be subject to coding standards developed by BMS and/or its Fiscal Agent. Providers must use the most current CPT, HCPCS, and ICD diagnosis manuals applicable to the date of service when billing for services provided to Medicaid members. Providers are encouraged to implement Electronic Health Records (EHR). Information for EHR is available at www.cms.gov/EHRincentiveprogram .

WV Medicaid covers speech therapy, language and audiology services provided to Medicaid members admitted to an acute care hospital, a critical access hospital, or in an outpatient setting or in the member's home. Therapy services must be ordered by an enrolled treating/prescribing physician, APRN, or PA and provided by a Medicaid enrolled speech therapist/pathologist or audiologist. Any enrolled therapist/audiologist is eligible for direct billing and reimbursement of services provided by BMS.

Effective January 1, 2012, Outpatient speech/audiology services are not reimbursable directly to the hospital. Services must be billed by the therapists, who may have a pay-to of a medical group owned by the hospital.

Speech therapy and audiology services require prior authorization by the UMC prior to the provision of services. Evaluations and re-evaluations do not require prior approval unless they exceed the service limits. A recommendation or approval to seek medical care does not in itself make the care medically necessary or a covered service, nor does it mean that the member is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are provided.

Any covered speech-language and audiology service is available to Medicaid members up to 21 years of age. Limited services for members over 21 years of age include augmentative communication/speech generating systems, artificial larynx, tracheostomy speaking valves, speech therapy and limited evaluation function tests for specific medical conditions. Treatment visits are defined as face-to-face and encompass any covered speech-language and audiology services provided to Medicaid members at each visit. Prior authorization is required for medical necessity. Request for prior authorization does not guarantee approval or payment.

This chapter describes West Virginia's Medicaid coverage policies for speech-language and audiology services. Refer to the BMS' website at www.dhhr.wv.gov/bms, BMS' Fiscal Agent website www.wvmmis.org, and BMS' UMC website at www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx for covered services, service limits, when appropriate, prior authorization requirements and special instructions.

530.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Definitions and Acronyms*. In addition, the following definitions for speech-language and audiology services also apply.

Audiologist –A person who practices audiology in accordance with his/her licensure, scope of practice and licensed under either West Virginia State Code or the code of the State in which they are practicing and meets the qualifications established by the American Speech-Language Hearing Association (ASHA).

Augmentative Communication (AC)/Speech Generating Device – A speech aid that provides the ability to meet functional speaking needs of members with severe speech impairment.

Binaural – Pertaining to both ears. Only 1 unit and binaural procedure codes are to be billed when supplying hearing devices for both ears.

Communication Disorder – An impairment in a person's ability to receive, send, process, and comprehend concepts of verbal, nonverbal, and graphic symbol systems as defined by the American Speech-Language-Hearing Association (ASHA).

Cochlear Implant – An implanted electronic hearing device, designed to produce useful hearing sensations to a member with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear.

Direct Supervision –The supervising/teaching therapist/audiologist must be present at the out-patient site where Medicaid covered services are provided.

Electronic Health Record – A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface—including evidence-based decision support, quality management, and outcomes reporting. It is important to note that an EHR is generated and maintained *within an institution*, such as a hospital, integrated delivery network, clinic, or physician office. An EHR is not a longitudinal record of all care provided to the patient in all venues over time. Longitudinal records may be kept in a nationwide or regional health information system. Refer to www.cms.gov/EHRincentiveprogram for additional information.

Evaluation – An initial assessment to determine the need for services and develop a plan of care.

Hearing Aid – An electronic device that increases the loudness of sounds and speech for the hearing impaired.

Hearing Aid Dealer – An individual who is licensed by the West Virginia Board of Hearing Aid Dealers or the State in which they operate and provides hearing aids to enrolled members based on medical necessity.

Indirect Supervision – The therapist/audiologist is on the premises when Medicaid covered services are rendered and is available for any emergency or questions that may arise.

Medical Necessity – Services and supplies that are appropriate and necessary for the symptoms, diagnosis, or treatment of an illness; provided for the diagnosis or direct care of an illness; within the standards of good practice; not primarily for the convenience of the Medicaid member or provider; and the most appropriate level of care that can be safely provided.

Monaural – Pertaining to one ear. Only 1 unit and the monaural procedure codes are to be billed when supplying a hearing device for 1 ear. Each ear cannot be billed separately.

Mountain Health Trust – The name of West Virginia Medicaid's Managed Care Program that consists of the Physician Assured Access System (PAAS) and the Medicaid Managed Care Organizations (MCOs).

National Provider Identification (NPI) – A unique 10-position, intelligence-free numeric identifier and must be used in lieu of legacy provider identifiers in the HIPAA standards transactions and providers

must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Plan of Care - A written document that outlines the progression of speech therapy and hearing devices that will be used in the course of treatment.

Primary Care Provider (PCP) – A physician, physician assistant or advanced practice registered nurse (APRN) associated with the health home that is the primary contact for provision and coordination of a member's health care services or needs.

Re-Evaluation – A subsequent evaluation/examination of a member for the purpose of assessing the effectiveness of prior treatment and the plan of care.

Speech-Language Pathologist – A person who practices speech-language pathology in accordance with his/her licensure, scope of practice and licensed under either West Virginia State Code or the code of the State in which they are practicing and meets the qualifications established by the American Speech-Language Hearing Association (ASHA).

Speech-Language Pathologist Assistant – A person who practices speech-language pathology under the direction and supervision of a licensed speech-language pathologist, who does not act independently and is licensed under either West Virginia State Code or the code of the State in which they are practicing. These individuals are not eligible for enrollment in the West Virginia Medicaid Program.

530.2 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

To be eligible for participation and reimbursement for services provided to Medicaid members, all providers must:

- Meet all applicable licensing, accreditation, and certification requirements;
- Have a valid signed provider enrollment application/agreement on file; and,
- Meet and maintain all BMS provider enrollment requirements as outlined in *Chapter 300, Provider Participation Requirements.*

Important: Renewal of license and/or certification must be maintained in a current status and the documentation must be submitted to the BMS' Provider Enrollment Unit for inclusion in the provider record. In order to be reimbursed for services related to skills attained after the initial enrollment, an individual must submit documentation of the new certifications and request additional services to their provider profile.

The BMS' (Bureau of Medical Services) website www.dhhr.wv.org/bms , BMS' Fiscal Agent website, www.wvmmis.org and BMS' UMC website at www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx are the recommended methods for keeping current on updates and information regarding BMS. If the Internet is not available in your area, contact BMS' Provider Enrollment to request a paper copy or CD of this chapter for the office.

Refer to *Common Chapter 300, Provider Participation Requirements,* for additional information.

530.3 COVERED SERVICES

Speech and audiology services must be ordered by an enrolled physician, physician assistant or advanced practice registered nurse and provided by or under the direction of an enrolled licensed speech therapist and or audiologist. Prior authorization is required for any covered service and when service limits for initial evaluation and re-evaluations are exceeded.

530.3.1 SPEECH-LANGUAGE THERAPY

Speech-language therapy requires a written referral from an enrolled physician, APRN, or PA and prior authorization before therapy is provided. Any covered speech-language services are available to Medicaid members up to the age of 21 years.

For members 21 years of age and older, speech therapy services are limited to specific medical/surgical conditions. The conditions include, but are not limited to, Cerebral Vascular Accident (CVA), tracheotomy or tracheostomy, laryngectomy, traumatic brain injury (TBI), nerve injuries (e.g., 5th, 7th-12th), amyotrophic lateral sclerosis (ALS), cerebral palsy, and dysarthia. Prior authorization and a referral from an enrolled physician, APRN, or PA are required before therapy is provided.

The initial evaluation for speech therapy is limited to 1 per calendar year; the re-evaluation is limited to 2 per calendar year. Prior authorization is required when service limits are exceeded and with a request for continuation of the approved initial speech therapy regimen. .

Speech therapy is deemed not medically necessary when the member has:

- Reached the highest level of functioning and is no longer progressing; OR
- The established plan of care goals and objectives are met; OR
- The established plan of care does not require the skills of a speech-language therapist/pathologist; OR
- The member or his/her legal representative has demonstrated the knowledge and skill of providing the speech therapy regime themselves.

530.3.2. AUGMENTATIVE COMMUNICATION/SPEECH GENERATING SYSTEMS AND DEVICES

Speech generating device, artificial larynx, tracheostomy speaking valve, and voice amplifier for communication are covered for children up to 21 years of age and adults 21 years of age and older. The device must be prescribed by a treating physician, APRN, or PA and provided under the direction of an enrolled Speech-Language Pathologist trained in augmentative communication/speech generating device and services. Prior authorization is required for medical necessity and when service limits are exceeded.

Accessories for the speech generating device (e.g., operating system, Word core software, battery charger, mounting plate, built-in stand, vocabulary software, USB cable, 1 battery pack, and a standard 1 year warranty) are included with the initial placement of the device and cannot be billed separately. Accessories not included in initial placement (e.g., cables, battery pack, carrying case, and picture communication symbols (PCS) are billed separately and require prior authorization for medical necessity and when service limits are exceeded.

Repair/modification to the augmentative communication/speech generating device requires prior authorization.

Artificial larynxes including an initial battery and tracheostomy speaking valves require prior authorization when service limits are exceeded.

530.3.3 Audiology/Hearing Aid Dealers

West Virginia Medicaid covers medically necessary audiology services to Medicaid members up to 21 years of age. Services provided on or after the 21st birthday are not available for reimbursement. Audiology covered services include mandatory newborn hearing screens, 1 initial evaluation per calendar year to determine hearing capability, 2 re-evaluations per calendar year, diagnostic audiology testing, hearing aids and batteries. Prior authorization is required for specified services as noted in this section.

- Hearing Aids

  Hearing aids, approved by the Food and Drug Administration (FDA) are covered for members up to 21 years of age. The most economical hearing aid based on the member's basic healthcare need must be provided. Prior authorization for medical necessity, a referral from an enrolled physician, APRN, or PA with documentation of a medical examination and documentation of a hearing evaluation with audiometric results by an audiologist within the past 6 months is required before the hearing aid will be provided. An unaltered cost invoice must be submitted to the Utilization Management Contractor (UMC) for pricing within 30 days of providing the hearing aid. A cost quote is not accepted.

  When a hearing aid is initially provided, the selection, ordering, modification, fitting, dispensing, cleaning, calibration, re-calibration, evaluation of appropriate amplification, orientation to use, adjustment, and batteries are included in the cost of the hearing aid.

  Replacement hearing aid batteries require prior authorization when service limits are exceeded.

- Warranty of Hearing Aids

  West Virginia Medicaid requires a 2 year hearing aid warranty which is included in the reimbursement of the hearing aid.

- Repair of Hearing Aids

Repair of hearing aids is covered when the medical need is expected to continue, the repair is more economical than a new purchase, and the 2 year warranty has expired. Note: When the warranty is in effect, the hearing aid repair will not be reimbursed. An unaltered cost invoice for the repair must be submitted with the claim form to the BMS' Fiscal Agent for payment consideration. A cost quote is not accepted. Prior authorization for repair is required when service limits are exceeded.

- Replacement of Hearing Aids

  Hearing aid replacements require an enrolled physician, APRN, or PA referral and prior authorization. Replacements are covered due to growth or changes in the member's physical condition, wear, theft (with the submission of a police report), irreparable damage, or loss by disaster. When documentation of malicious damage, neglect, or misuse of the hearing aid is reported and confirmed, the request is denied.

- Ear Molds/Impression

  Ear molds, including fitting and adjustment and In-the-ear hearing aid impressions, after the member has received the aid, are available to children up to 21 years of age. Prior authorization for medical necessity is required when service limits are exceeded.

- Cochlear Implant

  Cochlear implants, approved by the FDA, are covered for members up to 21 years of age with severe to profound nerve deafness and there is reasonable expectation that a significant benefit must be achieved from the implant. The cochlear implant includes all internal and external components when initially provided and must not be billed separately. Prior authorization is required.

- Replacement of Cochlear Implant/Accessories

  Replacement of a cochlear implant and/or its external components (e.g., speech processor, microphone headset and audio input selector) is considered medically necessary when the existing device cannot be repaired OR when replacement is required because a change in the member's condition makes the present unit non-functioning AND improvement is expected with a replacement unit. Prior authorization is required.

  Replacement of accessories for the cochlear implant (headset/headpiece, microphone, transmitting coil, and transmitter cable) requires prior authorization and may be billed separately. Batteries do not require prior authorization unless limits have been exceeded.

- Newborn Hearing Screen

  Newborn hearing screenings are covered for Medicaid members. When testing is performed while the infant is in the hospital the screening is included in the DRG or the hospital's per

diem rate and therefore, not reimbursed separately. Newborn hearing screenings are a covered service for the first 90 days of life using the HCPCS Code V5008. This code covers screenings completed using either OAE (Otoacoustic Emissions) or ABR (Auditory Brainstem Response) testing. The policy governing this service can be found at www.wvdhhr.org/nhs.

530.4 NON-COVERED SERVICES

Speech-language and audiology services not covered by West Virginia Medicaid include, but are not limited to, the following:

- Experimental/investigative services/procedures for research purposes
- Evaluations provided by an employee or an individual that has a financial interest with providers of devices.
- Evaluations by the Speech-Language Pathology Assistant (SLPA).
- Speech therapy services provided:
    - to a member in a nursing facility (included in the nursing facility per diem rate)
    - to individuals who are not Medicaid eligible on the date of service
    - by persons not duly certified to provide the services
    - to members showing no progress in treatment/therapy
    - to members by out-of-network providers
- Upgrades to, or subsequent versions of the speech generating device software program or memory modules that may include enhanced features or other improvements
- Any device that is not a dedicated augmentative communication/speech generating device or can run software for purposes other than speech generating device (e.g., word processing application, accounting program, or other non-medical functions)
- Augmentative communication (AC)/speech generating systems or devices intended to meet social, educational, vocational or non-medical needs
- Any device that allows input of information via a pen-based system using a stylus and handwriting recognition software, keyboard, or downloaded from a personal computer using special cables and software
- Handheld devices, such as personal digital assistants, that integrate the functions of a small computer with features such as a cell phone, personal organizer, electronic mail, or pager
- Multiple AC's or software programs that perform the same essential function are considered a duplication of services and are not medically necessary
- Laptop computers or desktop computers which may be programmed to perform the same function as a speech generating device
- Printers (which are not a built-in component of a augmentative communication/speech generating device), printer paper, printer cables
- Environmental control devices which are not a built in component
- Purchase of a new PC, repair or replacement of a previously owned PC or any related hardware
- Extended vocabulary software packages
- An AC device provided without severe speech impairment
- Rental of hearing aids
- Hearing aids, hearing aid evaluations and fittings for members 21 years and older
- Personal FM Systems

- Assistive technology devices that are maintained at a school facility for the general use of disabled students and assistive technology services related to the use of such devices
- Upgrading of hearing aids to accommodate school facility FM systems

Non-covered services are not eligible for a Department of Health and Human Resources (DHHR) fair hearing or a document/desk review.

530.5 PRIOR AUTHORIZATION

All requests for covered services requiring prior authorization must be submitted to the UMC. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual or other medical appropriateness criteria approved by BMS is utilized for review of services requested.

Prior authorization is required for any covered service and when service limits for initial evaluation and re-evaluations are exceeded. It is recommended that the UMC's web portal at www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx be utilized for submitting any request for services requiring prior authorization. Providers using the UMC password protected web portal for requests may also use the password protected web portal to obtain the approval with an assigned prior authorization number or the denial and the reason(s) for the denial after submitting the request and clinical documentation. Support clinical documentation must not be more than 6 months old when submitted for prior authorization. If the covered services are provided before the prior authorization is confirmed, the services will be denied and is not eligible for reimbursement by BMS. The request for prior authorization does not guarantee approval or payment.

When a request for service is denied, the denial is communicated to the provider of service via the UMC's password protected web portal with the reason(s) for denial and their right for reconsideration of the denial. The member or their legal representative is notified of the denial with information related to their right of a fair hearing with a copy of the Request for Fair Hearing Form for submission to BMS

It is the responsibility of the treating/prescribing physician, APRN, or PA to submit a referral with a diagnosis code and clinical documentation for speech, language and audiology services to the servicing Speech/, Language Pathologist, Audiologist or Hearing Aid Dealer before services are provided. The Speech/Language Pathologist, Audiologist or Hearing Aid Dealer is responsible to submit a copy of the practitioner's referral and the individual plan of care to the UMC.

The use of an unlisted code is prohibited when an appropriate code is available. Therefore, unlisted codes for procedures/services require prior authorization by the UMC. The practitioner must provide medical documentation and the reason(s) why an unlisted code must be utilized for the specific procedure/service requested.

530.5.1 RETROSPECTIVE REVIEW

Retrospective review is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer providing all requirements for the primary payer have been followed including appeal processes; or

- Retroactive West Virginia Medicaid eligibility.

A request for consideration of retrospective authorization does not guarantee approval of review or payment.

530.6 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements, providers submitting claims for Medicaid reimbursement of services provided to a Medicaid member must maintain complete, individual, accurate and legible medical records. Records must include documentation of medical necessity for the procedures/services provided and be available to BMS or its designee upon request. When documentation is not available, BMS will recover payments made to the provider.

Electronic health records (EHR) for Medicaid members are recommended. Information for EHR and EHR Incentive Program is available on the BMS' website at http://www.dhhr.wv.gov/bms/ehr or refer to *Common Chapter 100, General Information.*

The Speech/Language Pathologist and Audiologist documentation must include, but not limited to, the following:

- A written referral from the treating/prescribing practitioner with pertinent clinical documentation for service(s) requested. The referral must include, but not limited to, the member's name, date of referral, type of service requested, frequency and duration of treatment, diagnosis, and physician, APRN, or PA's signature. Supporting documentation must not be more than 6 months old.
- The plan of care which must include, but is not limited to, the date the plan was developed, diagnosis, short and long-term functional goals, measurable treatment objectives, frequency and duration of treatment, education/training in speech therapy or hearing devices for the member or their legal representative to attain maximum rehabilitation, prognosis, date discussed with member or legal representative, signature and date of the member or legal representative agreeing to the treatment, date, and signature and title of the individual providing treatment.
- The progress notes which must be written at each face-to-face visit and signed and dated by the individual providing the service.
- A copy of the prior authorization approval with assigned PA number received from the UMC or a copy of the denial with reason(s) of denial, when appropriate.
- The hearing aid description, make, model, date of purchase, instructions for use and care, measurement and narrative of the fitting, and the signature and title of the individual providing a hearing aid to Medicaid members. Any supplies or accessories for the aid must be documented.
- An audiology evaluation with audiometric results which cannot be more than 6 months old prior to dispensing the hearing aid.
- Warranty information.

- A copy of CMS 1500 claim form utilized for billing of services provided.
- A copy of an Individual Education Plan (IEP), if applicable

Progress/improvement must be documented for continuing coverage of therapy. The provider must document the member's compliance or noncompliance with therapy and the home regimen plan. Continuation of services may be considered when an exacerbated episode is clearly documented. Prior authorization is required.

530.7 OTHER SERVICES

530.7.1 SCHOOL BASED VERSUS PRIVATE PRACTICE SERVICES

Parents have the freedom to choose services from Medicaid providers outside the school system. However, West Virginia Medicaid does not reimburse private practice providers for the same services provided in the school system. This constitutes duplication of services. If a parent or legal representative chooses therapy to be provided by a private practice provider, the parent or legal representative must notify the school district, the Regional Education Services Agency, school or county board in writing not to seek Medicaid reimbursement for therapy services. A copy of the correspondence must be attached to the request for prior authorization to the UMC by the private practitioner chosen by the parent or legal representative to provide the services.

When school is not in session, continuation of therapy services, if necessary, is to be coordinated with a qualified therapist in private practice and the written Individualized Education Plan (IEP) established by the school system must include the continuation of the treatment plan by the private practitioner.

Speech therapy services are covered to members, from 3 years of age up to 21 years of age, when the services are requested by a practitioner and provided by an enrolled Speech-Language Pathologist employed by the West Virginia Department of Education. Reimbursement is based on the Medicaid Fee for Service Rate and apportioned based on a 15 minute unit of service.

530.7.2 BIRTH TO THREE SERVICES

The Birth-to-Three Program must coordinate the treatment plan of care between the providing therapists and the Program providers to avoid duplication of speech therapy and coordinate the member's transition to the school system after the age of 3 years.

530.7.3 EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's EPSDT Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members up to 21 years of age. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services. Prior authorization of speech therapy is required.

530.7.4 INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)

Any service required in an ICF/MR by the member is reimbursed as an all inclusive rate. However, if the ICF/MR does not provide the required service(s) on-site, such as speech, language or audiology services, a written agreement between the ICF/MR and an outside source must be developed and implemented to provide these services. The ICF/MR is responsible for reimbursement of therapy services to the provider. Services provided by outside sources are included in the ICF/MR rate and must not be billed separately. Refer to *Chapter 511, Intermediate Care Facility for the Mentally Retarded* for more information.

530.7.5 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

All services provided to a member in a PRTF are reimbursed to the PRTF in an all inclusive rate. However, if the PRTF does not provide the required service(s) on-site, such as speech, language or audiology services, a written agreement between the PRTF and an outside source must be developed and implemented to provide these services. The PRTF is responsible for reimbursement of therapy services to the provider. Services provided by outside sources are included in the PRTF rate and must not be billed separately. Refer to *Chapter 531, Psychiatric Residential Treatment Facility* for additional information.

530.7.6 NURSING FACILITY

Speech, language and audiology services are not eligible for reimbursement as a direct billing to Medicaid if the Medicaid member is a resident of the facility at the time the services are provided. Refer to *Chapter 514, Nursing Facility Services,* for additional information.

530.7.7 INPATIENT HOSPITAL

Speech therapy by enrolled Medicaid therapists may be provided to Medicaid members who are inpatients of acute care and critical access hospitals. Reimbursement of speech therapy for inpatients is included in the DRG or hospital's per diem rate, and will not be reimbursed separately.

530.7.8 OUTPATIENT SETTING

Speech therapy and/or audiology services may be provided in an outpatient setting by Medicaid enrolled speech therapists and/or audiologists. Acute care and critical access hospitals are not eligible for direct reimbursement for outpatient therapy services.

530.8 BILLING/REIMBURSEMENT

530.8.1 Billing

West Virginia Medicaid utilizes Current Procedural Terminology (CPT) and/or Healthcare Procedure Coding System (HCPCS) procedure codes for billing of services provided to Medicaid members. Only enrolled providers are eligible for reimbursement of services provided. Billing prior to providing services is prohibited. Providers must not directly bill a Medicaid member for any non-covered service without first informing the member that the service is not covered by Medicaid AND obtaining a written and signed agreement by the member or his/her legal representative, signifying that they accept responsibility for payment of the billed charged by the provider.

Any enrolled therapist/audiologist is eligible for direct billing and reimbursement of covered speech/audiology services provided by BMS. Outpatient speech and audiology services are not

reimbursable directly to the hospital.

Claims must be submitted to the BMS' Fiscal Agent within 12 months of the date of service and a separate claim must be completed for each individual member for payment consideration. Place of service must be included on the claim form.

Providers are encouraged to bill electronically. The professional paper claim form, CMS 1500, or electronic transmission of ASCX12N837P (004010X098A1) must be used to bill covered services/procedures provided by practitioners. The date of service on the claim must be the day the service occurred or was provided.

Some services are not assigned a CPT or HCPCS code; therefore, an unlisted code may be available for the service provided. The appropriate unlisted code with the documentation describing the service performed must be submitted on a paper claim for payment consideration. Unlisted procedure codes require prior authorization. The use of an unlisted code when a national code is available is not reimbursable.

Clinical auditing bundling software for prepayment review of claims is utilized by WV Medicaid. When the RBRVS (Relative-based Resource Value Scale) schedule identifies procedure codes as Status Code "B" indicating the services are bundled, procedures will not be reimbursed as payment is included in other procedures performed.

When billing for hearing aids, 1 unit of service must be billed for Monaural and Binaural codes in accordance with the code description. Monaural cannot be billed separately for each ear. If hearing aids are needed for both ears, the binaural code must be used. When billing for Hearing Aids all discounts given to dispensers must also be reflected on the cost invoice submitted to the UMC.

530.8.2 Reimbursement Methodology

Reimbursement to Medicaid enrolled providers is considered payment-in-full. The Bureau for Medical Services does not negotiate fees.

Speech-language and audiology services are reimbursed based on:

- Resource-Based Relative Value Scale (RBRVS)
- Medicare fee schedule less 20%
- Lesser of the upper limits of established fees or the provider's usual customary charge for the service to the general public
- Unaltered cost invoice.

The current RBRVS (Relative-based Resource Value Scale) Spreadsheet is available at www.dhhr.wv.gov/bms .The RBRVS identifies resource-based relative value units (RBRVUs) for services provided in facility and non-facility settings, other billing information, and identifies service coverage with the established fees assigned to each service.

Medicaid is the payer of last resort. Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities.

WV Medicaid utilized the Third-Party Liability (TPL) information regarding other liable parties from the member's files to ensure that Medicaid is the last payer to reimburse for covered services. The TPL may be an individual, institution, corporation of a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, United Mine Worker's of America (UMWA) benefits, Veterans Administration benefits, CHAMPUS, Medicare, West Virginia Division of Vocational Rehabilitation (DVR), etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan. Subsequent establishment of liability that provides compensation and payment for the costs of such medical/surgical care requires an adjustment by the provider or other health care professionals to the Medicaid agency for benefits paid.

Prior authorization is not required for services reimbursed by TPL. However, if the primary payer denies a Medicaid covered service, an explanation of benefits noting the denial must be submitted with the documentation to the UMC for review.

Refer to *Common Chapter 600, Reimbursement Methodologies*, and/or the RBRVS schedule available at www.dhhr.wv.gov/bms .

530.9 MANAGED CARE

If the Medicaid member is enrolled in a Medicaid Managed Care Organization (MCO), MCO requirements must be met for reimbursement. The MCO is responsible for all covered speech-language and audiology services. If the Medicaid member is enrolled in an MCO, MCO requirements must be met for reimbursement.

530.10 PHYSICIAN ASSURED ACCESS SYSTEM (PAAS)

If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for all services ordered prior to rendering the service. Medicaid does not reimburse for services provided when PAAS requirements are not met.

519. 11 MOUNTAIN HEALTH CHOICES

Mountain Health Choices program is offered by West Virginia Medicaid for certain eligibility categories. It includes a choice of benefit package and primary care provider (PCP), encourages personal responsibility, and provides care coordination for its members through the member's medical home.

Providers can view the member's benefit plan designation on the member's Medicaid card. Providers may also call the provider eligibility telephone line or utilize the Medicaid Management Information System (MMIS) vendor web portal to determine member eligibility and benefit package. The following will be noted on the member's card to identify the benefit plan in which the member is enrolled:

- "TR" Traditional Medicaid Benefit Package
- "BA" Basic Adult Benefit Package
- "EA" Enhanced Adult Benefit Package
- "BC Basic Child Benefit Package
- "EC" Enhanced Child Benefit Package.

See *Chapter 527 Mountain Health Choices* for information on the Basic and Enhanced Packages, which can be found on BMS' website at www.dhhr.wv.gov/bms.

CHAPTER 531—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES (PRTF) CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	February 1, 2013	May 1, 2013

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CHAPTER 531—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES (PRTF)

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

Psychiatric Residential Treatment Facility (PRTF) care is the most restrictive type of care for children in the foster care system. A secure facility is used for treatment of children who have been clearly diagnosed as having a psychiatric, emotional or behavioral disorder that is so severe the child is a danger to himself or others. All services must be delivered under the direction and orders of a physician and licensed psychiatrist. Educational services for the child must be provided on the grounds of the facility. The ultimate goal of the PRTF services is to promote a successful return of the child or adolescent into the community.

A PRTF is defined as a separate, stand-alone entity or a distinct part of an acute care general psychiatric hospital which holds licensure in West Virginia as a behavioral health agency pursuant to West Virginia code §27-9-1 or §27-2A-1 and is licensed as a child care agency pursuant to West Virginia Code §49-3B-2. PRTF's located outside the State of West Virginia must meet all licensing requirements for PRTFs in the state where the facility is located and be certified to serve Title XIX recipients in that state as a PRTF. West Virginia is not in a position to interpret other state's descriptive designations to confirm that they do in fact comply with the PRTF designation. Therefore, if a state does not offer a PRTF designation on a license, facilities will be required to provide documentation from their state's licensing agency, signed and dated by the director of the state licensing agency, on official states' letterhead, that the facility meets all criteria for psychiatric residential treatment facility service provision as indicated in 42 CFR and is approved to serve Title XIX recipients in that state as a PRTF or evidence of certification as a PRTF provider from another jurisdiction. PRTFs must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting body with comparable standards that are

recognized by the State licensing agency. When different accreditation, certification or licensing standards exist, between West Virginia and the state where the facility exists, the more stringent standard must be followed, for West Virginia Medicaid members (West Virginia CSR §78-3-22.2. Accreditation Requirements).

PRTFs are limited in size to 30 beds within the state of West Virginia according to the West Virginia State Plan. PRTFs providing services to children out of state are limited to the number of beds prescribed by that state's plan or licensure.

This chapter describes West Virginia Title XIX Medicaid's coverage policies for Psychiatric Residential Treatment Facilities and any service, procedure, or situation not discussed in this chapter must be presumed not covered. Providers of Psychiatric Residential Treatment Facilities are required to provide services as they are outlined in this manual. Each agency is subject to monitoring and evaluation by all appropriate State entities and is bound to all requirements outlined in this manual.

531.1 ACRONYMS & DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Acronyms & Definitions*. In addition, the following definitions apply and/or relate to PRTF Services.

Child And Adolescent Needs and Strengths Assessment (CANS): A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Child and Adolescent Functional Assessment Scale (CAFAS): The CAFAS is the gold standard for assessing a youth's day-to-day functioning across critical life domains (subscales) AND for determining whether a youth's functioning improves over time The CAFAS is a professionally-rated measurement tool designed to assess the level of functioning in children and adolescents with emotional, behavioral, or substance use symptoms or disorders (Hodges, 1990).

Clinical Pathways: Standardized, evidenced-based, multidisciplinary management plans, which identify an appropriate sequence of clinical intervention, time frames, milestones and expected outcomes.

Guardian: A person who has temporary or ongoing legal responsibility to care for another person or to manage that person's property and affairs, in whole or in part. Courts appoint guardians to protect the interest of minors or legally incompetent adults.

Individualized Education Plan (IEP): A written statement for an eligible student with an exceptionality that is developed, reviewed and revised in accordance with Policy 2419: Regulations for the Education of Students with Exceptionalities and IDEA 2004. The IEP is a product of collaboration between a parent or adult student and educators who, through full and

equal participation, identify the unique needs of the student with a disability or giftedness and plan the special education and related services to meet those needs. It sets forth in writing a commitment of resources necessary to enable the student to receive needed special education and related services. In addition, the IEP is a management tool that is used to ensure that each eligible student is provided special education and related services appropriate to the student's special learning needs. It serves as an evaluation device for use in determining the extent of the student's progress toward meeting the projected outcomes. The IEP is a compliance/monitoring document that may be used by authorized monitoring personnel from each governmental level to determine whether an eligible student is actually receiving the free appropriate public education agreed to by the parents and the school.

Interdisciplinary Team (IDT): Team intervention or collaboration on behalf of a specific client or client system, which involves members of various professions or disciplines who develop an individualized plan for the treatment and discharge of each member. The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible. Discharge planning begins on admission and is carried through on the initial treatment plan and each revision of the plan during the entire stay of the West Virginia Medicaid member.

Interstate Compact on the Placement of Children (ICPC): The Compact is a uniform law that has been enacted by all 50 states, the District of Columbia, and the U.S. Virgin Islands. It establishes orderly procedures for the interstate placement of children and fixes responsibility for those involved in placing the child. The Compact law contains 10 articles. They define the types of placements and placers subject to the law; the procedures to be followed in making an interstate placement; and the specific protections, services, and requirements brought by enactment of the law.

Loco Parentis: Latin word meaning, "in the place of a parent" or "instead of a parent". Refers to the legal responsibility of an adult or institution assuming the relationship toward an infant or minor of whom the adult is not a parent, but to whom the adult or institution owes the obligation of care and supervision of making legal decisions. It refers to an individual who assumes parental status and responsibilities for another individual, usually a young person, without formally adopting that person.

Milieu Therapy: A form of treatment and rehabilitation for people with social and mental disorders who usually live in institutional settings. Treatment is not restricted to individual hours with a professional therapist but also occurs in the total environment of this closed setting, which is also referred to as the "therapeutic community." Those being treated attend group sessions for everyone in the facility, elect their own leaders and provide one another with social and emotional support throughout the day. The entire environment is considered vital to the treatment process.

Multidisciplinary Treatment Team (MDT): A group of individuals from different disciplines who work together to:

- Access, plan and implement a comprehensive individualized service plan for a child involved in a court proceeding either because of abuse/neglect or status or juvenile

delinquency proceedings
- Work with a child and family to develop a service plan and coordinate services

Be the central point for decision making during the child's stay at the PRTF.

MCM-1: A form developed and used by the BMS to meet Federal Regulation (42 CFR) Subpart D, Inpatient Psychiatric Services for Individuals Under the Age of 21 in Psychiatric Facilities or Programs, Section §441.151. General Requirements, Inpatient psychiatric services for individuals under age 21, must be certified in writing to be necessary in the setting in which the services will be provided. The West Virginia Medicaid Program utilizes the MCM-1 to meet the requirements for certification of inpatient services in the Medicaid-approved psychiatric facility for individuals under the age of 21 years. The MCM-1 must be certified by an independent team that includes a physician, has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and has knowledge of the individual's situation.

Non-Custodial Placement: The placement of a child into a PRTF by physician order utilizing the West Virginia Medicaid Card as reimbursement for services provided the child. The attending physician/psychiatrist must provide documentation of treatment and lack of response to treatment. The physician/psychiatrist must certify the need for this level of service and complete and sign the MCM-1. The parent retains legal custody and financial responsibility for expenses related to treatment, supervision, room and board, education, etc. not covered by medical insurance/Medicaid. Non-custodial placements must meet all eligibility requirements for this level of care.

Variance: A written declaration by the Secretary that a certain requirement of this rule may be satisfied in a manner different from that set forth in the rule.

Waiver: A written declaration by the Secretary that a certain requirement may be treated as inapplicable in a particular circumstance.

531.2 PROVIDER PARTICIPATION REQUIREMENTS

To be certified as a PRTF, the facility must attest to meeting the Conditions of Participation (CoP) found in 42 CFR Subpart A, Definitions §440.160, Subpart D-Inpatient Psychiatric Services for individuals under age 21 in Psychiatric Facilities or Programs, §441.150 - §441.182, Subpart G, Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21, §483.350 - §483.376.

Each PRTF that provides inpatient psychiatric services to individuals under age 21 must attest, in writing that the facility is in compliance with CMS' standards governing the use of restraint and seclusion. This attestation must be signed by the Facility Director. A facility with a current provider agreement with West Virginia Medicaid must provide that attestation to BMS at the time of enrollment and yearly by July 21, or upon a change in the Facility Director. (42 CFR §483.374)

Providers of PRTF services will receive a reminder to submit the attestation letter to BMS' fiscal agent 90 days prior to the July 21 each year. Facilities failing to submit the attestation letter will be considered in non-compliance and will be subject to withholding payment until the facility is in compliance.

In order to participate in the West Virginia Medicaid program for reimbursement of covered services provided to West Virginia Medicaid members, PRTF services must be approved through BMS' fiscal agent contract enrollment process **prior** to billing for any services. *Common Chapter 300, Provider Participation Requirements* (see www.dhhr.wv.gov/bms) presents an overview of the minimum requirements that health care providers must meet to enroll in and be reimbursed by the West Virginia Medicaid Program.

All providers are required to meet eligibility requirements. In addition to the licensing and certification requirements, all PRTF's must maintain good standing with the West Virginia Bureau for Medical Services, the West Virginia Bureau for Children and Families (BCF), and the West Virginia Department of Education, (DOE) in order to continue to participate as a West Virginia Medicaid provider. The Bureau for Medical Services requires that all educational instruction for West Virginia Medicaid members meet West Virginia standards, unless the standards are higher in the state where the PRTF is located. West Virginia is the final arbitrator of whether the treatment services or educational standards are sufficient for West Virginia Medicaid members. Failure to remain in good standing with the BCF and/or DOE resulting in admission restrictions by BCF will result in admission restrictions by the Bureau for Medical Services. If the state agency licensing the facility places admission restrictions on the PRTF facility as a result of a negative review of services, the West Virginia Bureau for Medical Services will place admission restrictions on the facility until the negative action is corrected and BCF/BMS is notified by the licensing agency that the admission restrictions have been lifted.

All providers are required to sign/date a West Virginia Medicaid Provider Agreement. Additionally an agreement specific to psychiatric residential treatment services must be signed/dated by the Administrator. This agreement may be renewed at BMS' discretion and is subject to the terms and conditions contained therein and all applicable state and federal law and regulations.

The goal for WVDHHR is for all children to be served within the state. Out-of-state facility applications for enrollment with West Virginia Medicaid will be considered **ONLY** if a child in DHHR custody requires this level of service and the service is not available to meet the child's needs in West Virginia.

531.2.1 Physical Environment/Equipment

The facility must be housed, equipped, and maintained in a manner that is suited to the program of services being provided and that reflects the facility's positive regard for its members. The physical environment must be consistent with contemporary, accepted concepts of service and care and is one that enhances individual dignity and feelings of self-worth for the members served.

Bedrooms must be adequately furnished and provide a minimum of 80 square feet of floor space per person for one person occupancy and a minimum of 60 square feet of floor space per person for two or more person occupancy. Each member of a facility shall be provided a permanent, separate bed with a clean, comfortable, covered mattress, clean bedding, clean towels and other furnishings appropriate to the length of stay and needs of the member. Each bedroom window must have covering for privacy. Furnishings shall be homelike and personalized.

The facility must allocate sufficient space and safe and varied equipment for outdoor play to meet the member's recreational needs.

Offices or rooms must be available and accommodating to personnel to engage in interviewing or counseling families and children in a private and confidential manner.

531.2.2 Non-Discrimination

The facility must assure that no person shall be excluded from participation, denied benefits, or otherwise subjected to discrimination in the performance of the services or in employment practices on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, West Virginia State Constitutional, or statutory law.

- Written facility policy must assure that the need for the facility's services are the primary criterion of eligibility and its services are offered without discrimination.
- The facility must have a written equal opportunity policy that clearly states its practices in recruitment, employment, transfer and promotion of employees.
- The facility must actively recruit, employ, and promote qualified personnel broadly representative of the community it serves and administer its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, disability, or religion of the individual under consideration.
- The facility provides for internal and external dissemination of its equal opportunity policy and recruitment materials that specify the nondiscriminatory nature of the facility's employment practices.
- If the facility recruits and selects with regard to specific characteristics, it does so with the needs of the facility's defined clientele in mind and in accord with exemptions in the law(s) governing equal opportunity employment.
- The facility shall show proof of nondiscrimination and post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- The facility is free of those architectural barriers that restrict the employment of or use by personnel with disabilities. Likewise, the facility is free of architectural barriers that restrict use by the aged, families with young children, and persons with disabilities and/or makes provision for use of accessible facilities in order to provide services to persons with disabilities.

A copy of the Resident's Rights and Responsibilities is visibly displayed in the facility. At time of admission the West Virginia Medicaid member and the parent/guardian must be provided with a

clearly written and readable statement of rights and responsibilities. The statement must be read to the resident or parent/guardian if either cannot read.

531.2.3 Staffing Requirements

PRTF's participating in the West Virginia Medicaid program are required to have the following staff:

1. Facility Director: The governing body of the PRTF must appoint a Facility Director to be responsible for the overall management of the facility. The Facility Director must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The Facility Director is responsible for the fiscal and administrative support of the facility's clinical program.
2. Medical Director: The facility must appoint a medical director to be responsible for coordinating medical services and directing member treatment. The medical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.
3. Clinical Director: The facility must appoint a full-time director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry), a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, a licensed psychologist who is experienced in child/adolescent mental health treatment, a psychiatric mental health nurse practitioner (PMHNP)/advanced practice registered nurse (APRN) who is experienced in child/adolescent mental health treatment, or a Licensed Professional Counselor (LPC), a Marriage and Family Therapist (MFT) or a licensed certified social worker who is experienced in child/adolescent mental health treatment.
   A board eligible or board-certified psychiatrist with experience in child/adolescent psychiatry (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) may serve as both medical director and clinical director provided that he/she is a full-time employee.
4. Professional staff: The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate residential supervision 24 hours a day, seven days a week. Professional staff must be appropriately licensed, trained, and experienced in providing mental health and residential treatment.

The mental health treatment team must include at a minimum the following:

- A Board-eligible or Board-certified Psychiatrist (experienced in child/adolescent psychiatry);
- A Licensed Psychologist; (as indicated by needs of child)
- A Registered Nurse(s);
- A Psychiatric social worker(s), LPC;
- A Certified Teacher(s); and,

- An Occupational/Physical/Speech Therapist (as indicated by needs of child).

The PRTF must notify BMS of changes in the facility director, medical director or clinical director. The Director of Facility Based & Residential Care at BMS must receive notification via the signed/dated Attestation Letter from the facility, in writing within 72 hours of the effective change.

Attestation Letters must be mailed to BMS, Attention: Office Director, for Facility Based and Residential Care.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

The staffing ratio for a PRTF shall be one staff to three members (1:3) during day and evening hours (one staff whose primary responsibility is providing direct care for every three children) and (1:6) during sleep hours with the capability to increase staff ratio in response to acuity, extending to the provision of one-on-one (1:1) care when necessary. (78 CSR §3.22.3 Staffing) Staff assigned to work a defined unit and providing care to the children on that unit including nursing, teachers, and activity's therapists can be included in the staff to client ratio. Staff assigned to supervisory duties or whose duties cause them to be away from the unit (nursing supervisor) cannot be included in the count.

531.2.4 Criminal Investigation Background Check

West Virginia Code, Chapter 49 (Child Welfare), Article 2B, Section 8 requires a criminal background check of personnel criminal records for licensed, certified and registered child welfare agencies. The Adoption and Safe Families Act requires criminal background checks on all individuals and agency staff providing care for foster children.

A thorough Criminal Investigation Background Check (CIB) including fingerprinting and review by a Federal Registry is required with results of an on-line preliminary check available for review **PRIOR** to employment of any individual (including volunteers) who will be working in a facility providing treatment or care for **all** West Virginia Medicaid members (custodial and non-custodial). The on-line preliminary results may be used for a period of three months (90 days) while awaiting the final results of fingerprinting. During that time period the individual may **not** work unsupervised. Results of the CIB must be documented in the personnel file **within three months (90 days)** of hiring the employee. (Refer to requirements listed below regarding exclusions/sex offender registries lists which must be completed with a negative result prior to hiring or allowing to volunteer.) An applicant must complete a Statement of Criminal Record every two years after the initial submission to the respective agency or department. A subsequent CIB check must be completed at least every five years, but may be submitted at any point if there is an indication that the CIB information may have changed.

The applicant shall not be approved, employed, utilized nor considered for employment if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, malicious wounding, unlawful wounding, felonious domestic assault or battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Misdemeanor domestic battery or domestic assault;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Health care fraud;
- The applicant shall not be approved or employed if on parole or probation for a felony conviction.

It is the responsibility of the employer to assure that the exclusions are checked and may be beneficial to check the exclusions list monthly. Providers must check the list of excluded individuals/entities:

- (LEIE) at: http://exclusions.oig.hhs.gov/; https://www.epls.gov; and West Virginia's state police offender registry at www.statepolice.wv.gov
- National Practitioner data bank at: http://www.npdb-hipdb.hrsa.gov/

Providers must check sex offender registries for the home state and surrounding states to ensure the potential employee/volunteer is not listed. Results of this check must be present in the employee/volunteer personnel file and available for review upon request.

The following list is not all inclusive, each facility must determine those states that will be necessary to check to ensure that an appropriate check has been completed. The facility assumes all responsibility for the safety of each child.

Ohio's sex offender registry is at www.drc.ohio.gov

Kentucky's sex offender registry is at http://kspsor.state.ky.us/sor/html/SORSearch.htm
Virginia's sex offender registry is at http://sex-offender.vsp.virginia.gov/sor/
Maryland's sex offender registry is at www.dpscs.state.md.us
Pennsylvania's sex offender registry is at http://www.pameganslaw.state.pa.us/

Current federal requirements state that all states must check for exclusions. Central data bases will be created. Please check the BMS website at www.dhhr.wv.gov/bms for updates.

531.2.5 Staff Training

A PRTF facility that contracts with DHHR ensures that qualified personnel meet or exceed the requirements for pre-service and in-services trainings with respect to facility objectives, policies, services, community resources, DHHR policies, and best practice standards. All direct care staff shall have a minimum of a high school diploma or GED and professional staff shall have appropriate education and certification consistent with professional licensing standards. (78 CSR 3 22.4.a. Staff Training and Credentials)

The facility is required to document evidence of the participation/completion of all employee training and retain in each personnel record the required new worker orientation and annual in-service training, as well as any in-service training provided by the facility during the year. Facilities will provide proof by individual employee records that training requirements are fulfilled. Review of those records will occur during monitoring both by the UMC retrospective reviews and the Certification Review Process as well as review by the Office of Quality and Program Integrity (OQPI). Personnel records must reflect the date of training, number of training hours, and the signature of the participant.

In addition, the facility will keep a log/calendar of ongoing training that includes the title of the training, the type of training (video/lecture/lab), dates of training, location of training, sign-in sheets, subject matter, name, phone number, credentials of the instructor and any reviews by employees.

All training is to be provided by licensed or certified professional staff, or an agency qualified trainer. Video, audio, and on-line or web based trainings are restricted to no more than 50% annually for each employee. Training which includes live lecture must also contain demonstration and the active participation of employees. Training attendees are expected to attend training for the entire session. The log on training is to be kept by the facility for a period of five years.

531.2.6 Direct Care Staff, Case Manager, and All Clinical Staff:

Personnel development is an ongoing, integral, and identifiable part of the facility's program of services, and the facility has specific guidelines as to the time commitment expected of personnel in various positions. Pre-Service Training including all of the following that demonstrates training sessions last at a minimum eight and one-half hours excluding first aid and CPR training which are prescriptive in nature with specific training criteria.
The following pre-service training is required:

All personnel are required to have pre-service and annual in-service trainings in the following topics.

- All appropriate/applicable facility policies
- Conflict resolution
- Member rights
- Managing behavior
- Psychiatric emergencies
- First aid (All staff having direct contact with West Virginia members must receive training in first aid.).
- CPR (facility staff member must be immediately available who has been trained in CPR.)
- Incident reporting/completion/follow up
- Recognition of substance abuse
- Elopement procedure/reporting
- Child abuse prevention/reporting
- Suicide prevention
- HIPAA/Confidentiality
- Emergency/Disaster Preparedness
- Infection Control
- Sexual harassment including prevention
- Cultural awareness
- De-escalation procedures

All training sessions must include both lecture and active participation (return demonstration) activities for the staff.

All policy on de-escalation, restraint, seclusion, CPR certification and requirements must be readily available to all staff 24 hours a day, seven days a week. The facility shall post in a centralized location the name of at least one person who is on-duty with proper CPR certification for the use of all staff at all times West Virginia Medicaid members are in the facility. Evidence of current certification in CPR must be maintained and available upon request.

All staff utilizing or monitoring restraints must do so as required under federal regulations. Such staff shall be CPR certified and fully trained and certified in nationally recognized physical restraint methods. Facility policy regarding Restrain/Seclusion must be readily available to all staff 24 hours a day, seven days a week.) (See also the section of this manual on Special Procedures/Restraint Seclusion, 531.10)

531.2.7 Confidentiality

- Strict standards of confidentiality of medical records and information must be maintained in accordance with applicable state and federal law.
- The facility must have written policies and procedures governing access to, use of, and release of all information about its members, and assures that such policies meet any

applicable legal requirements. Written policies must be approved by the governing board and must specify the responsibility of all personnel for maintaining confidentiality of information contained in member and personnel records.

- Access to medical records is limited to the member, the parent or legal guardian (when the West Virginia member is a minor), authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.
- A release of information form must be obtained and approved prior to sharing information in any situation other than that described above.
- A West Virginia member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need to know basis and as permitted under federal and state law and any relevant court rulings.
- Pictures of West Virginia Medicaid members are to be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays or for promotional materials, are prohibited.
- All West Virginia Medicaid member information is kept locked in a secure place.

531.2.8 HIPAA Regulation

1. Providers must comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all corresponding federal regulations and rules.
2. The enrolled provider will provide upon request of BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of BMS.
3. Additional information on HIPAA may be found in *Common Chapter 300, Provider Participation Requirements* and at http://www.dhhr.wv.gov/bms.

531.2.9 Emergency/Disaster Preparedness Procedure

The facility's governing body/designee must establish written procedures for personnel to follow in an emergency/disaster. Evacuation of a facility may become necessary in the event of an emergency/disaster (e.g., fire, smoke, bomb threat, explosion, prolonged power failure, structural damage, water loss or sewer loss, tornado, flood, earthquake, chemical leak, chemical spill, or elopement. This is not an all-inclusive list of emergency/disasters). The facility's emergency/disaster care procedures must include at a minimum:

- Care of the child;
- Notification of the attending physician, EMS, law enforcement, parent/guardian and other persons responsible for the West Virginia Medicaid member;
- Arrangements for transportation;
- Arrangements for hospitalization;

- Arrangements for other appropriate services;
- Arrangements for emergency physician services; and,
- An elopement plan.
- An evacuation plan

The facility's governing body/designee must ensure staff rehearses, at a minimum of annually, the facility's emergency, disaster plans. Fire drills must be conducted as required by the state where the facility is located.

531.2.10 Parental Involvement

1. Services are provided to children in order to meet their permanency needs. Each West Virginia Medicaid member served is;
   a. prepared for a placement outside the home and helped with conflicts about the placement and separation from family members;
   b. encouraged to maintain contact with the biological family and provided with support in making such arrangements, unless specifically contraindicated because of the child's safety;
   c. provided information about parents activities and progress toward the goal of returning home, unless the home is not a possibility;
   d. provided with assistance in maintaining the relationship with siblings through visits and shared activities; and
   e. prepared for the return home, adoption, or for placement in a stable, nurturing environment that is to be permanent, and when this in not possible;
   f. prepared for independent living and helped to identify a significant adult with whom a relationship can be maintained.
2. As appropriate, the PRTF facility should involve the family and/or other individuals identified in the permanency plan as permanency options. Permanency is the primary goal for discharge.
3. As permitted under the law and as appropriate for the child's safety and well-being, the facility shall make efforts to engage the parents in continuing contact with their child and implementing the plans for permanency for the child. Such contact shall include participation in developing case plans, updating the parents on progress and inviting the parents to all case conferences.
4. When in the best interests of the child, the facility designs and implements service in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles.
5. When appropriate, a written plan of family involvement shall be developed at intake and updated no less than quarterly. The plan of family involvement will address but not be limited to the following issues:
   - visitation guidelines and/or restrictions;
   - facility responsibility for working with the family;
   - the state agency's (BCF) responsibilities for working with the family;
   - any other appropriate issues.
6. The facility must provide coordination of social services to children, adults, and families as needed. The goals of such services may include family reunification, to stabilize

family ties, or to obtain a permanent family for a child receiving services in the PRTF facility.

7. Services are to be provided to the child and family to enable them to plan for the child's return home or, if a return home is not indicated, for a permanent nurturing family for the child.
8. Services must be provided to help the child's parents maintain and enhance parental functioning—parental care, the maintenance of parental ties, or, when in the best interest of the child, termination of parental rights.

531.2.11 Incident/Accident Reporting and Policy

PRTF's are required to maintain a written Incident/Accident Reporting Policy in a centralized location for easy access to all staff personnel. The written policy must be approved by the governing body of the facility.

The facility accepting/admitting West Virginia Medicaid members for care must ensure that they are cared for in an environment which meets high standards of safety and maintenance and that special precautions are taken that no harm or injury to the member occurs. The facility promptly reports to appropriate state and/or legal authorities any serious accident, emergency, or dangerous situation, including immediate verbal reporting of instances of child abuse, and reports to parents or legal guardians any of the above which affect their child or the child for which they are responsible. The PRTF must **verbally** report to the parent/legal guardian any accident or incident involving a child which results in injury within 24 hours of the facility's knowledge of the accident or incident. The PRTF must verbally report suspected abuse or neglect of a child to the parent/guardian and the appropriate authorities in the state where the facility is located within 24 hours of the facility's knowledge of its occurrence with a detailed written report within five days. The PRTF must verbally report the findings of abuse and neglect investigations conducted by the state where the facility is located within 24 hours of completion of the investigation, with a detailed written report within five days.

Incident/Accident reports will be forwarded the following business day to BMS, Attention: Office Director, for Facility Based and Residential Care. Reports may be mailed to:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office Director, Facility Based & Residential Care
350 Capitol Street, Room 251
Charleston, West Virginia 25301

Serious injury of a West Virginia Medicaid member is defined as any significant impairment of the physical condition of the member as determined by qualified medical personnel. This includes, but is not limited to:

- Burns, lacerations, substantial hematoma requiring medical intervention by a licensed physician.
- Bone fractures

- Injuries to internal organs, whether self-inflicted or inflicted by someone else
- Suicide attempt
- Elopement (see also 531.7.2 Elopements/Run Away)
- Any allegations of sexual contact (member/member, member/staff)
- Any allegation of abuse and/or neglect
- Any injury of a member while in seclusion or restraint (See also 531.10 Special Procedures Restraint/Seclusion)
- Medication errors requiring medical intervention by a licensed physician.

A death of ANY member or a serious incident involving harm to ANY member, regardless of whether they are a West Virginia Medicaid member or not, must be reported as follows:

- Immediately upon death (within eight hours) a phone call must be made to BMS at (304) 558-1700. If the death is that of a West Virginia Medicaid member, staff must identify the name of the member and a narrative description of the incident. If the death is not a West Virginia Medicaid member, the caller must provide sufficient details that will permit review of the incident.
- Within 24 hours, facility staff must fax a written report to BMS at (304) 558-1542.
- Immediately notify local law enforcement of the incident.

Reports may be faxed to the Bureau for Medical Services at (304) 558-1542, Attention: Director, Office of Facility Based and Residential Care.

531.2.12 Quality Assurance/Utilization Review

1. The facility must have an ongoing quality assurance program in which each service of the facility and service to individual members is reviewed quarterly and monitored in order to promote the highest quality service, to resolve problems that are identified, and to assure that services meet the facility's expectations as to outcome.
2. The overall scope of the quality assurance program is described in a written plan that describes mechanisms, committees, or other methods used to coordinate the facility's approach to monitoring and evaluating the quality and appropriateness of service.
3. The facility must set goals and objectives for the benefits or outcomes to be achieved by members who use the facility services, and on a regular basis the facility conducts member satisfaction surveys or utilizes other methods of determining the outcome of its services, including the reasons for termination of members who drop out of service, to the extent this can be ascertained.
4. The facility must monitor the quality of care and review the appropriateness of service at least quarterly.
5. The facility must have a utilization review or other quality assurance mechanisms that ensures that the cases of all members are formally reviewed on a quarterly basis.

    - The facility must participate in utilization reviews at least every 30 days. Utilization reviews are to include the Bureau's Utilization Management Contractor (UMC) representatives to evaluate the necessity, appropriateness, quality, and intensity of individual member services to

facilitate permanency and less restrictive service delivery as soon as possible. The utilization review focuses on appropriateness and effectiveness of member services, and reduction of length of stay in out-of-home care. Documented, measurable criteria are utilized in the review process, extended treatment or service, changes in status or level of need presented by the member, and/or other criteria developed by the facility. Retrospective review of prior authorization requests and relevant clinical information will be conducted on and off site by the UMC. Requested information will be provided for reviews.

6. The facility cooperates with authorized external review systems (including the Bureau's Utilization Management Contractor (UMC), the Bureau for Children and Families (BCF), and the West Virginia Department of Education (DOE)), and, where applicable and where possible, organizes its internal review schedules to complement those conducted by external review systems.

531.2.13 Out-of-State Certification/Review Process

West Virginia Code 49-7-34 establishes the Commission to Study Residential Placement of Children. The Commission has been actively involved in carrying out their responsibilities since 2005. The Commission was to study and provide recommendations regarding:

- Current practices of placing children out-of-home and into residential placements, with special emphasis on out-of-state placements and,
- ways to certify out-of-state providers to ensure that children receive high quality services consistent with this state's (West Virginia) standards of licensure and rules of operation.

As a result of their work, recommendations currently being implemented include:

- Requirements that out-of-state placements be made **only** to providers meeting West Virginia standards of licensure, certifications, and expected rules of operation.
- Requirements that ensure education standards are in place and students are fully receiving the appropriate education services in all out-of-state facilities where West Virginia children are placed.

The West Virginia DHHR through BCF, BMS, and the West Virginia DOE through the Office of Institutional Education Programs (OIEP) and the Office of Special Programs (OSP) have engaged in a collaborative effort to evaluate and monitor the quality of services provided by out-of-state facilities. This is to ensure children are in a safe environment and are provided behavioral health treatment and educational services commensurate with acceptable standards as set forth by West Virginia DHHR and the West Virginia DOE.

The Team representing West Virginia DHHR and West Virginia DOE will conduct on-site reviews of facilities out-of-state that are providing services for West Virginia children. Focus will be on **all** West Virginia Medicaid members. West Virginia's ultimate goal is to solicit services

from only facilities having demonstrated success in promoting positive growth and expected outcomes for children as defined within the West Virginia Out-of-State Facilities Standards.

When BMS has identified unnecessary and inappropriate practices through monitoring or other reviews, it may pursue one or more of the following:

- Recoupment of inappropriately paid monies;
- Requirement of a satisfactory written plan of correction;
- Limited participation in the plan that may include:
  - Prior authorization for all services;
  - Prepayment review of all applicable claims;
  - Suspension of payment until a plan of correction is filed and accepted;
  - Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
  - Ban on approving admissions for inpatient services.

When deficiencies are identified within the facility that constitute an immediate danger of serious harm to the child/children served by the facility, immediate action will be taken to remove the child/children from harm. That state's surveying agency will be notified immediately of the immediate jeopardy.

In those instances BMS may pursue exclusion from participation in the West Virginia Medicaid Program through the following actions:

- Suspension;
- Disenrollment;
- Denial, non-renewal, or termination of provider agreements.

Refer to *Common Chapter 800.6.1, General Administration,* for details regarding compliance issues.

513.2.14 Corrective Action Plans

Within ten working days after receipt of the request for a plan of correction, the organization shall submit to the Secretary for approval a written plan to correct all areas of non-compliances that are in violation of this rule, unless a variance is requested by the organization and granted by the Secretary. The plan shall specify:

- Any action taken or procedures proposed to correct the areas of non-compliance and prevent their reoccurrence;
- The date or projected date of completion of each action taken or to be taken; and
- The signature of the chief executive officer or his or her designee.
- The Secretary shall approve, modify or reject the proposed Corrective Action Plan in writing. The organization may make modifications in conjunction with the Secretary.
- The Secretary shall state the reasons for rejection or modification of any Corrective Action Plan.

- The organization shall submit a revised Corrective Action Plan within ten working days whenever the Secretary rejects a Corrective Action Plan.
- The organization shall immediately correct an area of non-compliance that risks the health or safety of child or other persons.
- The Secretary may determine if corrections have been made.

531.2.15 Waivers and Variances

A center shall comply with the provisions of West Virginia Code §49-2B-1 et seq., the requirements of this rule, terms of the license or certificate of approval and any plan of correction, unless a written waiver or variance has been granted by the Secretary. A center may not obtain a waiver of the requirements of this rule on the basis of the inability to achieve compliance with the rule.

A request for a variance shall be submitted to the Secretary in writing. The request shall include:

- The specific requirement of this rule to be waived or varied: and
- The reason or reasons for seeking a waiver or variance.

A waiver or variance of a specific provision of this rule may be granted by the Secretary only if the following criteria are met:

- The center has documented and demonstrated that the provision of the rule is inapplicable in a particular circumstance, or that the center complies with the intent of the provision in the rule in a manner not permitted by the rule;
- The health, safety, and well-being of a child is not endangered; and
- The waiver or variance agreement contains provisions for a regular review of the waiver or variance;

The waiver or variance agreement is subject to immediate cancellation if the center fails to comply with the stated terms of this rule.

531.2.16 Notice To BMS and Legal Guardian/Parent of Adverse Action

PRTF's are required to inform BMS within 72 hours of all deficiencies noted by any state educational institution, certification institution, surveying agency, licensing agency or any other state certification entity. Deficiencies include standard and complaint investigations. The written notification and a copy of any notice, survey or complaint may be sent to, Attention: Office Director, for Facility Based and Residential Care. Reports may be mailed to:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

Once a plan of correction has been accepted by the state educational institution, certification institution, surveying agency, licensing or certifying agency, it must be sent to the above address immediately.

When there is an adverse review of a facility that identifies moderate potential for harm or direct harm, termination of certification or a provider agreement, the facility must notify all West Virginia Medicaid members legal guardian/parent by regular mail within 72 hours of receipt of the deficiencies or termination notice. A copy of the letter of notification must be included in the West Virginia Medicaid member record.

531.2.17 Infection Control

The facility must have in place policy and procedures approved by the governing board that address:

a. Infection control policies and practices (e.g. **hand washing**, glove use, isolation procedures, and outbreak precautions).
b. The potential for the spread of infection in bathrooms, bedding, food preparation areas, prevention of the spread of preventative infection control practices including; infectious diseases including antibiotic resistant strains of bacteria, Cabapenem Resistant Klebsilla Pneumoniae (CRPK), Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcl (VRE), Clostridium Difficile (C Diff), eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, nosocomial infection, etc.
c. Locked storage of cleaning supplies and hazardous materials, including medication in a safe locked location, with all controlled medications under double locks.
d. Maintenance of a hazard-free environment in facilities through a daily log of all refrigerator temperatures and water temperatures, covering electric outlets, securing floor covering or equipment, and reviewing the adequacy of lighting and ventilation.
e. Policies and Procedures for the use of personal protective equipment (PPE)
f. Policies and Procedures concerning the cleaning of blood spills, Biohazards
g. Policies and Procedures to cover safety measures when physical injuries occur.

531.3 MEDICAL ELIGIBILITY/MEDICAL NECESSITY

The West Virginia DHHR, BMS, utilizes a Utilization Management Contractor (UMC) to certify West Virginia Medicaid member medical necessity for admission and continued stays in all PRTF's. BMS is not financially responsible for reimbursement of a West Virginia Medicaid member who is not prior authorized for admission or continued stays in any facility by the UMC. The facility may not bill the West Virginia Medicaid member for any charges unless it is specifically documented, signed and dated that the parent/guardian is made aware and understands that West Virginia Medicaid will not reimburse for the service and the parent/guardian understands and agrees to pay for services.

PRTFs provide treatment to individuals under the age of 21 with severe emotional disturbances and/or long term psychiatric illnesses. The service must be provided before the individual reaches 21 years of age. If the individual was receiving services immediately before he or she reaches age 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches 22 years of age. (42 CFR §441.151(3)(i)(ii))

Children in parental custody are referred to as non-custodial placements. When parents place their child in a PRTF, documentation must indicate the child has been receiving services in the community for at least **six months** with significant functional deficits in the school, home and community. except as a planned step down from acute care. Participation in the treatment process by the child and support for treatment by the parent must be documented and provided upon request for the prior authorization for services. The referring physician/psychiatrist, not affiliated with the receiving facility, must provide documentation of treatment and/or lack of response to treatment. The referring physician/psychiatrist, not affiliated with the receiving facility, must certify the need for this level of service and complete, sign and date the MCM-1. The parent retains legal custody and financial responsibility for expenses related to treatment, supervision, room and board, education, etc. not covered by medical insurance/Medicaid. The child must meet all other admission criteria set forth for PRTF level of care also (see admission criteria).

531.4 SERVICE PROVISION

PRTFs provide a range of comprehensive services to treat the psychiatric condition of members on an inpatient basis under the direction/order of a physician/licensed psychiatrist. The purpose of such comprehensive services is to provide treatment to individuals under age 21 with severe emotional disturbances and/or long term psychiatric illnesses. Symptoms are complex and of a significant duration, that have not responded to shorter-term interventions and/or community based interventions. Psychiatric care is provided to individuals under the age of 21 that do not require acute psychiatric care, but whose immediate treatment needs require active treatment on a 24 hour inpatient basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. PRTF services are generally short term (nine to twelve months) inpatient services intended to improve the West Virginia Medicaid member's condition or prevent further regression so that the services will no longer be needed. A PRTF is to provide a less medically intensive program of treatment than a psychiatric inpatient hospital or a psychiatric unit of a general hospital could provide, and must include an on grounds educational component that provides a continuum of the West Virginia Medicaid member's current grade level.

All services must be delivered under the direction and orders of a physician or a licensed psychiatrist. PRTF services focus on the improvement of West Virginia Medicaid member's symptoms through the use of strength and evidence-based strategies which include:

- group and individual therapy
- family therapy
- behavior management
- medication management and medication monitoring
- active family engagement

Services are designed to improve and/or ameliorate the West Virginia Medicaid member's mental health or co-occurring mental health and substance abuse condition. (See admission Criteria 531.4.2)

531.4.1 Admission

An admission occurs upon the formal acceptance by an enrolled PRTF of a West Virginia Medicaid member who has been prior authorized for admission by the West Virginia Medicaid program UMC. The day of admission is considered a day of care; the day of discharge is not considered a day of care.

PRTF services are appropriate when a West Virginia Medicaid member does not require emergency or acute psychiatric care but does require nursing supervision and meet medical necessity for treatment on a 24 hour basis. A board certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges at the PRTF must order and provide oversight for each admission.

PRTF admissions are planned and **not** an emergency admission. Admissions after 5 p.m. on Friday or on holidays require prior authorization for reimbursement for services **prior** to placement.

Facilities accepting West Virginia Medicaid members into treatment are permitted to accept children within age groups defined by their licensing entity. When accepting West Virginia Medicaid members under age 12, the facility must provide, at time of enrollment application, documentation regarding the ability to provide increased staffing, depending on the acuity of the child, this may be 1 on 1 staffing, etc. to provide for the younger child as well as the policy standards that address therapy, milieu effects, and supervision to ensure the prevention of the child being targeted for abuse. Facilities serving younger children must provide groupings for the child that will provide for "separation according to developmental functioning, sex, social skills, group dynamics, and other variables if appropriate and necessary. Children have the right to be housed with children of the same approximate ages, developmental levels and social needs. This separation must be a matter of organizational policy." (78CSR3 14.12.b) The facility must also describe their process to provide educational requirements necessary to serve the younger child.

West Virginia Medicaid members under the age **nine** are not to be placed in an out-of-state PRTF unless there is documentation provided indicating this is the only alternative available for the child because alternative resources have been explored and are not available in state and if the placement is not made the safety/well-being of the child is at risk.

For each West Virginia Medicaid member admitted to a PRTF facility a MCM-1 must be completed by the referring physician, with no affiliation to the receiving facility, certifying the need for this level of care. A copy of the MCM-1 must be submitted to the UMC along with a request for authorization for admission to the facility. The original signed/dated MCM-1 must be

part of the West Virginia Medicaid member record at the receiving facility and must be available for review immediately upon request. The signed/dated MCM-1 is effective for a period of 30 days prior to the request for prior authorization for admission. If prior authorization is not requested within 30 days of the physician's signature and date, a new MCM-1 will be required for prior authorization for admission. Prior authorization for admission to the PRTF is effective for 10 days. If the child is not placed within the facility within the 10 day period, a new authorization is required. Children entering care utilizing private medical insurance with the prospect of obtaining a West Virginia Medical Card for reimbursement after the insurance has expired are required to have an MCM-1 signed prior to admission to the facility.

The UMC reviews all requests for admission to and continued stay requests in all approved and enrolled PRTF's. The role of the UMC is to determine the medical necessity of PRTF services for child/adolescent members with psychiatric diagnoses, the appropriateness of a particular PRTF setting for each West Virginia Medicaid member, and the number of days reasonably required to treat a child/adolescent's condition.

The following information must be included in the admission packet:

a. Immunization records (See also 531.5.3 Physical Health Services);
b. Court order(s) if applicable;
c. Birth Certificate;
d. Social Security card;
e. Insurance information/Copy of West Virginia Medical Card;
f. MCM-1; and,
g. School records, including special education records (where applicable);

531.4.2 Admission Criteria

Admission to a PRTF facility requires the West Virginia Medicaid member meet following criteria:

1. West Virginia Medicaid member is under the age of 21 and has a diagnosed DSM IV-TR mental health or a co-occurring mental health and substance abuse condition (42 CFR §456.180 (b)). A diagnosis of substance abuse alone will not constitute medical necessity for an admission to a PRTF, **and,**
2. Severe to acute psychiatric symptoms manifested from the qualifying diagnosis or condition. The severity of these symptoms contraindicate treatment at a lower level of care safely occurring **and,**
3. Severe functional impairment due to psychiatric diagnosis, in three or more major life domains (school performance, family relationships, interpersonal relations, communication/thought processes, self-care and community) is documented. Youth's impairments are determined in comparison to same age peers/developmental age, **and,**
4. Failure in less restrictive levels of care within the past three months, despite active participation in treatment based on clinical pathways addressing their qualifying condition, except as a planned step down from acute care. (Clinical pathways are

standardize, evidenced-based, multidisciplinary management plans, which identify an appropriate sequence of clinical intervention, time frames, milestones and expected outcomes,) **and,**

5. Individual demonstrates the ability capacity to positively respond to treatment services. Child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

When an admission is denied by the PRTF, the facility must notify the referral source of the reason(s) for the denial within 72 hours. The PRTF must keep a log of all denial notifications for review by UMC. If placement is denied because medical necessity is not established, the UMC will notify the referral source, the facility and the parent/guardian of the denial and the appeal process rights. Refer to *Common Chapter 800, General Administration*, for additional information on the appeals process. (www.dhhr.wv.org/bms)

531.4.3 Resident Rights and Responsibilities

Upon admission to the PRTF, staff must provide the West Virginia Medicaid member and parent/guardian with a statement of rights and responsibilities which must cover at a minimum:

- The member's right to access treatment regardless of race, religion, or ethnicity;
- The member's right to recognition and respect of personal dignity in the provision of treatment;
- The member's right to be provided treatment and care in the least restrictive environment possible;
- The member's right to an individualized treatment plan;
- The member and family's right to participate in planning for treatment;
- A description of care, procedures, and treatment the member will receive;
- The member's right to informed consent related to the risks, side effects, and benefits of all medications and treatment procedures used; and
- The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the member refuses treatment.

Discipline measures must be fully explained to each West Virginia Medicaid member and the member's parent/guardian. PRTF's must prohibit all cruel and unusual disciplinary measures including the following:

- Corporal punishment;
- Forced physical exercise;
- Forced fixed body positions;
- Group punishment for individual actions;
- Verbal abuse, ridicule, or humiliation;
- Denial of three balanced meals per day;
- Denial of clothing, shelter, bedding, or personal hygiene needs;
- Denial of access to educational services;

- Denial of visitation, mail, or phone privileges for punishment;
- Exclusion of the West Virginia Medicaid member from his/her assigned living area; and
- The use of restraint or seclusion as a punishment or implemented for the convenience of staff.

531.4.4 Interstate Compact on the Placement of Children (ICPC)

All approved admissions to out-of-state facilities require the completion of Interstate Compact on the Placement of Children (ICPC) **prior** to the placement. In every state, the Compact office and personnel are located in an office that is part of the department of public welfare or the state's equivalent agency. In West Virginia, the Compact Administrator is the Commissioner of BCF. **All** out-of-state placements (DHHR custody and non-custodial placements) into PRTF's require approval prior to placement. Non-custodial placements require a signed/dated Statement of Assurance indicating the parent/guardian retains legal and financial responsibility for the child while in placement. The Statement of Assurance is kept by the ICPC office as part of the ICPC record.

531.4.5 Assessment

The initial assessment contains information concerning the child's initial treatment needs. Information will come from referral packets, intake information, family members, previous placements, and information forwarded in the referral packet.

The assessment process must be initiated within 24 hours of admission. The initial treatment plan completed within 72 hours of admission and will document minimally one primary treatment goal/problem listed on the MCM1. A more comprehensive treatment plan in the first 14 days after admission to a PRTF must document the need for the PRTF level of care by the Multidisciplinary Team (42 CFR §441.155(b)(1)). The assessment process must include, but is not limited to, the following:

- A psychiatric evaluation;
- A medical history and examination (42 CFR §441.155(b)(1));
- A psychosocial assessment which includes a psychological profile, a developmental profile
- A behavioral assessment (42 CFR §441.155(b)(1));
- An assessment of the potential resources of the West Virginia member's family (42 CFR §441.156(b)(2));
- A Child and Adolescent Needs and Strengths (CANS) assessment, or other nationally recognized functional assessment;
- An educational evaluation;
- A nursing assessment;
- A nutritional assessment; and,
- An occupational/physical/speech assessment as indicated.

The facility will maintain a policy to ensure the transfer of educational records, information, and individual support when a West Virginia member enters the PRTF within seven days of admission. The transfer of records from one school to another is vital to proper and prompt placement in a new school system. The facility will obtain and review previous educational records for each student prior to admission to the facility. West Virginia members who require special education services must be identified, and the facility must ensure that those services are provided according to the rules and regulations of the West Virginia Department of Education.

Upon admission, an academic assessment must be administered by a qualified instructor that measures (at a minimum) math, reading, and written expression skills. A nationally recognized vocational assessment must be administered to any student at least 14 years of age who has not been previously assessed.

531.4.6 Treatment Planning

The treatment planning process is a collaborative process through which the members of various disciplines jointly develop a comprehensive, individualized plan for the treatment of each member. The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible. (42 CFR §441.154(b)) The treatment plan process begins within 24 hours of admission with implementation of the initial assessments/interviews defined above. A preliminary treatment plan must be completed within 72 hours of admission and will document minimally one primary treatment goal/problem, the member's treatment schedule, and preliminary treatment goal objectives. A more formalized initial treatment plan must be in developed and implemented no later than 14 days after admission to the facility. The treatment plan document must contain evidence of the member's and his/her parent/guardian's active participation in the treatment planning/review/revision process (42 CFR §441.155(b)(2)). The multidisciplinary treatment team will meet to staff each member and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first 14 days following admission and monthly (30 days) thereafter. The West Virginia Medicaid member will participate to the maximum extent feasible in the development of the treatment plan. Participation (or lack of participation) by the member and the family in the treatment planning process must be documented in the member's record. Repeated failure to participate after attempts to engage must be documented in the member record.

531.4.6.1 Treatment Team Composition

The individual plan of care under (42 CFR §441.155) must be developed by the multidisciplinary team of physicians and other personnel who are employed by, contracted by, or provide services to member's, in the facility.

Based on education and experience, including competence in child psychiatry, the team must be capable of (42 CFR §441.156 (b)):

- Assessing the member's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- Assessing the potential resources of the member's family;
- Setting treatment objectives; and,
- Prescribing therapeutic modalities to achieve the planned objectives.

The mental health treatment team must include at a minimum the following:

- A Board-eligible or Board-certified Psychiatrist (experienced in child/adolescent psychiatry);
- A Licensed Psychologist; (as indicated by needs of child)
- A Registered Nurse(s);
- A Psychiatric social worker(s), LPC;
- A Certified Teacher(s); and,
- An Occupational/Physical/Speech Therapist (as indicated by needs of child).

531.4.6.2 Treatment Plan Development

The treatment plan delineates all aspects of the West Virginia Medicaid member's treatment and includes, at a minimum:

- A multi-axial diagnosis
- An assessment of the member's immediate therapeutic needs (42 CFR §441.156(b)(1))
- An assessment of the member's long-range therapeutic needs (42 CFR§441.156(b)(1)
- An assessment of the members' personal strengths and liabilities (42 CFR §441.156 (b)(1))
- Identification of the clinical problems that are to be the focus of treatment,
- Measurable and realistic treatment goals for each identified problem,
- Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement (42 CFR §441.156(b)(3)),
- Specific treatment modalities and/or strategies that will be employed to reach each objective (42 CFR §441.156(b)(4)), e.g. psychotherapy (individual, family, group), medication, behavior modification programs, etc.
- Special procedures (i.e. those providing for the seclusion or restraint of a West Virginia Medicaid member) must **not** be included in the treatment plan unless justified by evidence (current or historical) of aggressive behavior which cannot be controlled by less restrictive interventions. If special procedures become necessary, the treatment plan must be amended or modified within one working day of the first incident to reflect the use of the least restrictive necessary measures.
- The clinician identified as responsible for each aspect of treatment.
- Identification of goals, objectives and treatment strategies for the family as well as the member, and identification of the clinician responsible for treatment.
- When a continued stay at the facility is needed, it is the responsibility of the member's Multidisciplinary Treatment Team and the Clinical Director to establish that the requirements for a continued stay have been met.

- An individualized discharge plan that includes:
  - Discharge criteria, indicating specific goals to be met, and
  - An estimated discharge target date
- Prior to discharge the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the member. ("at an appropriate time") (42 CFR section §441.155(b)(5)).

The member's treatment plan must include a specific strength-based family integration/reintegration treatment plan when appropriate. It must also include guidelines for family participation while the member is at the facility. These family participant guidelines must contain frequency of family visits, whether visits are supervised, and location of visitations. Family counseling and family visits must **not** be contingent on the West Virginia Medicaid member's behavior.

531.4.6.3 Treatment Plan Review and Revision

The treatment team reviews and revises the treatment plan for each West Virginia Medicaid member as often as necessary to provide optimum treatment but must meet at least once during the first 14 days following admission and monthly (every 30 days) thereafter.

The treatment review team will assess the member's progress in treatment by:

- Documentation of treatment successes/failures (which objectives and/or goals have been achieved and when) and explaining treatment outcomes;
- Documenting changes in the treatment plan as needed (42 CFR section §441.155(c)(2));
- Documentation of the re-assessment of the member's need for continued residential care, as opposed to less restrictive treatment (42 CFR section §441.155(c)(1));
- Documentation of the member's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed.

531.5 ACTIVE TREATMENT

Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, (42 CFR §441.154), described in §441.155 that is;

a) Developed and implemented no later than 14 days after admission;
and
b) Designed to achieve the member's discharge from inpatient status at the earliest possible time.

Active treatment (42 CFR §441.154): The use of the term "treatment" in this manual refers to the active treatment of the West Virginia Medicaid member. Active treatment is a process comprising:

- Multi-disciplinary diagnostic assessment (42 CFR §441.155(b)(1));
- Interdisciplinary treatment planning (42 CFR §441.154);
- Therapeutic intervention (42 CFR §441.155(b)(4));
- Treatment evaluation/revision (42 CFR §441.155(c));
- Discharge/aftercare planning (42 CFR §441.155(b)(5));
- Provision of Educational services in an on grounds school.

531.5.1 Mental Health Services

Psychotherapy is defined as the intentional, face to face interaction (verbal and/or non-verbal encounters) between a mental health professional and a client (an individual, family, or group) in which a therapeutic relationship is established to help resolve symptoms of the member's mental and/or emotional disturbance. It is required that all individual therapy, family therapy and group therapy must be provided by master's level therapists.

Individual therapy is defined as psychotherapy that takes place between a mental health therapist and a member. A minimum of one hour of individual therapy must be provided each week unless its contraindication is documented in the treatment plan. It is required that providers of individual therapy must be a master's level therapist.

Family therapy is defined as psychotherapy that takes place between a mental health therapist and a member's family or guardian, with or without the presence of the member. If a member is in the custody of the Department of Health and Human Services (DHHR), family therapy may also include, DHHR representatives, foster family members acting *in loco parentis*.

Each member's family, guardian, or person acting *in loco parentis* must participate in family therapy at least twice a month unless its contraindication is documented in the treatment plan. If the Medicaid member's family is more than a two hour drive from the PRTF, one face-to-face family therapy session and one therapeutic conference call will be acceptable. Both of these contacts must be therapeutic in nature, (i.e. to discuss the member's functioning, treatment progress, goals and objectives). Social visits or phone calls are not considered family therapy.

Members who are in the custody of the Department of Health and Human Services (DHHR) should complete one face-to-face family therapy session at the PRTF facility and complete the second family therapy session via telephone. In the case of non-custody placements, the facility is required to make every effort to accommodate the member's family in therapy sessions. Documentation of attempts and the family's ability to participate or noncompliance with attempts to involve the family must be recorded in the member's record and available for review.

It is required that providers of family therapy will be master's level therapists.

Group therapy is defined as psychotherapy that takes place between a mental health therapist and at least two but not more than twelve members at the same time. Groups of more than 12 participants are allowed if the primary therapist for the group is assisted by a co-leader. Group co-leaders are not required to be master's level therapists. Possibilities for groups include, but are not limited to, those which focus on relaxation training, anger management and/or conflict resolution, social skills training, self-esteem enhancement, etc.

Each member must participate in a minimum of three hours, each week unless contraindication is documented in the treatment plan. The manner in which services are delivered (length, frequency, and timing of sessions) should be determined by what is developmentally appropriate for each member. It is required that providers of group therapy must be master's level therapists although larger groups (more than 12 participants) may be co-led by a person with a lesser level of training.

Milieu therapy is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Emphasis is placed on clear, healthy, respectful communication between member/member, staff/staff, and staff/member, and on shared problem-solving and decision-making. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process.

One essential component of milieu therapy is the community meeting. This is a time when all members and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions (i.e. planning recreational activities for the group, etc.), set goals, and resolve conflicts. More than on community meeting may be held during the day. As a group function, participation and outcomes of the group must be documented.

Milieu therapy must be available.

Occupational/Physical/Speech Therapy is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the member achieve functional outcomes that promote the highest possible level of independence. Occupational therapy must be provided by an Occupational Therapist Registered (OTR).

531.5.2 Therapeutic Behavior Management

Behavioral Management Services are specific activities that have been planned and tailored to eliminate inappropriate (maladaptive) behaviors and to increase or develop desired adaptive behaviors for an individual member. These services result from areas of need identified on the member's service plan. Behavior management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

The use of behavior management interventions, (e.g. time out, behavioral contracts, point systems, logical and natural consequences, incentive programs, level systems, positive behavioral reports, etc.) with members must be guided by policies and procedures developed by the facility. Policies must indicate the intent to maintain a safe, nurturing, and therapeutic environment that protects the rights of all members and that respects the ethnic, religious, and identified treatment parameters for each individual member in care. Policies must comply with DHHR licensing rules and applicable state/federal statutes and generally accepted best practice standards promulgated by national accreditation organizations.

Therapeutic Behavioral Services - Development includes four major components:

- Behavior Assessment
- Plan Development
- Implementation Training
- Data Analysis and Review of the Behavior Management Plan after implementation

Therapeutic Behavioral Services - Implementation is an integral component of Behavior Management services (refer to *Chapter 503.13.1 and 503.13.2, Behavioral Health Rehabilitation Services.*) (www.dhhr.wv.gov/bms)

531.5.3 Physical Health Services

PRTF facilities must provide physical health services as part of their treatment of West Virginia Medicaid members. Physical health services may be provided directly by the facility or may be provided by a vendor outside the facility. Physical health services must be addressed on the member treatment plan and must include:

- Assessments and evaluations as required in (42 CFR §441.155(b)(1))
- Diagnosis, treatment, and consultation for acute or chronic illnesses occurring during the West Virginia Medicaid member's stay at the facility or for problems identified during an evaluation.
- Preventative health care services to include periodic assessments in accordance with the periodicity schedule established by the American Academy of Pediatrics.
- Completion of immunizations if a West Virginia Medicaid member's immunization is not complete.
- Routine medical care for all West Virginia Medicaid members (i.e. care during outbreaks of flu, non-complicated lacerations, scrapes, burns, etc.)
- Dental examination within six months of admission with periodic screenings. If the West Virginia Medicaid member has dental work that is ongoing (i.e. braces) the treatment plan must include plans to ensure the necessary follow-up dental care/exams are completed as needed.
- Speech, language and hearing services to meet the identified needs of the West Virginia Medicaid members.
- Vision screening and follow-up as indicated.

If physical health services are provided outside the PRTF, the facility must track:

- The referral of West Virginia Medicaid members;
- Qualifications of staff providing services;
- Exchange of clinical information must be provided.

531.5.4 Pharmacy Services

Medication is an important cornerstone of psychiatric treatment. Documents pertaining to this aspect of treatment (patient/family education and consent, medication orders, administration, monitoring) must be accurate, readily located and available for review. When medication is a prescribed intervention for a problem identified in the member's treatment plan, it must be noted as such in the treatment plan. When medication changes are made, they should be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes must be reviewed for all team members' updated at the next available staffing opportunity.

Psychotropic medication must be used only as one component of a total therapeutic program, and the diagnosis and projected/targeted behaviors must be included in a written treatment plan. Psychotropic medication must not, under any circumstances, be prescribed or administered for the purposes of program management control, for discipline or punishment reasons, for convenience of staff, or for experimentation or research purposes.

A facility director or designee must provide pharmaceutical services as outlined in (42 CFR §483.60) to accurately and safely provide or obtain pharmaceutical services, which include the provision of routine and emergency medications and biologicals and consultation of a licensed pharmacist, in order to meet the needs of its members. The facility director or designee shall ensure the development and implementation of written procedures based on policies approved, signed and dated, by the governing body, related to the provision of pharmaceutical services, including procedures that assure the accurate acquisition, labeling, receipt, dispensing and administration of all medications and biologicals. The facility director or designee shall assure that pharmaceutical services are provided in accordance with this rule and all other applicable federal, state and local laws and the rules of the states' Board of Pharmacy. The facility director or designee must employ or contract the services of a Licensed Pharmacist who is licensed to practice in the state in which the facility is located and is currently registered as a consultant pharmacist with the states' Board of Pharmacy. A pharmacist providing pharmacy consulting services in a PRTF must comply with all applicable federal, state and local laws and the rules of the state's Board of Pharmacy. In review of best practice, the consultant pharmacist must not be an employee of the pharmacy servicing the facility and operate independently as a consultant.

The consultant pharmacist must review the medication regimen of each member once a month or more frequently based on the member's needs. The consultant pharmacist must document the results of each member's medication regimen review in the member's medical record. The medication regimen review must include substances that are regarded as herbal products or dietary supplements. The consultant pharmacist must report any irregularities in the medication

regimen review along with documented recommendations to the clinical director and the psychiatrist. The PRTF's pharmacist consultant must be available to advise the PRTF staff regarding questions or concerns. The consultant pharmacist recommendations must be reviewed within seven days by the psychiatrist with changes made in the medication regimen. If the decision is not to follow the recommendations, the psychiatrist must document the decline on the same form as the recommendations with signature and date of decision.

Drugs and biologicals used in the PRTF must be labeled in accordance with the requirements of federal, state and local laws, rules and regulations. The labels must include the appropriate accessory and cautionary instructions with the expiration date and time to be administered per physicians order. All over the counter medications must have the date opened and initiated by the employee administering the medication.

In accordance with state and federal laws, the facility director or designee must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility director or designee must provide separately double-locked, permanently affixed compartments for the storage of drugs subject to abuse and controlled drugs as identified by federal regulations. The PRTF may also use single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

The facility director or designee and the dispensing pharmacy must maintain prescription records in accordance with state and federal laws, and provide such prescription records upon request by the West Virginia Medicaid agency or its representatives.

531.5.4.1 Consent for Medication

When medications are prescribed or changed, a member of the professional staff will review with each member's parent/guardian and document in the medical record the following information:

- The name/class of medication;
- The method of administration (oral, injection, etc.);
- The symptom(s) targeted/expected outcomes;
- Possible side effects of the medication;
- Possible long-term effects of the medication;
- Treatment alternatives;
- Likely outcomes of using/not using the medication.
- The minimum and maximum dose to be administered.

When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference may be held by telephone, with the parent/guardian's responses noted and dated. This form must be signed by the parent/guardian within 30 days after the telephone consent is obtained. The PRTF professional staff must document this telephone consent obtained with one witness signature/date on the form after talking with the parent/guardian. Documentation regarding the parents verbal consent must be

located in the member record. Documentation of efforts to obtain the above signature must also be contained in the member record if the parent fails to return the form within the 30 day period.

Documentation that the education was presented and consent to proceed must be provided when parents/guardians are informed of all drugs being prescribed off-label (diagnosis not approved by the FDA, dosage outside the FDA guidelines, or if the drug has not been approved for the age of the West Virginia member). Decline in consent by the parent/guardian must be documented along with physician notification.

531.5.4.2 Administration of Medication

Only licensed professionals may administer medications to WV Medicaid members. Examples of licensed staff include physicians, physician assistants, nurse practitioners, registered nurses and licensed practical nurses. No unlicensed or certified individual may administer medications to West Virginia Medicaid members in a PRTF facility, regardless of whether they are certified to do so by the state where the PRTF facility is located or are supervised by a professional staff member when administering medications.

Documentation must substantiate that medications have been accurately administered in accordance with the physician's or other licensed practitioner's orders. Any variances must be justified in the record by licensed medical staff. A Medication Administration Record (MAR) for monitoring medication side effects must be identified and includes all medications that are routinely administered to each member who is prescribed medication and will have documentation review by the psychiatrist upon admission, as medically necessary and at least every 30 days during his/her stay, and again at discharge.

"**Standing Order PRN medications" are not permitted.** Over the counter medications (PRN's), for each member must be prescribed for the member by a physician with prescribing privileges, with clear indications for use and start and stop dates for each medication prescribed.

531.5.4.3 Medication Errors

Medication errors will be tracked and quantified as part of the continuous quality improvement program of BMS to ensure that children in DHHR custody and non-custodial placements are receiving the best care possible.

Medication errors will be analyzed in terms of the type of error (e.g., wrong dose, omission, wrong time, etc.) and the severity of the error. All documentation related to medication errors will be readily available upon request by BMS.

The physician must be notified immediately of a medication error and the physician order (if any) be obtained by nursing personnel or the physician themselves.

531.5.5 Dietary Services

The PRTF must have written policies and procedures approved by the governing body for the provision of dietetic services for members. Adequate staff, space, equipment, and supplies must be provided for safe sanitary operation of the dietetic services, the safe and sanitary handling and distribution of food, the care and cleaning of equipment and kitchen area, and the washing of dishes. Nutritional aspects of member's care will be planned, reviewed, and periodically evaluated by a qualified dietician.

Food must be served to members and staff in a common eating place and:

- Must account for the special food needs and tastes of members;
- Must not be withheld as punishment, and;
- Must provide for the special dietary needs of each member.

At least three meals per day must be served with no more than a 15 hour span between the substantial evening meal and breakfast. The facility must arrange for and make provision for between-meal and unscheduled snacks.

531.5.6 Visitation with Parents and Extended Family

Visitation arrangements must be agreed upon as soon as possible after placement of the child and documented in the member's record. These arrangements must be made in agreement with the family/guardian, the residential facility and the member's DHHR caseworker. Any restrictions on visitation arrangements by the DHHR caseworker or the court must be noted in the member's treatment plan. All visits will be coordinated through consultation with the parent/guardian and the member's DHHR caseworker.

The facility must design and implement services in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles. When a member's presenting problem affects or is affected by a member's family, the facility will provide coordination of social services to children, adults, and families that may be necessary to achieve family reunification, stabilize family ties, or obtain a permanent family for a member receiving out-of-home care. The family of a member in out-of-home care is expected to participate in making case plans, is kept advised of ongoing progress, and is invited to case conferences. When a member is in out-of-home care, the agency fully involves the family or individuals identified in the permanency plan as permanency options with a focus on timely permanency as the primary goal. The facility cannot deny visits, telephone calls, or mail contacts with a DHHR approved family. The facility is responsible for coordinating visitation with the member's family including provision of transportation as available to enable the visitation to occur.

In instances of non-custodial placement, transportation arrangements must be made with the facility, and the parent involved to ensure that the visitation does take place. Non-Emergency Medical Transportation (NEMT) **cannot** be used to transport the child to a facility located out of-

state. The use of NEMT to transport a parent to the facility for visitation with the child is **not** a covered service.

531.5.7 Life Skills

Facilities providing care to members has the responsibility to help them develop into self-sufficient adults. In addition, all facilities and individuals who provide substitute parental care for members are charged with helping to ensure that their social, emotional, and intellectual development is achieved to each member's highest potential.

The facility must ensure that all adults entrusted with the care of West Virginia children and youth demonstrate appropriate social behavior; respond properly to stressful situations; and promote good physical, emotional, and intellectual well-being. It is through the observation of positive adult behavior and through interaction with positive adult role models that children and youth develop and demonstrate positive attributes.

531.5.8 Therapeutic Leave

Therapeutic leaves are a necessary and integral part of a member's treatment. Therapeutic leaves allow for an evaluation period to determine the member's ability to adjust to the transition back into the home setting and/or to a lesser level of care facility. Therapeutic leaves of absence would occur when clinically appropriate, particularly toward the end of a member's placement to ensure adequate transition into the family/foster family home. A therapeutic leave day is defined as a day of absence when the member spends a night away from the PRTF. The maximum allowable and reimbursable therapeutic leave days (absences) shall be limited to eight (8) days per calendar year.

The medical record must contain a physician's order for therapeutic leave, the date and time of the beginning of the therapeutic leave, and the date and time the member returns to the PRTF. For therapeutic leave, the date the member leaves the PRTF is counted as a leave day and the day the resident returns to the facility shall not be counted as a leave day.

Documentation

- The date/time of check-out
- The required time of return
- The name(s) of the person(s) with whom the leave will be spent
- The member's physical/emotional condition at the time of departure (including vital signs)
- The types/amounts of medication being provided and instructions (in lay terms) for taking them
- Therapeutic goals for the leave. Goals must relate to the goals established in the treatment plan.
- The name and signature of the person with whom the member is leaving
- The signature of the staff person checking the member out.

Documentation upon return must include

- The date/time of check in
- The member's physical/emotional condition at the time of return (including vital signs and notation of any physical injury or complaint)
- Whether or not any contraband was found
- The types/amounts of medication being returned, if any, and explanation of any missed does
- An explanation of any early return from leave
- A brief report on the outcome of the leave by the parent or guardian (were therapeutic goals achieved? Was the member's behavior appropriate?0
- The name and signature of the person returning the member to the facility
- The signature of the staff person checking the member in
- An assessment of the outcome of the leave must be documented by the member's therapist within seventy-two (72) hours of the member's return from leave.

531.6 CONTINUING STAY CRITERIA

When West Virginia Medicaid members are prior authorized for PRTF admission by the UMC, they are authorized a limited number of days for that admission. It is the PRTF's responsibility to help the member accomplish treatment goals within that time frame or to justify to the UMC why a longer stay should be prior authorized. When a continued stay is needed, it is the responsibility of the member's Multidisciplinary Treatment Team and the Clinical Director to establish that the requirements for a continued stay have been met.

No later than seven days prior to the end of a member's authorized stay, the treatment team must have;

- developed a detailed discharge/aftercare plan for the member;

or

- applied to the UMC for additional treatment time.

In reviewing requests for extended treatment, the UMC reviews the appropriateness and quality of the member's ongoing treatment as planned, provided, evaluated, revised and documented by the treatment team.

The following criteria must be met in order for a continued stay prior authorization:

- Individual is still under the age of 21 and has a confirmed DSM IV-TR mental health or co-occurring mental health and substance abuse diagnosis,

and

- Psychiatric symptoms manifested by the qualifying diagnosis or conditions continue to be severe and/or complex and the severity of the symptoms contraindicate treatment occurring safely at a lower level of care. The treatment plan has been modified to address barriers to achieving goals,

or

- New symptoms have emerged or previously unidentified symptoms have manifested that require continued treatment and the severity of symptoms contraindicate treatment occurring safely at a lower level of care,

and

- Multiple symptoms and functional impairments due to psychiatric diagnosis continue to be present despite progress being documented,

and

- Individual and/or family continues to be actively engaged and participating in the care plan.

When discharge problems arise because of the lack of an appropriate placement for the member (ex: unsuitable family environment, foster home unavailability, no group home vacancies), it is the responsibility of the PRTF, together with the party having legal responsibility of the member, to locate and/or arrange an appropriate placement. **The lack of post-discharge options alone will not be considered a valid basis for continued PRTF stay.** The discharge process begins on the day of admission and must be finalized at a minimum of seven days prior to discharge.

531.7 DISCHARGE

Discharge planning begins during the intake and placement process, for the member. When plans for the member are being developed with the member and the family, discharge plans are made, and continue as part of ongoing discussion throughout placement. After determining a tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, keeping the group care facility informed of the plan, informing the member of the plan, or helping the member prepare for emancipation.

Discharge criteria would indicate that the symptoms and functioning have improved and a lower level of care can be safely provided or that a higher level of care is required to meet the member's needs. Discharge planning is also initiated when the member's treatment plan goals and objectives have been substantially met and the discharge plan with appropriate, realistic and timely follow-up care is in place. When the care being provided at the facility no longer meets medical necessity, the member is discharged.

Discharging also occurs when the member is not making progress toward treatment goals despite persistent efforts to engage him/her and there is no reasonable expectation of progress at this level of care related to their psychiatric condition nor is it required to maintain the current level of functioning.

The discharge plan must also include an aftercare plan that addresses coordination of family/legal representative, school/vocational and community resources to provide the greatest possible continuity of care for the member "at an appropriate time". (42 CFR §441.155(b)(5)) The plan's content will include, but not be limited to:

- The planned discharge date;
- The date of the member's admission and discharge;
- The name of the person/agency expected to assume care and custody of the member;
- The physical location/address where the member is expected to reside; and,
- A list of the member's psychiatric diagnoses.

At the time of the member's discharge from the facility, the PRTF will provide the parent/guardian with:

- A written copy of the final aftercare plan;

- A supply of all current medications prescribed for the member, equal to the amount already stocked for that member by the PRTF but not less than a seven day supply; (When dispensing to a Long Term Care Facility, if the medications are not in the hands of the patient, they have reduced labeling requirements. If they are to be able to be taken home, the pharmacy would have to do full labeling. That would have to be spelled out for the pharmacy ahead of time so they can make sure any unit dosing system or unit of use system they are using to dispense would be able to do full labeling on the packaging, etc. if the patient is only to be gone one or two doses (That are unit dose packed) the nurse might give to caregiver with time instructions. Otherwise pharmacy must re-label to contain instructions for use.):

- Prescriptions for a 30 day supply of all medications prescribed for the member; and,

- Documentation of communication between the facility psychiatrist and the community psychiatrist assuming responsibility for the ongoing treatment to discuss the member's treatment plans while in the facility as well as the discharge plan.

The PRTF will seek the parent's/guardian's consent to release copies of the member's educational summary and recommendations to the member's school. When this consent is obtained, the educational information must be mailed to the member's school within one week following the member's discharge. The PRTF must not send the member's complete aftercare plan, but must provide only information pertaining to education.

The PRTF will seek the parent/guardian's consent to release copies of the member's aftercare plan and discharge summary to the providers of follow-up mental health services. When this consent is obtained, copies of the aftercare plan and discharge summary must be mailed to the mental health aftercare provider within two weeks following the West Virginia member's discharge.

531.7.1 Emergency Discharge

Occasionally an emergency discharge/exit from a PRTF that are not in accordance with the West Virginia Medicaid member's case plan, are unavoidable. The facility must provide the West Virginia Medicaid member's caseworker with at least 72 hours' notice of discharge; parent/legal guardian notification must occur immediately when the decision is made. Upon

receipt of such notice, the worker will begin locating and developing an alternative placement that is appropriate for the West Virginia Medicaid member's current and immediate situation and needs. The facility must work with the parent/guardian to ensure a safe and appropriate discharge is available to the non-custodial West Virginia Medicaid member and the member's family.

If the member is discharged for medical reasons (i.e., medical needs not provided by the facility such as surgery, etc.), the parent/guardian must obtain a new MCM-1 and make a request for prior authorization for services prior to re-admission to the facility. The child must meet all other admission criteria set forth for PRTF level of care (see admission criteria).

There must **not** be any instance when a West Virginia Medicaid member is discharged immediately for his safety or the safety of others while the member is placed in a PRTF. The facility is required to provide sufficient staffing 1:1 if necessary to allow for a safe and appropriate discharge.

531.7.2 Elopements/Run Away

A member is considered in elopement/run-away status if the West Virginia Medicaid member leaves without authority/supervision. If the member is under the age of 12 or is a member with mental or physical issues that, without supervision may pose a child safety or community safety risk, the elopement/run-away incident is reported immediately. As soon as staff determines that a member has eloped/run-away from the facility, that person will immediately call the local law enforcement agency and law enforcement may choose to enter the member into the National Crime Information Center (NCIC) data base. Members in custody as a status offender or with child abuse/neglect issues may be listed by local law enforcement as a Missing Person. The facility will notify the parent/guardian immediately. A member charged with juvenile delinquency must be reported to local law enforcement. Members in custody as an adjudicated juvenile delinquent may be listed by local law enforcement as a Wanted Person. A complete incident report form must be initiated to include the time of discovery along with all processes implemented to assist with locating and returning of the member to the facility and the outcome.

Reimbursement is not available when a child has eloped or is missing and is not in residence at the facility for more than 24 hours.

In cases of elopement/run-away incidents where the member has a history of "repeat run-away incidents", the facility must develop a safety plan for the member in their treatment plan. Consideration should be given to the member's history of running away, safety concerns (for both the member and the community), need for additional supervision, and/or need for a more secure facility placement.

Upon the return of a West Virginia Medicaid member from an elopement/run-away incident, the facility will notify the parent/guardian and law enforcement of the return so any alerts can be cancelled and documented. The incident report must have attached all written accounts of all processes implemented to assist with locating and returning the member to the facility. The

documentation must contain the written account as well as written statements, names and times of all persons involved including the physician.

If a West Virginia Medicaid member has been on elopement/run-away status and has missed his/her medication(s) for 48 hours or longer, the physician/licensed psychiatrist must be notified for instructions/orders before restarting the medication(s) on the member's return to the facility.

531.8 DOCUMENTATION REQUIREMENTS

Documentation must include a physician/psychiatrist's order for admission, the results of the evaluation which establishes medical necessity for this level of service and the West Virginia Medicaid MCM-1. A permanent clinical record maintained in a manner consistent with applicable state and federal licensing regulations and agency record keeping policies. The clinical record is an essential tool in treatment. It is the central repository of all pertinent information about each member. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. Clinical records must be complete, accurate, accessible, legible, and organized. Records must contain five broad categories of information; Administrative, Assessments, Treatment Planning, Therapeutic Interventions, and Medications. The following information must be located in each category:

531.8.1 Administrative

This portion of the record contains all information related to the West Virginia Medicaid member's identification. It must include, at a minimum, a copy of the member's birth certificate and/or social security card, a recent photograph of the member, a copy of any legal documents verifying custody or guardianship of the member when the responsible party is anyone other than the members' legal parent(s). The name, address and phone number of the party bearing legal responsibility for the member must be clearly identified, along with his/her relationship to the child, e.g. "mother", or "paternal aunt, legal guardian". If the member is in the custody of the West Virginia Department of Health & Human Resources (DHHR), the county of custody must be specified and the caseworker identified as an agent of DHHR. The original MCM-1, withphysician signature/date and supporting documentation that establishes medical necessity for this level of service must be contained in this section of the record and available for review.

531.8.2 Assessments

This portion of the record contains information gathered through history taking, observation, testing and examination of the member. It must include, at a minimum, all assessments identified as necessary in the Assessment section 531.4.5 of this chapter. Assessments must be updated as needed to provide current and continued treatment planning and provision of therapeutic services.

531.8.3 Treatment Planning

This portion of the record contains the individualized multi/interdisciplinary treatment plan, as well as all reviews and revisions. It must be noted that the treatment planning process is

intended to take place in a multi/interdisciplinary forum where many points of view may be expressed and consensus reached, rather than through a process of serial communication among professionals. Treatment planning documents must reflect the collaborative nature of the process. The treatment team will meet to staff each member and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first 14 days following admission, again prior to the conclusion of the first month of stay, and monthly thereafter.

531.8.4 Therapeutic Interventions

All interventions attempted/provided during the course of the West Virginia Medicaid member's treatment must be appropriately, accurately and legibly documented. Documentation for individual services must include at a minimum:

A. Psychotherapy Notes

Essential elements that must be documented for each therapy session are as follows:

- The date and time of the session (time in and time out);
- The type of therapy (individual, family or group);
- The person(s) participating in the session;
- The length of the session;
- The goals of the session with the member;
- Clinical observations about the member (demeanor, mood, affect, mental alertness, thought processes, risks, etc.);
- The content of the session;
- Therapeutic interventions attempted and the member's response to the intervention(s);
- The member's response to any significant others who may be present in the session; The outcome of the session;
- A statement summarizing the member's degree of progress toward the treatment goals;
- Periodic (at least monthly) reference to the member's progress in relation to the discharge criteria; and the estimated discharge date; and,
- The signature (and printed name, if needed for clarity) of the therapist.

Monthly summaries are not acceptable in lieu of psychotherapy session notes.

B. Milieu Therapy Notes

Milieu notes must present a clear picture of the member's participation and interactions in the therapeutic community. Milieu notes for each day should describe the West Virginia member's actions, staff interventions, and the West Virginia member's response to those interventions. Milieu notes are completed by direct care staff. If a checklist is used, it must be accompanied by a brief narrative. Milieu notes must be behaviorally focused. Behavior and events must be described rather than labeled. For example:

- Behavior labeled: member was oppositional;
- Behavior described: member refused to make up bed when asked.

Milieu notes must be maintained in a professional manner and must accurately document any communication between staff and the member. The notes should emphasize the member's level of involvement and collaboration in his/her own treatment.

C. Community Meeting Notes

Participation in community meetings must be documented for each member and a brief narrative maintained for each community meeting describing the goals and achievement.

531.9 RECORDS MAINTENANCE

Clinical records must be maintained for a period of five years from the date of discharge. The facility must ensure that the clinical record is not lost, destroyed or put to unauthorized use. The facility must ensure the confidentiality of all information contained in the member's record except when its release is authorized by the member's parent/legal guardian or required by State or federal law.

531.10 SPECIALIZED PROCEDURES/RESTRAINT/SECLUSION

Special procedures, **seclusion and restraint**, must be used as an immediate response only in emergency safety situations (42 CFR §483.356(a)(1)) when needed to help a member regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. Documentation indicates that the more restrictive techniques, while relieving stress for the adults in charge, usually increase stress for the youths with whom they are applied. The potential therapeutic effects (prevention of self- and other-injury and reinforcement of behavioral boundaries) must be weighed against the counter-therapeutic effects which include loss of dignity, increased feelings of impotence/helplessness, increased resentment/rage towards authority figures, and, for member's in recovery from physical/sexual abuse, the subjective experience of re-enacting their victimization.

531.10.1 Staff Training

When a facility provides for the use of seclusion/restraint, all staff who have direct member contact must have prior education, training, and demonstration of knowledge of the proper and safe use of seclusion/restraint **and** alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. (See Staff Training 531.2.5 and 531.2.6) Training in the application of physical restraint must be a professionally recognized method which does not involve restraining a member in a face-down or spread-eagle (legs apart) position.

531.10.2 Member/Parent Notification

When a facility provides for the use of seclusion/restraint, the facility must inform, with documentation evidence, the prospective member and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. In the event that a member requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than 24 hours after the initiation of the procedure. Documentation must include notification was provided with date and time of notification and the name of the staff person providing the notification. (42 CFR 483.366(a))

531.10.3 Types of Seclusion and Restraints

Seclusion is the involuntary confinement of a member in an area, including rooms without locks or doors, from which they are physically prevented from leaving. It is used to ensure the physical safety of the member or others and to prevent the destruction of property or serious disruption of the milieu.

Restraint is the restriction of a member's freedom of movement or normal access to their body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the member's physical safety.

Personal/Physical Restraint is the restriction of a member through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a member from causing harm to self or others or to prevent destruction of property.

Mechanical Restraint is the restriction of a member through the use of any physical or mechanical device, material or equipment attached or adjacent to the member's body that they cannot easily remove.

Pharmacological Restraint is the limited use of a medication, which is not a standard part of the member's treatment regimen, to control or alter the member's mood or behavior or to restrict freedom of movement on a short term basis. Pharmacological restraint is used to ensure the safety of the member or others through a period of extreme agitation when less restrictive measures have not been effective. Pharmacological restraint may be initiated only by medical staff acting on a physician's orders. At the time of the order, the physician must identify a specific time when the procedure is expected to end (i.e., the expected duration of the medication's effects).

Medication Adjustment refers to the process of medication reduction attempts including anti-psychotics, hypnotics, anti-depressants, narcotics, sedatives, and all schedule II drugs. Medication adjustment is not considered to be a special procedure. When an additional physician order is provided to increase a member's routine medication in a *non-routine way* to help the member through a period of heightened stress or agitation, e.g., ordering the administration of an extra dose (usually in a lower amount) of the same (or similar, from the same class) medication that is already part of the member's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the member's treatment plan. When physician orders for medication

increase due to a period of heightened stress or agitation up to three times in a 30 day period, the physician must determine if the increase in medication needs to become a change in the member's medication regime. If this does not occur then the medication must be considered a pharmacological restraint and the treatment plan must be updated. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedating, are only administered orally, and must be taken voluntarily by the member (and in some cases may be requested by the member).

531.10.4 Appropriate Use

Seclusion or restraint must be used only in situations where less restrictive interventions have been attempted and determined to be ineffective. Documentation in the record must reflect the attempted use of less restrictive interventions date/time/signature of staff responsible for use of the interventions. Neither procedure may be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a member's behavior, or as a substitute for individualized treatment. (42 CFR §482.356(a)(1)) Any use of seclusion or restraint must be:

- In accordance with the member's treatment plan (if the treatment plan does not provide for the use of seclusion/restraint prior to its use, the plan must be modified within one working day of the first occurrence)
- In accordance with the policy and procedures restraint/seclusion may only be applied by staff who have been trained and approved to use such techniques (42 CFR §482.356(a)(3);
- Implemented in the least restrictive manner possible (CFR §483.364(b)(2);
- In a room where the member will be constantly viewed and monitored, that is safe and sanitary, with adequate lighting, ventilation and temperature control;
- All vital signs must be obtained every hour, times 12 hours unless documentation by licensed physician indicates this can be modified;
- Access to fluids and toilet facilities must be offered and provided hourly with clear documentation of fluids ingested;

- Evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the member's condition (42 CFR §483.356(a)(3)(ii).

531.10.5 Prohibited Practices

Restraint and seclusion must not be used simultaneously. (42 CFR §482.356(a)(4));

- Any personal or mechanical restraint of a member in a face-down position is prohibited;
- Any personal or mechanical restraint of a member in a "spread-eagle" (legs and arms apart) position is prohibited;
- Standing or "as needed" (PRN) orders for seclusion or restraint are prohibited. (42 CFR §483.356(a)(2))

531.10.6 Procedural Requirements

The following actions are required and must be documented for **any form of special procedure** with the exceptions as noted below.

- Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State Law and the facility to order restraint and seclusion and trained in the use of emergency safety interventions. (42 CFR §483.358(a))
- If seclusion or personal/mechanical restraint is initiated verbally by order from a physician or other licensed practitioner, a verbal or telephone order must be obtained from the physician or other licensed practitioner (42 CFR §483.358(d)) and documented in the chart as soon as possible, but no later than one hour after the start of the procedure. If the physician's or other licensed practitioner order cannot be obtained within the one hour, the procedure must be discontinued.

The physician's or other licensed practitioner's order for seclusion or personal/mechanical restraint may under **no** circumstance exceed one hour for members younger than nine years of age, or two hours for members nine to 17 years of age and four hours for members ages 18 to 21. (42 CFR §483.358(e))

The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure. (42 CFR §483.364(a))

Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the member, and the safe use of restraint throughout the duration of the emergency safety intervention. (42 CFR §483.362(a))

Within one hour of the initiation of the emergency safety intervention, a physician or other licensed practitioner must conduct a face-to-face assessment of the physical and psychological well-being of the member, to include but not be limited to the following:

- The member's physical and psychological status,
- The member's behavior,
- The appropriateness of the intervention measures, and any complication resulting from the intervention. (42 CFR §483.358(f))

Even if the intervention is terminated in less than one hour, the face-to-face assessment must be conducted within 60 minutes of its initiation.

The health and comfort of the member must be assessed every 15 minutes by direct observation, and staff must record their findings at the time of observation.

There must be a policy and procedure for ending the special procedure (except for pharmacological restraint, which has an end-time identified by the physician or other licensed

practitioner), and the member must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate. A physician or other licensed practitioner must evaluate and document the member's well-being immediately after the seclusion or restraint is terminated. (42 CFR §483.362(c))

No later than 24 hours following the conclusion of the special procedure, the member must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention. (42 CFR §483.370(a)) The goal is to enable the member to understand the precursors to loss of control and to rehearse acceptable means of handling frustration and emotional distress.

Within 24 hours after the use of restraint or seclusion, documentation must indicate that all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, conducted a debriefing session that included, at a minimum, a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention, alternative techniques that might have prevented the use of the restraint or seclusion, the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion. (42 CFR §483.370(b))

The Registered Nurse or other licensed personnel in the PRTF must notify with documentation of the same, the member's parent/guardian as soon as possible, but no later than 24 hours after the initiation of any special procedure. The documentation will include the name/date/time the parent/guardian was contacted and the content of the conversation.

If the member's treatment plan does not already provide for the use of seclusion/restraint, then it must be amended or modified within 24 hours following the first use of any special procedure to reflect the use of that method as a part of the member's treatment.

531.10.7 Documentation of Seclusion/Restraint

Documentation of each incident of seclusion or restraint (personal, mechanical and pharmacological restraint) will include, but not be limited to, the following information:

- The date/time the procedure started and ended (42 CFR §483.358(h)(2));
- The name of the physician or other licensed practitioner who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring, and were responsible for terminating (42 CFR §483.358(h)(5));
- The reason the procedure was initiated (42 CFR §483.358(h)(4));
- Which less restrictive options were attempted, and how they failed;
- Criteria for ending the procedure (except for pharmacological restraint, when the end time is identified by the physician or other licensed practitioner);
- The results of a face-to-face assessment conducted by a physician or other licensed practitioner within one hour after initiation of the procedure to include

1. the member's physical and psychological status,
2. the member's behavior,
3. the appropriateness of the intervention measures and
4. any complications resulting from the intervention (42 CFR §483.358(f));

- The member's condition at the time of each 15 minute reassessment and at the end of the procedure;
- The signature/date of the person documenting the incident;
- A record/documentation of both debriefing sessions (staff/member and staff only) which are required to take place within 24 hours of the use of seclusion/restraint, to include the names of staff who were present for or excused from the debriefing and any changes to the member's treatment plan that resulted from the debriefings. (42 CFR §483.370(c)); and,
- The facility must provide notification of the member's parent/guardian within 24 hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification. (42 CFR §483.366(b)).

This documentation must be part of the West Virginia member's permanent record.

A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. (42 CFR §483.358(i)) A multidisciplinary team must review the seclusion/restraint log monthly and must maintain documentation of such meetings in the form of minutes signed and dated by the participants

Information regarding the number of times seclusion or restraint have been employed by a facility must be included **monthly** as part of the facility's census report.

531.11 Education

When caring for children in out-of-home placement it is necessary to provide services outside those identified as meeting medical necessity. These services are considered necessary for the health and safety of the member. Provision of education is a necessary component for all out-of-home placements. DHHR is committed to ensure all members receive educational services and continue educational goals. It is the responsibility of all involved parties to support each member's school placement and educational plan. The West Virginia Department of Education oversees the provision of educational services for West Virginia member's.

For information regarding educational standards for West Virginia members, the West Virginia Department of Education can be reached at:

West Virginia Department of Education
Office of Assessment and Accountability
State Capitol Complex
Building 6, Room 330
Charleston, West Virginia 25305
Telephone: (304) 558-7805
http://wvde.state.wv.us

531.12 Transportation And Vehicle Maintenance

Transportation of members to and from medical appointments, court appearances, emergency transportation and transportation to family visits is a requirement of the PRTF. It is considered included in the PRTF per diem rate and not separately reimbursable.

- All vehicles must be maintained and operated in a safe manner.
- The facility provides adequate passenger supervision, as mandated by level of care.
- All facility-owned and staff-owned vehicles used for transportation of members **must be adequately covered by vehicular liability and comprehensive insurance** for personal injury to all occupants of the vehicles in the maximum amount allowed recommended by the state in which the facility is located. Documentation of such insurance coverage must be maintained in the facility's records, updated yearly, and readily available for review upon request by DHHR or designee. Staff providing transportation must possess a valid driver's license. Documentation of the license must be maintained in the facility's records and must be validated annually.
- All facility-owned and staff-owned vehicles used for transportation of members have a current license, registration and inspection, as required by the county of residence.
- Age-appropriate safety restraints must be used as required by state and federal law.
- The facility maintains the responsibility for and must be willing to provide transportation to members in the program including transportation to and from all medical/dental appointments, court appearances, emergency transportation, and transportation to family visits.
- No member must access public transportation unless supervised by a staff person or designee of the facility.

In instances of non-custodial placement, the cost of transportation must be provided by the facility and/or the parent. NEMT cannot be used to transport the child to a facility located out-of-state. The use of NEMT to transport a parent to the facility for visitation with the child is **not** a covered service.

531.13 Clothing

Members in DHHR care enter custody through the judicial system, or through the actions or inactions of adults in their lives. Therefore, DHHR urges child care facilities, whenever possible, to afford members the freedom to dress in ways that preserve their dignity, their freedom of expression, and their cultural identity. At the very least, agencies are to refrain from using uniforms, outfits, or identifying visual markers according to the children's disabilities, diagnoses, or referral behaviors. To do so classifies and stereotypes members in ways that add to the stigma associated with being in the custody of the DHHR. Wearing one's own clothing should not be held out as a reward but as a basic right. Additionally, any facility policy which requires uniform or identifying clothing when a member is in a community setting must be eliminated.

DHHR recognizes the need for facilities to utilize dress codes in order to maintain standards of hygiene and decency or to maintain accountability to the member at certain times. If dress code policy exists, it must be explained to the member and the parent/guardian at the time of

admission to the facility. DHHR challenges facilities to involve members as much as possible in decisions about reasonable limits of clothing or dress codes.

The facility must supply any special clothing required for the member to participate in a certain program (i.e. camping, hiking, equine therapy, etc.)

The facility is responsible for program and normal age-related personal incidental costs for members in the program such as bedding, diapers for infants, toiletries, and personal feminine hygiene items for females, etc.

531.14 Reimbursement Methodologies

BMS will reimburse PRTFs according to the WV Medicaid State Plan, Attachment 4.19-A-2, *Payment for Medical and Remedial Care and Services*.

"Reimbursement will be based on a cost-based retrospective reimbursement system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under Title XVIII of the Social Security Act, prior to the Social Security Amendments of 1983 (Section 601, Public Law 98-21).

At final settlement a provider's total interim reimbursement for the reporting period will be reconciled to total allowable WV Medicaid program cost to an assigned WV State agency. Allowable WV Medicaid program cost will be determined using tests of reasonableness, appropriateness, and medical necessity, as demonstrated in Medicare Regulations. Final settlements will be calculated based upon a provider's filed cost report, appropriate supporting financial documentation, including the State's processing and statistical claims reports. Each provider, which does not request or qualify for a low utilization exemption, will be required to file a CMS 2552 cost report with the State. All filed cost reports will be subject to final settlement determinations utilizing internal desk review (un-audited) or full or partial financial audit procedures. Final payment determinations will not consider the incentive and cost sharing amounts provided for in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (public Law 97-248).

Development of a facility's initial interim per diem payment rate may be based upon one of the following: a documented host states' Medicaid reimbursement rate, a pro forma cost report, a similarly sized facility within close proximity. For established providers, interim per diem rates may be based upon a provider's most recent settled cost report or host state's PRTF approved rate. For interim cost rate reviews and rate update requests, a provider must submit their most recent fiscal year cost report to WVDHHR-Office of Accountability & Management Reporting Division of Audit & Rate Setting. Providers are responsible for adherence to cost reporting requirements as established in Chapter 300, Provider Participation Requirements."

531.14.1 PRTF Services Included In the Daily All Inclusive per Diem Rate

The West Virginia Medicaid daily per diem rate provides reimbursement for all medically necessary services identified on the child's treatment plan during the child's placement at the facility.

The PRTF agrees to:

- File appropriate claims for reimbursement in accordance with established BMS procedures. The submission by or on behalf of the PRTF of any claim for payment under the Medicaid program shall constitute certification by the PRTF that the services or items for which payment is claimed were actually provided by the PRTF to the person identified as the West Virginia member;
- File claims that do not exceed the PRTF's daily per diem rate.
- File claims for items provided to persons who are West Virginia Medicaid members only;
- File claims which are correctly coded in accordance with billing instructions prescribed by BMS and file them in a timely manner in accordance with federal and state regulations; and
- Submit all information, with or in support of the information, in a true, accurate and complete manner.

531.14.2 Prerequisites for Payment

All PRTF's must have a current accurate signed and dated agreement with the Title XIX Medicaid Program on file with BMS' fiscal agent. The PRTF agrees to comply with all applicable rules, regulations, rates and fee schedules promulgated under Federal and West Virginia State laws. The PRTF represents and acknowledges that provider shall obtain a copy of those portions of the regulations and plans which bear on the providers of medical services of the type furnished by the PRTF. The PRTF further agrees to assure that all Medicaid services comply with Title VI of the Civil Rights Act of 1964; services shall be made available without discrimination due to race, religion, color, sex, national origin, age, ancestry, handicap or inability to pay; and all buildings and services shall comply as applicable, with Section 504 of the Rehabilitation Act of 1973 and the American With Disabilities Act (ADA).

The PRTF agrees to provide methods and procedures as required by Title XIX standards to safeguard against unnecessary or overutilization of care and services and assure that charges will be consistent with efficiency, economy and quality of care.

The PRTF agrees to maintain records in accordance with federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by the Department of Health and Human Resources. All supporting documentation for services provided to a member, including education, must be maintained in the individual members' cumulative record for a minimum of five years after discharge from the facility. Files must be stored in a secure manner. Appropriate measures must be taken to ensure the confidentiality of records, as well as safety from physical threats (e.g., fire, flood, etc.).

The PRTF agrees to make all records and documentation available upon request to DHHR, and/or the United States Department of Health and Human Services (HHS) for audit purposes. Such records and documentation shall include, but not be limited to:

- Financial Records;
- West Virginia Medicaid member Information;

- Description of Medical Services Implementation;
- Identification of Service Sites;
- Dates of Service for Each Service Component by member, client records, personnel records; and,
- MCM-1

The PRTF agrees, subject to appropriate procedural standards, to assume responsibility for repayments for state and/or federal funds which are subsequently disallowed or deferred by the state or federal government.

The PRTF agrees to participate in evaluations and audits authorized by the West Virginia DHHR and the United States HHS, the Comptroller General of the United States, or their duly authorized representatives relative to evaluation of the quality, appropriateness, and the timeliness of services pursuant to this agreement.

The PRTF agrees that payment and satisfaction of provider claims by BMS will be from federal and state funds, and that any false claims, statements or documents or concealment of material fact by a provider may be prosecuted by the Department under applicable federal or state law.

The PRTF agrees to permit regular medical reviews of each member, including a medical evaluation of the individual's need for PRTF services and to cooperate with state and federal personnel who make inspections, medical reviews and audits.

The PRTF must maintain in the member's medical record all information regarding the Interstate Compact Placement of Children (ICPC) and the 100-A form.

The PRTF's located out of state agree to inform BMS of all deficiencies received by that state's surveying licensing agency including annual and complaint investigations. The PRTF must have documentation of receipt that the member's parent/guardian(s), (non-custodial placement) and DHHR caseworker (custody placement) have received the results of the state surveying agency with deficiencies and complaint investigations. The state surveying agency's results will be easily accessible for all DHHR caseworkers West Virginia members/parent/guardian(s), and state personnel at all times and must be kept current.

The PRTF will provide to BMS' fiscal agent the results of the new nationally recognized accreditation when completed/updated.

The PRTF agrees to keep current with BMS' fiscal agent a new signed and dated Attestation/Certification letter by the Facility Director for all programs/sites when changes occur from information previously supplied. A completed attestation statement must be submitted to BMS annually by July 21st. (See 531.2)

531.15 General Administration

Responsibility for the administration of the West Virginia Title Medicaid Program within the West Virginia DHHR is placed within the BMS. The Commissioner of BMS has overall responsibility

for the administration of the Medicaid Program (Title XIX). For further information regarding general administration please refer to *Common Chapter 800*, *General Administration*. Additional information and requirements may also be found in the other chapters of the Provider Services Manuals located at www.dhhr.wv.gov/bms.

CHAPTER 532 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRIVATE DUTY NURSING SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	July 16, 2012	September 1, 2012

CHAPTER 532 - COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PRIVATE DUTY NURSING SERVICES

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CHAPTER 532 - COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PRIVATE DUTY NURSING SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

532.1 PURPOSE

Private Duty Nursing is supportive to the care provided to the member by the member's family, foster parents, and/or delegated caregivers, as applicable. Nursing services shall be based on medical necessity. Increases or decreases in the level of care and number of hours or visits authorized shall be based on a change in the condition of the member, limitation of the program, and the ability of the family, foster parents, or delegated caregivers to provide care.

532.2 DEFINITIONS

Activities Of Daily Living – activities usually performed in the course of a normal day in a member's life, such as eating, dressing, bathing and personal hygiene, mobility, and bowel and bladder control.

Admission – acceptance of the member into the private duty nursing program contingent upon meeting the criteria.

Family/in-home Caregiver - any person who assumes a portion of the member's nursing care in the home when Private Duty Nursing staff is not present. Family/in-home caregivers may live in the member's home, or may come to the member's home to provide care.

Initial Hospital Discharge – first hospital discharge that occurs after the member's birth or the first hospital discharge after the onset of the condition that resulted in the need for Private Duty Nursing.

Length of Time – assignment of time for authorization of private duty services not to exceed 60 calendar days.

Maintenance Care – level of care needed when the goals and objectives of the care plan are reached and the condition of the member is stable/predictable. Example: For the mechanical ventilated member, stable condition will be evidenced by ability to clear secretions from tracheostomy, vital signs stable, blood gases stable with oxygen greater than 92% and the pulse oximetry greater than 92%, the plan of care does not require the skills of a licensed nurse in continuous attendance, or the member, family, foster parents, or caregivers have been taught and have demonstrated the skills and abilities to carry out the plan of care.

PAAS - a Primary Care Provider, including a group practice or clinic that serves eligible PAAS enrolled members through assignment or by member choice after completion of a Physician Assured Access System Provider Agreement.

Plan of care – written instructions detailing services the member will receive. The plan is initiated by the Private Duty Nurse or nursing agency with input from the prescribing physician.

Private Duty Nursing – face-to-face skilled nursing that is more individualized and continuous than the nursing that is available under the home health benefit or routinely provided in a hospital or nursing facility.

Referring Provider - a doctor of medicine (MD), osteopathy (DO) or Advanced Registered Nurse Practitioner (APRN) who must be a West Virginia Medicaid enrolled provider.

Re-hospitalization – any hospital admission that occurs after the initial hospitalization as defined above.

Respite – short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

Skilled Nursing – services provided under the licensure, scope and standards of the West Virginia Nurse Practice Act, by a Registered Nurse (RN) under the direction of a physician, or a Licensed Practical Nurse (LPN) under the supervision of a Registered Nurse and the direction of a physician.

532.3 MEDICAL NECESSITY REVIEW AND PAYMENT AUTHORIZATION FOR PRIVATE DUTY NURSING (T1000)

Private Duty Nursing Services for eligible Medicaid and Children with Special Health Care Needs (CSHCN) Program members are subject to the same prior authorization medical necessity requirements. Coverage for PDN services is limited to eligible members under 21 years of age (through the age of 20). The West Virginia Medicaid Program has contracted with a Utilization Management Contractor (UMC) to review for PDN. All PDN services (procedure code T1000) provided to children participating in CSHCN Program (Title V) and Medicaid members under age 21 years will require prior authorization from the UMC. If the member is enrolled in the PAAS program, authorization or a referral must be given by the member's PCP. All forms attached to the PDN policy can be photocopied.

532.4 SCREENING CRITERIA AND SERVICE REQUIREMENTS FOR PRIVATE DUTY NURSING SERVICES

All of the following information is required and must be submitted to the UMC within seven working days prior to the start of care date:

A. Physician (MD or DO) or APRN Plan of Care (signed and dated) must include all of the following information on the CMS 485 form:
   1. Diagnosis and procedure;
   2. Medical history;
   3. Prognosis (include specific expectations for the member's diagnosis and condition);
   4. Approximate length of time PDN services will be needed;
   5. Medical justification for services requested, including orders;
   6. Documentation that the member is medically stable, except for acute episodes that PDN can manage.

B. Nursing Plan of Care
   1. Proposed start of care date;
   2. Diagnosis and procedures with ICD-9-CM codes;
   3. Justification for skilled nursing services eight hours or more in a 24 hour period. Description of needs must include interventions, measurable objectives, and short and long term goals with timeframes
   4. Medications, (new or changed) including dose, frequency and route;
   5. Technology dependent:
      a. Ventilator dependent **and one of the following**: (1 or 2)
         1) Mechanical ventilator support is necessary for at least eight hours per day and not at maintenance level; or
         2) Oxygen supplementation for ventilator dependent members at or below an inspired fraction of 40% (FI02 of 0.40).

PHYSICIAN/APRN REVIEW REQUIRED FOR:

- **Ventilator dependent:** if indicators (5 a 1 or 2) are not met and member also requires one or more of the following indicators (5 b, c, d, or e)

- **Non-ventilator dependent:** if one or more indicators (5 b, c, d, or e) are required

      b. Non-ventilator: Tracheostomy care requires documentation of site appearance, type/frequency of wound care/dressing changes and description of any drainage around site. Also, record frequency of suctioning, including amount, color, consistency of secretions;
      c. Oxygen: documentation required concerning rapid desaturation without oxygen;
      d. Tube feedings: (NG tube, G-tube and J-tube) requires type and frequency of product given. Also include bolus feeding or continuous infusion via pump;
      e. Intravenous Infusions: Intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids require documentation of type of line, site, dose, frequency, and duration of infusion. Also record gravity or pump installation.

6. Rehabilitation potential including functional limitations related to ADLs, types/frequency of therapies, and activity limitations per physician order;
7. Member is residing in a home environment;
8. Social History: number, names and relationship of family members to the member. List the family/in-home caregivers that are trained to care for the member with supplement of PDN and other health professionals;
9. Record the family's community support system and any transportation equipment;
10. Describe teaching, delegation, assignment of care and availability of PDN;
11. Equipment and supplies necessary for the member's care;
12. Acuity and Psychosocial Grid (See Appendix I) with score meeting one of the following (a, b, c, or d):
    a. 61 points and above: up to 24 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition;
    b. 50-60 points: up to 16 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition;
    c. 40-49 points: up to 12 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition;
    d. 30-39 points: eight hours per day, if the score is 24 or above on the Psychosocial Grid in conjunction with the 30-39 points on the Acuity Grid.

NOTE: Physician/APRN review is required if the information on the Acuity is less than 30 or the Psychosocial Grid does not support the other clinical information provided.

THE PLAN OF CARE AND NURSING NOTES MUST ALSO BE MAINTAINED IN THE MEMBER'S HOME.

13. Family/in-home caregiver must require **all of the following** (a, b, and c):
    a. Family must have at least one person trained and fully able to care for the member in the home. Documentation of the demonstration by family/in-home caregiver of specific skills, including Cardiopulmonary Resuscitation (CPR) instruction and certification. A ventilator dependent member requires the availability of two or more trained caregivers;
    b. Family/in-home caregiver ability to maintain a safe home environment, including an emergency plan;
    c. Family/in-home caregiver will work toward maximum independence, including finding and using alternative resources as appropriate.
14. Home environmental must require **all of the following** (a, b, c, d, e, and f):
    a. Adequate electrical power including back-up power system;
    b. Adequate space for equipment and supplies;
    c. Adequate fire safety and adequate exits for medical and other emergencies;
    d. Clean environment to the extent that the member's life and health is not at risk
    e. Working telephone available 24 hours a day;
    f. Notification to power companies, fire department, and other pertinent agencies of the presence of a special needs person in the household, to ensure appropriate response in case of power outage or other emergency.

532.5 SIGNIFICANT CHANGE IN CONDITION

Comprehensive assessments must be updated and submitted to the UMC Nurse Reviewer by the next workday after any significant change of condition, e.g., emergency room visit, hospital admission, any change in status that will increase or decrease services. Also notify the UMC Nurse Reviewer if the member expires or is discharged from PDN services.

532.6 EXTENSION OF SERVICES

At least seven working days prior to the expiration of current authorization, all of the following must be submitted to the UMC for review:

A. Daily nursing notes from past 30 days; documentation of Private Duty shift care must be written at least every hour on the nursing notes and must include all of the following:
   1. Name of member on each page of documentation;
   2. Date of service;
   3. Time of start and end of service delivery by each caregiver;
   4. Anything unusual from the standard plan of care must be explained on the narrative;
   5. Interventions;
   6. Outcomes including in the member/family's response to services delivered;
   7. Nursing assessment of the member's status and any changes in that status per each working shift;
   8. Full signature of the private duty nurse;
B. Updated plan of care, including new goals and objectives outlined;
C. Updated medical and social information;
D. Progress reports, including the member's potential for discharge with timeframes;
E. Physician's (MD or DO) or APRN orders for service must be dated within 7 days prior to the date of request;
F. Recent, significant clinical findings from physician;
G. Current (within seven working days) completed Acuity Grid;
H. Documentation of delegation, teaching and assignment of care.

532.6.1 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members up to 21 years of age. These services target early detection of disease and illness and provide referral of members for necessary diagnostic and treatment services.

Interperiodic screens are any encounters with a health professional practicing within the scope of his or her practice and who provides medically necessary health care, diagnosis, or treatment to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition. The interperiodic screen is used to determine if there is a problem that was not evident at the time of the regularly scheduled screen but needs addressed before the next scheduled screen.

Any services identified through any EPSDT screening that are medically necessary are covered for members up to 21 years of age.

To obtain authorization for services that have been identified as a result of the EPSDT exam that are not covered in the benefit package, or for service limitations that have been previously met, the service provider must provide the medical documentation for the service requested and fax to the attention of BMS' Utilization Management Contractor at 304-343-9663. For those enrolled in an MCO, the respective member's MCO must be contacted.

532.6.2 SERVICES TO IDD WAIVER MEMBERS UNDER 21 YEARS OF AGE

I/DD Waiver members under the age of 21 are eligible to receive private duty nursing services. The following circumstances apply to services for those members.

1. There is no duplication of waiver services;
2. Requests for PDN services to the UMC includes waiver experience and relevant services;
3. Private Duty Nursing (PDN) services are evaluated in the context of the plan of care developed by the Waiver Team.

532.7 PROGRAM EXCLUSIONS FOR MEMBERS

1. Member is residing in a nursing facility, hospital, residential care facility, intermediate care facility for developmental disabilities (ICF/MR) or personal care home at the time of delivery of PDN services;
2. Care solely to allow the member's family or caregiver to work or go to school;
3. Care solely to allow respite for caregivers or member's family;
4. Care at maintenance level;
5. Only the agency authorized to provide the PDN services can bill. If the agency finds it necessary to subcontract services due to staffing needs, the services provided by the subcontractor are not reimbursable by Medicaid.
6. PDN services for members 21 years of age or older.

532.8 APPEALS PROCESS/FAIR HEARING

- If the UMC denies prior authorization for PDN services, a reconsideration request with additional supportive documentation may be submitted to the UMC.

- Failure to prior authorize will result in denial of the request.

- The member or provider may submit an appeal request to BMS upon receipt of the prior authorization denial.

- A request for retrospective review is available for members with back dated medical cards and/or primary insurance denials.

Retrospective requests for primary insurance denials must be accompanied with the Explanation of Benefits (EOB).

532.9 BILLING PROCEDURES

- Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- Claims must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.
- All claims must be billed using the UB04 or the 8371 electronic format; only revenue codes are required to be submitted on a claim form.

532.10 EMPLOYMENT RESTRICTIONS

The PDN Provider is responsible for ensuring that all staff are appropriately licensed and qualified to provide services.

No one with a conviction or prior history of abuse may be employed in a PDN capacity that provides services under the auspices of the West Virginia Bureau for Medical Services. Providers are expected to check Federal and State exclusion databases including the List of Excluded Individuals and Entities (LEIE) and the Excluded Parties List System (EPLS).

The PDN Provider must make sure all subcontractors comply with rules and regulations.

532.11 RECOVERY OF OVERPAYMENTS

Overpayments identified through review of claims data or audits are subject to recovery.

Employment of an individual with one or more sanctions, license restrictions, or criminal convictions will result in recoupment of monies paid for services provided during the applicable period or post-conviction date.

INQUIRIES:

Questions regarding billing or claim status should be directed to Molina Medicaid Solutions, P.O. Box 2002, Charleston, West Virginia, 25327. Toll Free number 1-888-483-0793

Questions regarding policy should be directed to Attn: Private Duty Nursing Program, Bureau for Medical Services at 350 Capitol Street, Room 251, Charleston, West Virginia 25301.

Questions related to medical necessity or authorization should be directed to APS at (304) 343-9663.

CHAPTER 532
PRIVATE DUTY NURSING SERVICES
EFFECTIVE SEPTEMBER 1, 2012

APPENDIX 1

PRIMARY CARE PROVIDER REQUEST FORM FOR PRIVATE DUTY NURSING

PRIVATE DUTY NURSING ACUITY GRID

PRIVATE DUTY NURSING PSYCHOSOCIAL GRID

PRIMARY CARE PROVIDER REQUEST FORM
FOR PRIVATE DUTY NURSING

Must be completed within 7 working days before start of care date and submitted to WVMI

Name:_____ Medicaid ID#_____

Address:_____

Telephone Number:_____ Date of Birth:_____

Diagnosis:_____

Prognosis and expectations of the Specific disease process:_____

Date of last physician assessment:_____

Approximate hours per day services required _____ hours

Approximate length of time services required: Weeks/Months. Specify length of time: _____

_____

Technology Requirements

1. **Ventilator dependent: _____YES _____ NO**

   Hours per day required on ventilator_____

2. **Intravenous fluids/medications: _____YES _____ NO**

   Type of intravenous fluids/medications:_____

3. **Enteral (Tube Feedings**
   Sole source of nutrition: _____YES _____ NO

   Type of nutrition/frequency: _____

4. **Oxygen: _____ YES _____ NO**

   Liters per minute and hours per day required: _____

5. **Non-ventilator dependent tracheostomy: _____ YES _____ NO**
   - **Please attach letter of medical necessity, also include medical history and start of care date for private duty nursing care.**

"I am in agreement that the individual is medically stable except for acute episodes that the Private Duty Nursing can manage."

Physician/APRN Signature: _____ Date:_____

Client _____ Private Duty Nursing Acuity Grid

	Pt	Sc		Pt	Sc		Pt	Sc
Weight < 100 lbs	2		Weight < 125 lbs	3		Weight 125 - 160 lbs	4.5	
Minimal ongoing assessments (less	2		Moderate ongoing assessments	4		Frequent visual monitoring	9.0	
than daily)			(Hands on every 4 - 6 hours)			(both technical and patient assessment)		
			VS/GLU/NEURO/RESP Assess < ❑ 4 hr*	1.5		Continual assessments	6.0	
						VS/GLU/NEURO/RESP Assess > ❑ 4 hr	1.0	
Routine meds more than ❑ 4 hrs	2		Complicated med schedule >❑ 2 hrs	5.0		VS/GLU/NEURO/RESP Assess > ❑ 2 hr	3.0	
			Central line	2.5		Reg blood draws/IV Peripheral site**	4.5	
			Occasional transfusion/IV < month	2.5		Reg blood draws/IV central line**	6.0	
						IV Rx less often than ❑ 4 hr	4.5	
Uncomplicated tube feeding	2		Tube feeding with minimal problem	2.5		IV Rx ❑ 4 hr or more often	6.0	
Difficult/prolonged oral feeding	2		Occasional reflux	0.5		Central line with TPN	6.0	
			Gastrostomy tube	0.5		Chemotherapy	6.0	
O2 via cannula low flow rate	2		Tracheostomy (routine care)	1.5		IV pain control	6.0	
Suctioning less often than ❑ 2 hrs	2		Suctioning more often than ❑ 2 hrs	2.5		Ventilator	9.0	
Aspiration precautions	2		Humidification	1.5		No resp effort 1	2.0	
						C PAP or IMV < 12 hrs/day	6.0	
						C PAP or IMV > 12 hrs/day	9.0	
			CPT or Neb Tx less than ❑ 4 hr*	1.5		Standby	3.0	
Requires all personal care/hygiene	2					Rehab transition (from ventilator)	9.0	
			Mild-mod seizures (Req min intervention)	2.5		CPT or NEB Rx > ❑ 4 hr* # _____	3.0	
			Frequency less than 4 x day	1.5		CPT or NEB Rx > ❑ 2 hr* # _____	3.0	
			Frequency 4 - 6 x day	2		Severe seizures (req IM or IV intervention)	4.5	
Uncontrolled incontinence	2		Intermittent straight catheter.	3.5		Frequency >6 x day	1.5	
Awake no more than 3 hr a night	2		Moderate sleep disturbance	3.5				
			(Awake/turned > ❑ 2 hr a night)			Uncontrolled incontinence	6.0	
Communication deficit (not cognitive	2		Disorientation/combative	5		(Frequent linen change)		
or verbal)			(Strikes out, attempts to hurt self)			Severe sleep disturbance (Awake >	6.0	
Developmental deficit	2		< 80 lbs	1.5		❑ 2 hr)		
			< 110 lbs	2		Disoriented/combative > 140 lbs	6.0	
			<140 lbs	2.5				
Developmentally delayed mobility	2					Requires isolation	6.0	
Basic ROM (No PT or OT program)	2		Full OT (Set program ❑ 4 hr)	5.5		Acute mobility problems	6.0	
Play therapy	2		Full PT (Set program ❑ 4 hr)	5.0		(Potential for skin breakdown)		
Fracture or casted limb	2					Attends school/therapy with nurse	6.0	
Body cast	2		RN case management < 4 hrs week	2.5		Peritoneal dialysis	6.0	
			RN case management > 4 hrs week	5.0				
TOTAL			**TOTAL**			**TOTAL**		

Pt - Point *** Give points** for each type of assessment and each Neb or CPT Rx **** Give points** for each IV Rx or blood draw ordered to a max of 10 points **Sc – Score**

Person Completing _____ **Date Completed** _____ **Total Points**_____

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Client _____ Private Duty Nursing Psychosocial Grid

	Minimal	Pt	Sc	Moderate	Pt	Sc	Extensive	Pt	Sc
Medical Management	Managed by primary care provider or one specialist.	**1**		Requires periodic medical specialty consultation.	**2**		Requires multidisciplinary team approach.	3	
Primary Caregivers	Other caregivers present in home to provide care.	**1**		Other caregivers available outside of home by arrangement.	**2**		No other caregivers available.	3	
Wage Earner	At least 2 responsible adults in home and primary caregiver is not primary wage earner.	**1**		At least 2 responsible adults in the home and primary caregiver contribute to wage earnings or is primary wage earner.	**2**		Primary caregiver may or may not be primary wage earner. Only one responsible adult in the home.	3	
Family Constellation	No other dependents/or dependents have minimal needs.	**1**		1 to 3 dependents with moderate medical or emotional needs.	**2**		Greater than 3 dependents in the home with intense medical or emotional needs.	3	
Problem Solving Skills	Exhibits problem identification and problem solving skills.	**1**		Requires assistance in identifying problems/problem solving.	**2**		Requires extensive assistance to recognize problems and identify solutions.	3	
Coping	Follows through with recommendations, keeps appointments.	**1**		Needs encouragement to follow through on recommendations. Inconsistent in keeping appointments.	**2**		Family follows through on recommendations only with extensive support and assistance.	3	
Support Systems	Support systems present and utilized.	**1**		Support system present but needs encouragement to utilize.	**2**		Support systems absent.	3	
Stressors	No history of mental illness, and/or behavior problems.	**1**		History of mental illness or behavior problems among family members.	**2**		Current diagnosis of mental illness and/ or behavior problems.	3	
Finances	Family's physical survival and security needs are met.	**1**		Family finances are inadequate, barely meets its needs for security and physical survival. Able to buy only necessities.	**2**		Family does not meet its needs for security and physical survival. Unable to buy the necessities.	3	
Resource Utilization and/or Private Insurance	Community resources and/or private insurance utilized.	1		Requires assistance in identification and utilization of resources.	**2**		Requires intensive assistance to identify and utilize resources.	3	
Safety/Shelter	No safety hazards or health hazards identified in home environment.	1		Needs assistance to correct safety and health hazards.	**2**		Home inadequate to meet minimum safety and health standards.	3	
ADL's	ADL's met consistently.	1		Inconsistent in meeting ADL's.	**2**		ADL's not met.	3	
	Total			Total			Total		

Pt – Point **Sc – Score**

Person Completing _____ Date Completed _____ Total Points_____

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CHAPTER 600–REIMBURSEMENT METHODOLOGIES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 615	CPT/HCPCS National Level Code Updates	12/16/05	01/01/06
Section 620	Third Party Liability	11/28/05	01/01/06
Section 640.16	Physician Services	07/18/05	Clarification of current policy
Sections620, 640.15, 640.16	Various	12/02/04	01/01/05
Section620	Third Party Liability	12/02/04	01/01/05
Section 630.2	Payment Recoveries	12/02/04	01/01/05
Section 640.15	Pharmacy Services	12/02/04	01/01/05

December 16, 2005

Section 615

Introduction: Effective 1/1/06, Medicaid will adopt the new 2006 National level 1 (CPT), and II (HCPCS) code updates. Covered procedures or services that were deleted by CMS 12/31/05, will be replaced with the appropriate National 2006 Code. Any procedure or service billed to Medicaid must be billed to Medicaid using the National Level I or II code. Permanent National codes will be used by Medicaid rather than the temporary codes. ***Please note that not all 2006 codes may be covered automatically by Medicaid.**

For non-covered services (NC), refer to the RBRVS file, or the applicable manual, etc., DME, J-Q code listing will be posted on the Bureau's web page at www.wvdhhr.org/bms. This notification will also appear on the Bureau's web page, as well as the banner pages of remittance vouchers.

Change: Inserting National Level Codes – CPT/HCPCS for 2006.

Directions: Replace all affected pages of current manual.

November 28, 2005

Section 620

Introduction: Revisions being made to reflect the change in Prior Authorizations requirements.

Change: Change the last sentence in the third paragraph to read as follows: Medicaid will then reimburse the lesser amount of the remainder of an approved claim up to the Medicaid allowable amount or the co-insurance and/or deductible amount.

Add the following statements as two new paragraphs after the third paragraph in each section:

Medicaid covered services which currently require a prior authorization (PA) from the BMS Utilization Management Contractor (UMC) will no longer need a UMC PA if a primary insurance approves that service. An approved service has one of the following listed on the explanation of benefits (EOB): allowed amount, deductible amount, co-insurance amount or payment amount. The EOB must accompany the invoice. If the service is not allowed by the primary insurance, but is a covered service for Medicaid and the service requires a PA from the UMC, Medicaid policy will be enforced.

Orthodontic and periodontic services will still require a Medicaid prior authorization from the UMC, when applicable, regardless of primary insurance requirements.

Directions: Replace all affected pages of current manual.

October 25, 2005

***Note: The changes noted in Section 620, Third Party Liability, of the manual have been effective since 1/01/05; however, due to a technological problem that occurred in July 2005, the manual contents reverted back to the content prior to the 1/01/05 effective date.**

July 18, 2005

Section 640.16

Introduction: Confusion has arisen from the example conversion factor calculation listed in the anesthesiology area of this section. The conversion rate shown is only an example, not the current conversion factor.

Change: Under *Anesthesiology*, added the wording “An example follows:” to clarify that the figures listed are only examples.

Directions: Replace the pages containing these sections.

December 2, 2004

Sections 620, 640.15, 640.16

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 620

Introduction: Changed methodology since conversion of Unisys.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 630.2

Introduction: The Office of Audits, Research, and Analysis has been changed.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Section 640.15

Introduction: Wording change to match Chapter 518 of the Pharmacy Services Manual.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

CHAPTER 600—REIMBURSEMENT METHODOLOGIES

TABLE OF CONTENTS

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CHAPTER 600–REIMBURSEMENT METHODOLOGIES

600 INTRODUCTION

This chapter provides an overview of various types of reimbursement methodologies utilized by the Bureau for Medical Services (BMS) to reimburse providers for West Virginia (WV) Covered Medicaid services. Information is also provided regarding Medicaid as a secondary payer, and Medicaid's relationship to Medicare.

610 DIAGNOSIS RELATED GROUPS (DRG)

"Diagnosis Related Groups (DRG)" is a classification system that groups patient services according to diagnosis, type of treatment, age, and other relevant criteria, and is widely used for reimbursement of inpatient services. All acute care hospitals are reimbursed using DRG methodology. It is a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual. The DRGs are reviewed and recalculated annually using adjustment/severity factors applicable to certain types of admissions.

611 RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)

The West Virginia Medicaid Program administered by the Bureau For Medical Services, West Virginia Department of Health and Human Resources (DHHR), together with the Public Employees Insurance Agency and the Worker's Compensation Fund of the Bureau of Employment Programs implemented a common payment system for reimbursement of physician and other practitioner services based on a modified version of the Resource Based Relative Value Scale (RBRVS) adopted by the Medicare Program. To the extent their services are covered by West Virginia Medicaid, the following types of providers are reimbursed under the RBRVS fee schedule:

- Physicians (including doctors of medicine and osteopathy and Physician Assistants working under their supervision)
- Limited licensed practitioners (including doctors of optometry, podiatry, dental surgery and dental medicine: oral and maxillofacial surgery and chiropractors)
- Independently practicing Physical Therapists and Occupational Therapists (when providing outpatient services only)
- Suppliers of the technical component of radiology or diagnostic services
- Family and Pediatric Nurse Practitioners
- Nurse Midwives
- Certified Registered Nurse Anesthetists.

615 CPT/HCPCS NATIONAL LEVEL CODE UPDATES

Effective 1/1/06, Medicaid will adopt the new 2006 National level 1 (CPT), and II (HCPCS) code updates. Covered procedures or services that were deleted by CMS 12/31/05, will be replaced with the appropriate National 2006 Code. Any procedure or service billed to Medicaid must be billed to Medicaid using the National Level I or II code. Permanent National codes will be used

by Medicaid rather than the temporary codes. ***Please note that not all 2006 codes may be covered automatically by Medicaid.**

For non-covered services (NC), refer to the RBRVS file, or the applicable manual, etc., DME, J-Q code listing will be posted on the Bureau's web page at www.wvdhhr.org/bms. This notification will also appear on the Bureau's web page, as well as the banner pages of remittance vouchers.

620 THIRD PARTY LIABILITY (TPL)

Medicaid is often referred to as the "payer of last resort." TPL is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid enrolled providers must always seek primary reimbursement from other liable resources, including private or public insurance entities.

Federal regulations require that State Medicaid Administration identify any third-party resource available to meet the medical expenses of a member. The "third party" may be an individual, institution, corporation, or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, United Mine Worker of America (UMWA) benefits, Veterans Administration (VA) benefits, Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), Medicare, etc. No Medicaid reimbursement will be made if the service is the responsibility of a public or private Workers Compensation Plan.

All providers must ask Medicaid members if he or she has other public or private insurance or if there is potential that another entity may be liable for the service expense. Once identified, the provider must bill the third party. After receipt of payment or notice of denial for services rendered, the provider may then bill the claim to Medicaid with an attached copy of the Explanation of Benefits (EOB) from the primary payer. Medicaid will then reimburse the lesser amount of the remainder of an approved claim up to the Medicaid allowable amount or the co-insurance and/or deductible amount.

Medicaid covered services which currently require a prior authorization (PA) from the BMS Utilization Management Contractor (UMC) will no longer need a UMC PA if a primary insurance approves that service. An approved service has one of the following listed on the explanation of benefits (EOB): allowed amount, deductible amount, co-insurance amount or payment amount. The EOB must accompany the invoice. If the service is not allowed by the primary insurance, but is a covered service for Medicaid and the service requires a PA from the UMC, Medicaid policy will be enforced.

Orthodontic and periodontic services will still require a Medicaid prior authorization from the UMC, when applicable, regardless of primary insurance requirements.

If the member receives the insurance payment or notice of denial, it is the responsibility of the member to forward the payment or denial to the provider. The member is considered "private pay" until such time as the member supplies needed information.

Medicaid members are not responsible for any third party related co-insurance amounts, deductible amounts, or Health Maintenance Organization (HMO) related co-pays and deductibles, even if the claim payment is zero ($0.00) when the claim payment has been

reduced to zero ($0.00) as a result of the insurance payment or capitation agreement. Medicaid will not reimburse for contractual adjustments, e.g., UMWA deductibles/co-payments or deductibles and co-payments related to HMOs and capitation agreements. The member is also not responsible for these charges.

When a third party has paid as primary and Medicaid is paying as secondary, the system will calculate the Medicaid allowed amount and then compare the co-insurance/co-pay amount and the deductible amount to the difference between the paid amount and the Medicaid allowed amount and pay the lesser of these amounts.

Example 1:

Medicaid allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/co-pay amount due	$20.00
Difference	$ 50.00
Deductible amount due	$10.00
Total amount due	$30.00

Medicaid would pay $30.00 because that is the lesser amount.

Example 2:

Medicaid allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/co-pay amount due	$ 0.00
Difference	$ 50.00
Deductible amount due	$ 0.00
Total amount due	$ 0.00

Medicaid would pay $ 0.00 because that is the lesser amount.

Example 3:

Medicaid allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/co-pay amount due	$0.00
Difference	$ 50.00
Deductible amount due	$100.00
Total amount due	$100.00

Medicaid would pay $50.00 because that is the lesser amount.

Providers must include the co-insurance/co-pay and deductible amounts in their electronic 837 transactions. A copy of the explanation of benefits (EOB) should then be mailed to Unisys with the member Medicaid ID number and provider number listed on the EOB. If a provider is billing on paper, a copy of the explanation of benefits (EOB) must accompany the claim. If a claim is denied by the insurance, the EOB must include the denial reason(s) not just the denial code.

Some West Virginia Medicaid members who are age 65 years or older, or disabled, or have End Stage Renal Disease, or other qualifying Medicare diagnoses, are also eligible for Medicare benefits. Medicare is therefore the primary payer for services covered by both Medicare and Medicaid. In such instances, West Virginia Medicaid pays the Medicare deductible and coinsurance amounts, up to WV Medicaid fee schedule.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and Third Party Liability (TPL) related are subject to a filing deadline of 12 months from the date of the Medicare payment. If another third party is billed for a service and the 1 year filing deadline for Medicaid billing is almost exhausted, the provider should bill Medicaid immediately even though the other third party has not furnished the provider with information about payment. The claim should be billed on paper. A note explaining the situation and a copy of relevant documentation must be attached to the claim when submitted to Medicaid. Even if Medicaid denies the claim, the submission will give the provider another year (from the 1-year anniversary of the date of service) to file a claim with Medicaid while the primary payer processes the claim.

In accordance with Federal regulations, a provider may not refuse to furnish services covered under a third party plan to an individual who is also eligible for Medicaid. A provider may not elect to bill Medicaid primary knowing the existence of potential TPL.

For additional TPL information and requirements please refer to Chapter 100, General Information, Chapter 300, Provider Participation Requirements, Chapter 400, Member Eligibility, and Chapter 800, General Administration.

620.1 COORDINATION OF BENEFITS (COB)

Medicaid members may have other third-party coverage of health expenses, such as Medicare, employment-related coverage, Medicare supplemental or private health insurance, long-term care insurance, automobile insurance, court judgments, or Workers' Compensation. For members with multiple plan coverage, coordination of benefits is the process that involves determining the order in which insurers are billed for a given service.

As required by law, Medicaid is the "payer of last resort," meaning that other parties must be billed before Medicaid can be billed for the service. In other words, the other party is the primary payer and Medicaid is the secondary or perhaps tertiary payer. All resources must be exhausted before Medicaid can consider payment. In addition, no Medicaid payment is made for services associated with a medical condition covered by Workers' Compensation. When the Ryan White Fund is available to a Medicaid member, the Ryan White Fund is the payer of last resort. Catastrophic Illness and Breast and Cervical Cancer Programs are also the payer of last resort.

West Virginia Medicaid cannot be billed for services that a member receives but the provider makes available at no charge to other individuals or groups of individuals.

620.2 TORT RECOVERY - OTHER INSURANCE SETTLEMENTS

In the case of TPL, the provider is required to pursue the possibility of TPL if the services provided are a result of an accident or trauma. If, after a reasonable time, a settlement has not been reached or payment from the liable party has not been received, the provider may choose to bill West Virginia Medicaid. However, you must accept the Medicaid payment as payment in full and cannot refund the West Virginia Medicaid Program in order to pursue reimbursement from any settlement proceeds.

The provider should secure information regarding possible third-party coverage and should require an assignment of benefits prior to the release of any information that can be used for insurance settlement.

Under section 1912(b) of the Social Security Act, the member is entitled to any remaining recovery amount after the Medicaid Program (both Federal and State shares) has been reimbursed.

When billing West Virginia Medicaid, documentation of all recovery efforts including the name, address and phone number of any attorney or insurance company must be submitted. The Bureau for Medical Services will then be responsible for recovering the amount of Medicaid payment from the liable third party.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and TPL related are subject to a filing deadline of 12 months from the date of the Medicare payment.

620.3 RELATIONSHIP TO MEDICARE (DUAL ELIGIBLE)

Medicaid covers medically necessary health services furnished to individuals who meet specific income, resource and eligibility standards. Medicare is a Federal program that offers health insurance coverage to individuals 65 years of age or older, to those who have received Social Security disability benefits for 24 consecutive months, to those who have end stage renal disease, to those on advanced life support, and to other eligible individuals, as specified by other provisions of the Social Security Act.

West Virginia Medicaid covers the applicable co-insurance and deductible amounts, not to exceed Medicaid's allowable payment, for services covered by Medicare Parts A and B for all eligible Medicaid members who are also entitled to Medicare benefits. The Medicaid Program may also provide payment for services not covered by Medicare.

A member with both Medicare and Medicaid coverage is identified as "dual eligible." Medicaid reimburses secondary to Medicare. If a Medicare Supplemental policy exists in addition to Medicare and Medicaid coverage, Medicaid is the third party payer subsequent to Medicare and Medicare Supplemental payments.

Refer to Chapter 300 for other specific provider information on the Medicare Program and its relationship to the West Virginia Medicaid Program, including Medicare provider numbers as part of your Medicaid enrollment responsibilities.

630 MMIS REIMBURSEMENT OR PAYMENT FUNCTIONS

The Medicaid Management Information System (MMIS) provider payment subsystem contains a gross adjustment and payment recovery function. These functions are routinely employed as follows:

630.1 GROSS ADJUSTMENTS

The gross adjustment function is used to make a lump sum provider payment. This function is used to pay: claims corrections, cost report settlements (amounts due provider), disproportionate share hospital payments, HMO payments, and Medicare Part A and B premium payments. All gross adjustments must be reviewed and approved by BMS staff as an internal control measure.

630.2 PAYMENT RECOVERIES

The payment recovery function is used to recover provider overpayments. Recoveries generally occur when providers bill incorrect services with higher rates, audit findings indicate inappropriate billings, and cost report settlements (amounts due Medicaid). Various authorized BMS staff prepares recoveries. The unit supervisor authorizes claim overpayment recoveries. The Department's Office of Accountability and Management Reporting authorize cost report settlement recoveries. The Bureau's Chief Financial Officer, Legal Counsel, Surveillance and Utilization Review Unit Director, or Commissioner authorizes audit-finding recoveries.

Refer to Chapter 800 for information on Administrative Hearings providing a process for providers to contest allegedly erroneous payment recoveries.

640 SPECIFIC PROGRAM REIMBURSEMENT

Specific programs are identified below in alphabetical order:

640.1 AGED AND DISABLED WAIVER SERVICES

Services are reimbursed based on the Medicaid fee schedule.

640.2 BEHAVIORAL HEALTH CLINIC SERVICES

Services are reimbursed based on the Medicaid fee schedule.

640.3 BEHAVIORAL HEALTH REHABILITATION SERVICES

Services are reimbursed based on the Medicaid fee schedule.

640.4 DENTAL SERVICES

West Virginia’s RBRVS fee schedule is used to pay for dental surgeries covered by the schedule when billed by a physician. Other covered dental services are paid using a fee schedule that establishes a fee for each American Dental Association (ADA) procedure code. In each case, Medicaid payment is based on the lower of the amount of the dentist charges for the service or the fee schedule amount.

640.5 DURABLE MEDICAL EQUIPMENT

Medicare fee schedules are used to pay for Durable Medical Equipment (DME), medical supplies and orthotic and prosthetic devices. DME and prosthetic or orthotic devices are separated into the following classes:

- Inexpensive or other routinely purchased DME
- Items requiring frequent and substantial servicing
- Customized items
- Prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment.

A separate method applies to each class. Medicaid payment is made on a rental or purchase basis. The total payment for rented equipment may not exceed the cost of purchasing the equipment. Custom items are constructed for the use of an individual and may not be used by anyone else, and may be purchased for that individual. All other items of medical equipment are reimbursed on a 10-month capped rental basis.

Medicaid payment is based on the lower of the amount the supplier charges for an item or the fee schedule amount. This same rule applies to payments for repairs and maintenance.

640.6 FREE STANDING AMBULATORY SURGICAL CENTERS

Reimbursement for these services is 90 percent of the Ambulatory Surgical Center levels of reimbursement determined by Medicare.

640.7 HOME HEALTH CARE SERVICES

Medicare fee schedules are used to determine the amount paid for skilled home health care for the following services: nursing care, rehabilitation services (occupational therapy, physical therapy, and speech pathology), home health aide services, and medical social services. The unit of payment is a visit.

Medicare fee schedules are also used to determine the amount paid to home health agencies for DME, medical supplies, and orthotic and prosthetic devices.

Medicaid payment is based on the lower of the amount a home health agency charges for a service or item or the fee schedule amount.

640.8 HOSPICE SERVICES

Hospital hospice and home hospice reimbursements are based on the Medicaid fee schedule. Nursing home hospice is reimbursed a percentage of the patient specific nursing home rate.

640.9 HOSPITAL INPATIENT CARE SERVICES

West Virginia Medicaid pays a prospective rate for each inpatient discharged from an acute care hospital. The rate is fixed and is established before care is provided. The rate depends on the DRG to which a patient is assigned. Patients are classified into DRGs based on their diagnoses, surgical procedures, age, and other relevant criteria. The payment rate varies directly with a patient's medical needs and expected treatment costs, and is adjusted for hospital wage

differences and medical education costs, if applicable. Cost differences between large urban hospitals and all other hospitals are also recognized.

Additional amounts are paid for patients who are extraordinarily costly to treat ("high cost outlier cases") and to disproportionate share hospitals. Payment for capital costs is on a prospective, per inpatient basis. Payment for direct medical education costs is reimbursed in a lump-sum amount.

Special prospective payment rules apply to community hospitals. Psychiatric, rehabilitation, and rural primary care hospitals are reimbursed on a cost-related basis**.**

Payment to out-of-State hospitals is based on the in-State prospective payment system.

640.10 HOSPITAL OUTPATIENT CARE SERVICES

Hospital outpatient services are reimbursed using several different methodologies. The following are examples of these methodologies:

- Emergency Room and Observation are reimbursed using the Medicaid fee schedule.
- Surgeries are reimbursed at a set amount multiplied by the total unit of time. Recovery is also based on a set amount multiplied by the total units of time.
- Radiology, physical therapy, and occupational therapy services are reimbursed using RBRVS.
- Critical Access Hospital (CAH) services are reimbursed by billing outpatient services at an encounter rate set by the Office of Audits or by fee for service, and are allowed to choose the method of reimbursement.

640.11 LABORATORY SERVICES

Medicare fee schedules are used to pay for clinical diagnostic laboratory tests provided by all clinical laboratories, except hospital-based laboratories performing such tests for their own inpatients. Payment for laboratory services is based on the lower of 90 percent of the Medicare fee or the amount the provider charges for the service.

Certain tests exempt from Medicare's fee schedule for clinical diagnostic laboratory services are paid under the RBRVS fee schedule. Specific Federal rules apply for determining payments for laboratory profile tests and organ/disease panels.

640.12 MR/DD SERVICES

The MR/DD program reimburses for services using the Medicaid fee schedule.

640.13 NURSING FACILITY CARE SERVICES

Reimbursement for nursing facilities is a cost-based per diem based on facility operational costs, nursing services, and investment/cost of capital and patient acuity.

640.14 PERSONAL CARE SERVICES

Personal Care Services are reimbursed using the Medicaid fee schedule.

640.15 PHARMACY SERVICES

Maximum reimbursement for each drug claim processed will be based on the lowest of:

(1) The usual and customary charge to the general public;

(2) The Maximum Allowable Cost (MAC) for each multiple-source drug as defined in 42 CFR 447.332 and published in the Federal Register plus a dispensing fee. A listing of Federal Multiple Source Drug Limits is available on the Centers for Medicare and Medicaid Services (CMS) website, www.CMS.gov/medicaid/drug10.htm.

EXCEPTION: The MAC shall not apply in any case where a physician certifies in his/her own handwriting that, in his/her medical judgment, a specific brand is medically necessary for a particular patient. A notation like "brand medically necessary" written by the physician on the prescription above his/her signature is an acceptable certification. A procedure for checking a box on a form will not constitute an acceptable certification. All such certified prescriptions must be maintained in the pharmacy files and are subject to audit by BMS.

(3) The State Maximum Allowable Cost (SMAC) plus a dispensing fee;

(4) The Medicaid AWP (MAWP) established by the Federal Office of the Inspector General plus a dispensing fee;

(5) Estimated Acquisition Cost (EAC) plus a dispensing fee. The EAC is defined as Average Wholesale Price (AWP) minus 12%.

640.16 PHYSICIAN SERVICES

Medicare's RBRVS is used to determine the fees that physicians are paid to diagnose and treat Medicaid members. The RBRVS is also used to pay for certain services furnished by other practitioners. The list of such practitioners includes:

- Audiologists
- Advanced registered nurse practitioners
- Certified registered nurse anesthetists
- Chiropractors
- Occupational therapists
- Optometrists
- Physical therapists
- Podiatrists

The payment amount is based on the lower of the fee or the amount the practitioner charges for the service.

The RBRVS is a list of services with a weight or relative value unit (RVU) assigned to each service. The weight indicates a service's costliness compared to that of the average service, which has a weight of 1.0 unit. A service with a weight of 1.75 units is therefore 175 percent as costly as the average service, while a service with a weight of 0.73 units is 73 percent as costly as the average service. The more a service costs to provide, the higher the amount paid for the service.

The fee for a service is determined by multiplying the service's weight by a conversion factor. The conversion factor is the dollar value of 1.0 relative value unit. The Bureau for Medical Services establishes the conversion factor for services provided to Medicaid patients. If the conversion factor was $30.00 and the weight for a service was 2.25, the fee for that service would be $67.50.

Conversion Factor x Relative Value Units = Reimbursement

$30.00 x 2.25 = $67.50

The RBRVS file can be found on the Bureau for Medical Services website. The information on the file shows the weights assigned to services covered by the RBRVS fee schedules. The Federal Government updates the weights annually.

A service's total weight consists of the following parts:

- Physician Work—time, effort, and skill that a physician (or other practitioner) expends on average to provide the service.
- Practice Expenses—wages, salaries, and fringe benefits paid to office staff, rent, utilities, and other office expenses plus medical equipment.
- Malpractice Insurance—cost of professional liability insurance.

There are two different practice expenses for many services. That explains why there are two total weights for most services. The weight that applies to a particular service depends on where the service is provided.

- The "facility practice expense" weight applies if the service was provided in a hospital or other facility setting
- The "non-facility practice expense" weight applies if the service was provided in a practitioner office setting.

The "facility practice expense" weight, if applicable, is often lower than the "non-facility practice expense" weight. The reason is so because the facility absorbs part of the cost of providing the service when the service is provided in a facility setting. The physician is not paid for costs absorbed by the facility.

Services that cannot be performed in a non-facility setting do not have a non-facility practice weight and no total weight is shown for these services. Such services are often surgical procedures that require the physician to have access to equipment and personnel that are not available in outpatient settings.

Anesthesiology—Medicaid fees for anesthesiology services are calculated somewhat differently from the fees paid for all other physician services. The fee equals the conversion factor for anesthesia services multiplied by the sum of the base units and time units for a service and not relative value units. The base units for a given anesthesia service are the same every time that service is provided and established by the American Society of Anesthesiologists (ASA). The time units depend on the length of time to provide the service. Time units are expressed in 15-minute blocks and are expressed in whole units of time. Thus, a service that takes 75 minutes would be assigned 5 time units.

If an anesthesia service has 3 base units and 5 time units and the anesthesia conversion factor is $15.25 per unit, the fee would be $122.00. An example follows:

Conversion Factor x Total Units = Reimbursement

$15.25 x 8 = $122.00

Time units do not apply to certain anesthesia services. These services are paid using base units only.

640.17 PSYCHOLOGY SERVICES

Most of the services for psychologists are reimbursed using RBRVS. Currently there is one procedure code that is reimbursed at 90 percent of Medicare's fee schedule.

640.18 RADIOLOGY AND CERTAIN OTHER DIAGNOSTIC SERVICES

Radiology services have a professional and technical component. The professional component (identified by modifier 26) represents the portion of the service associated with the physician's interpretation of the test. The technical component (identified by modifier TC) represents the portion of the service associated with the performance of the test. The physician may be paid for the professional component while a hospital where the service is furnished may be paid for the technical component. Alternately, the physician is paid for both components if he or she performs the entire or global service—that is, performs and interprets the service.

For example, the total weight for CPT 70010 (Contrast X-ray of Brain) is 5.28. This consists of a total weight of 5.28 units, consisting of weight for 1.56 units for the professional component and 3.71 units for the technical component.

640.19 RHC/FQHC

Medicare sets reimbursement for these services.

640.20 TRANSPORTATION

Reimbursement for transportation services utilizes the Medicaid fee schedule. Separate rates are paid for ground and air ambulances, including an amount for mileage.

640.21 VISION SERVICES

Vision services are reimbursed using the Medicaid fee schedule. Additionally, some services are paid at 90 percent of the Medicare fee.

CHAPTER 800(A) – GENERAL ADMINISTRATION

CHANGE LOG

Replace	Title	Change Date	Effective Date
New Manual	Chapter 800 - General Administration	January 1, 2009	January 1, 2009
Chapter Name	Chapter 800(A) – General Administration	December 1, 2012	December 1, 2012

CHAPTER 800(A) - GENERAL ADMINISTRATION

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Chapter 800(A) - General Administration

INTRODUCTION

This chapter provides a general overview of the organization of the Bureau for Medical Services (BMS), including information on provider relation services, utilization review activities, and recovery of provider overpayments. In addition, this chapter sets forth the BMS' general administrative requirements for all providers enrolled in the West Virginia Medicaid Program concerning the services provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein and published as regulations governing the provision of all services in the Medicaid Program are administered by the West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

Additional information and requirements may also be found in the other chapters of the Provider Services Manuals:

- Chapter 100 General Information
- Chapter 300 Provider Participation Requirements
- Applicable Provider Manuals, Covered Services, Limitations and Exclusions, for specific health care areas of expertise

800.1 ADMINISTRATIVE RESPONSIBILITY

Responsibility for the administration of the Medicaid Program within the West Virginia Department of Health and Human Resources (DHHR) is placed within the BMS. The Commissioner of BMS has overall responsibility for the administration of the Medicaid Program (Title XIX).

There are 8 major Offices within BMS. The Offices are:

- Office of the Chief Financial Officer
- Office of Facility Based and Residential Care Services
- Office of Home and Community Based Services
- Office of Medicaid Management Information System (MMIS) Operations & IT Support
- Office of Pharmacy Services
- Office of Policy and Administrative Services
- Office of Professional Health Services
- Office of Quality & Program Integrity

Each of these Offices reports to the Commissioner of BMS.

In addition to its internal organization, BMS contracts with other entities for a number of administrative and operational functions including, but not limited to, Medicaid Management

Information System (MMIS), utilization management, fiscal intermediary, program management, and third party liability.

800.2 BUREAU FOR MEDICAL SERVICES' ORGANIZATIONAL STRUCTURE

- **The Office of Financial Services:** The Office of Financial Services is responsible for developing and tracking the Bureau's annual budget request and subsequent appropriations. This Office is responsible for preparing quarterly expenditure estimates and reports required by the Centers for Medicare and Medicaid Services (CMS), and the State Legislature. During the annual legislative session, this Office is also responsible for reviewing all bills affecting the Medicaid Program, preparing fiscal notes, and attending hearings as assigned. Additionally, this Office is responsible for the following:

    1. Budget & Reporting Division - The Division is responsible for managing the Bureau's Medical Services, Administrative, and Federal Reporting activities.
    2. Rate Setting Division - The Division sets payment rates for services provided by hospitals, physicians, and other health care providers participating in the West Virginia Medicaid program. Rates are set annually for more than 35,000 covered services. Additionally, the Unit is responsible for setting rates for the Bureau's supplemental payments.

3. Accounting Division - The Division is responsible for the Bureau's accounts payable, cash management, inventory/asset control, and purchasing control activities.
    4. Drug Rebate Division - The Division is responsible for managing the Bureau's Federal, and supplemental Drug rebate programs; and collecting millions of dollars annually from drug manufacturers.

- **Office of Facility Based and Residential Care Services**: The Office of Facility Based and Residential Care is responsible for the administration and oversight of various aspects of the policy unit that includes, but are not limited to, hospitals, both medical and mental health, Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs), organ transplants, renal dialysis, child residential treatment facilities, Psychiatric Residential Treatment Facilities (PRTF), Partial Hospitalization programs, Nursing Facilities and Intermediate Care and Mental Retardation Facilities (ICF/MR).

  This Office is responsible for the maintenance of the policy for the following provider manuals:

    1. Ambulatory Surgical Centers and Birthing Centers Services
    2. Hospital Services
    3. ICF/MR Services
    4. Nursing Facility Services
    5. Partial Hospitalization Services
    6. PRTF Services

7. RHC/FQHC Services

- **Office of Home and Community Based Services**: The Office of Home and Community Based Services (OH&CBS) is responsible for the development of home and community based human services systems that provide home health, hospice, mental health, waiver based services to West Virginia's families, children and vulnerable adults.

  This Office is responsible for the maintenance of the policy for the following provider manuals:

  1. Aged and Disabled Waiver Services
  2. Behavioral Health Clinic Services
  3. Behavioral Health Rehabilitation Services
  4. Children with Disabilities Community Services Program
  5. Home Health Services
  6. Hospice Services
  7. MR/DD Waiver Services
  8. Personal Care Services
  9. Targeted Case Management
  10. Psychological Services

- **Office of MMIS Operations & IT Support**: The Office is responsible for managing the Bureau's Medicaid Management Information System (MMIS) and Information Technology supports (ITS). The Office manages the State's fiscal agent contractor, and coordinates with the Bureau's Policy Units and various Department activities to ensure the State's Medicaid eligibility and coverage policies are correctly implemented within the MMIS. The Office is responsible for screening and processing ad hoc data requests. Also, the Office is responsible for planning and managing the Bureau's Information Technologies and State and Department network access, Third Party Liability (TPL), Eligibility, and MWIN (Buy-In).

- **Office of Pharmacy Services**: The Office of Pharmacy Services (OPS) is responsible for providing policy for drug coverage for Medicaid members in compliance with all Federal and State requirements and for providing a means for which pharmacy claims can be processed in order to provide this service. The OPS also provides a means for State Programs, Juvenile Justice System Program, Children with Special Health Care Needs, and the AIDS Drug Assistance Program to process their claims for pharmacy services.

- **Office of Policy and Administrative Services**: The Office of Policy Administrative Services is responsible for the administration and oversight of various aspects of the policy unit that include, but are not limited to Policy Coordination and Provider Enrollment, State Plan Administration, BMS vendor Contracts, BMS Administrative policies and oversight of other associated programs.

- **Office of Professional Health Services**: The Office of Professional Health Services is responsible for the following outpatient services provided by practitioners, certified providers and Medicaid Managed Care Organizations in accordance with current State, Federal, and Local regulations, medical practice standards, and mutual contracts, as applicable.

  This Office is responsible for the maintenance of the policy for the following provider manuals:

  1. Chiropractic Services
  2. Dental Services
  3. DME/Medical Supplies
  4. Laboratory Services
  5. Radiology Services
  6. Occupational/Physical Therapy Services
  7. Orthotics and Prosthetics Services
  8. Practitioner Services
  9. Podiatry Services
  10. Transportation Services
  11. Vision Services
  12. Speech and Audiology Services

- **Office of Quality & Program Integrity**: This Office has three functions:

  Surveillance and Utilization Review (SUR)

  SUR is responsible for conducting on-site and desk audits to monitor Medicaid program compliance for fee-for-service providers in compliance with State and Federal Medicaid policy and regulations.

  Quality Assessment

  This Division performs research and analysis to determine the quality of services provided to West Virginia's Medicaid recipients based on best clinical practices. Also, the Division analyzes the outcomes resulting from the Bureau's medical policies to determine the overall impact on the health of its members.

Program Integrity
This oversees all aspects of maintaining the integrity of the Medicaid Program.

800.3 PROVIDER ENROLLMENT/RELATIONS

An effective Medicaid Program is dependent upon the support and cooperation of the providers that render medical care and services. BMS is responsible for establishing and maintaining effective communication with providers participating in the Medicaid Program. Appropriate provider relations staff is available to respond to provider inquiries regarding (1) program policy, (2) reimbursement, (3) proper filing of claims, and (4) various other issues.

For a list of contacts and telephone numbers for specific provider relation activities, please refer to Chapter 100 General Information.

800.4 PROGRAM POLICIES

Program policies are specified in and disseminated to the provider community through program manuals. BMS will update manuals with new, revised, or clarified information, as applicable. The process may include manual updates to the web site, email notification, and/or direct mail. Please reference Chapter 100, topic "Manual Updates".

800.5 PROVIDER PARTICIPATION

Any provider may make application to enroll in the West Virginia Medicaid Program. For specific provider enrollment requirements, please refer to Chapter 300, Provider Participation Requirements and/or applicable provider manuals.

800.5.1 EXCLUSION FROM PARTICIPATION

The Commissioner of BMS, or his/her designee, may suspend or exclude a provider from participation in the Medicaid Program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations, or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Medicaid Program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review.

800.5.2 EXCLUSION BY MEDICARE (TITLE XVIII)

A provider, who is excluded from participation in the Medicare Program (Title XVIII), is also excluded from participation in the Medicaid Program effective with the date of exclusion from Medicare.

800.5.3 EXCLUSION BY STATE MEDICAID AGENCY

A provider who is excluded from participation in the Medicaid Program (Title XIX) of another state may be excluded or denied participation in programs administered by BMS with the effective date the West Virginia BMS is notified of such exclusion.

800.5.4 DISCLOSURE REQUIREMENTS BY PROVIDERS

Providers must disclose to BMS the identity of any person who:

- Has ownership of 5 or more percent, or controlling interest in the provider practice or is an agent or managing employee of the provider;
- Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services;
- Has been included in the Office of the Inspector General's List of Excluded Individuals/Entities;
- Has been convicted of any crime related to health care delivery.

800.6 OFFICE OF QUALITY AND PROGRAM INTEGRITY

Federal Regulations as stated in 42 CFR 431.10 require the Single State Agency (in West Virginia this is BMS) to assure that services reimbursed by the Agency are medically necessary, appropriate, rendered in an approved setting by approved providers and that the services are supported by documentation in the record and recorded at the time of service.

The BMS addresses these requirements through activities performed throughout the BMS and in conjunction with our contractors, i.e., provider enrollment, claim system edits, prior authorization of services to assure they are medically necessary and appropriate and routine review of claims post payment to assure the processing of the claim follows BMS policy.

The Office of Quality and Program Integrity (OQPI) is the unit primarily responsible for post payment review of claims. One of the functions of this Office is to detect and examine unusual patterns of reimbursement to providers and unnecessary or inappropriate utilization of care and services rendered to Medicaid members. This function is commonly referred to as Surveillance and Utilization Review (SUR) activities. In addition, the OQPI researches complaints of fraud waste and abuse from all sources, and cooperates with CMS in the performance of various programmatic reviews such as Payment Error Rate Measurement (PERM), and program integrity reviews through the Medicaid Integrity Group as defined in the Deficit Reduction Act of 2005.

For additional information and contact telephone numbers on Utilization Review, please refer to Chapter 100, General Information, Chapter 300 Provider Participation Requirements, and applicable provider manuals for specific service authorization requirements.

800.6.1 SURVEILLANCE AND UTILIZATION REVIEW ACTIVITIES

The Office of Quality and Program Integrity (OQPI) is responsible for the evaluation of the medical necessity, appropriateness, adherence to current medical practice standards and conformance to nationally accepted billing practices. The reviews may involve the use of exception criteria, provider and member profiles, ad hoc reports obtained from the MMIS, and examination of provider records.

Provider reviews may be done by requesting documentation of services be submitted for review at the OQPI, or may be conducted at the provider's location. Medicaid members sign a release of information as part of the application process; therefore, no additional release of information is required for providers to make records available for review. Failure to comply with a request for records may result in a hold on all Medicaid payments until the records are received. Records may be selected using sampling techniques.

When onsite reviews are conducted, whenever possible, providers will make available a work area which provides some privacy and guarantees the confidentiality of the records during the review process. The cost of making necessary copies to validate appropriate utilization is included in provider reimbursement for Medicaid procedures.

When the BMS has identified unnecessary and inappropriate practices through monitoring activity or other reviews, it may pursue one or more of the following:

1. Recoupment of inappropriately paid monies
2. Requirement of a satisfactory written plan of correction
3. Limited participation in the plan that may include:
    - Prior authorization for all services;
    - Prepayment review of all applicable claims;
    - Suspension of payment until a plan of correction is filed and accepted;
    - Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
    - Ban on approving admissions for inpatient services;
4. Exclusion from participation in the West Virginia Medicaid Program through the following actions;
    - Suspension;
    - Disenrollment;
    - Denial, non-renewal, or termination of provider agreements.
5. Referral to Medicaid Fraud Control Unit (MFCU)
6. Withholding of payment involving fraud or willful misrepresentation.

Recoupment, if a provider is paid monies inappropriately, will be handled as defined in section 800.11.1 of this manual.

When a written plan of correction is required the provider must create and submit said plan to BMS within the time specified in the notice. Said plan should address all deficiencies noted in

the review report and give steps on how the actions will correct deficiencies and define time lines related to successful implementation of the corrective action plan.

In cases of limited enrollment, BMS will notify the provider in writing regarding the limitation placed on participation, the duration of the limitation, and the corrective action necessary to remove the restriction. In cases of exclusion from participation, BMS will notify the provider in writing in advance as to the reasons for exclusion and the effective date and duration.

After receipt of the notice that participation is being restricted or terminated, the provider may, within 30 days from the receipt, request a document/desk review.

800.7 PRIOR AUTHORIZATION OF SERVICES

- Please see applicable manuals for Prior Authorization requirements.

The provider must contact the medical review organization to obtain prior authorization for members who have exhausted their service limits. For contact and telephone number information for the contracted medical review organization, refer to Chapter 100 of the Provider Manual.

In order to receive payment from BMS, a provider shall comply with all prior authorization requirements. The BMS, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment. All other requirements must be met for payment.

Medical review organizations under contract to BMS are the final clinical authority. Also see Chapter 518 Pharmacy Services.

800.8 CLAIMS PROCESSING SCHEDULE

BMS processes provider payments once per week. Approved claims are posted to accounts payable after MMIS adjudication cycles. Approved claims are held in accounts payable until sufficient funds are available for payment. The provider payment cycle begins each Friday.

The Provider Relations department assists with questions regarding claims reimbursement, including face-to-face meetings where applicable. Further information regarding billing and reimbursement can be found in applicable provider manuals and Chapter 600.

800.9 ELECTRONIC CLAIMS SUBMISSION

Submitting claims via electronic media offers the advantage of speed and accuracy in processing. The provider may submit Medicaid claims through an electronic medium or choose from several firms that offer electronic submission services.

BMS Policy encourages electronic claim submission, as well as requires electronic funds transfer from its enrolled providers. If interested in submitting claims via electronic media, contact the Electronic Claim Specialists at the address below:

Bureau for Medical Services
C/o West Virginia MMIS Subcontractor
EMC Department
P.O. Box 2002
Charleston, West Virginia 25327-2002

800.10 CERTIFICATION ON CLAIM FORM

The medical services provider (professional practitioner or organization) is completely and solely responsible for the content of a claim. Federal regulations require that the following statement be printed on all Medicaid claim forms:

"This is to certify that the information on this invoice is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

The provider is responsible for all information provided on a claim form. This certification is also on the provider enrollment which can be accepted in place of the statement on the claim form.

800.11 TIMELY CLAIMS FILING

Federal regulations mandate that BMS must require providers to submit claims no later than 12 months from date of service. The West Virginia Medicaid Program will allow 24 months from the date of service for denied claims to be billed with corrections or paid claims to be replaced provided that the claims meet the requirements including requirements in 42CFR 447.45. Clean claims can be processed without obtaining additional information from the provider or a third party. Claims must have been timely filed. i.e., received by Medicaid within 12 months from date of service; must be on a prescribed form or through an approved electronic media transaction; must have valid provider and member ID number and a valid date of service. Services not billed prior to one year from the date of service cannot be added to a claim after a claim is one year old. Timely filing is the responsibility of the providers and is not subject to document/desk review hearings.

Previously submitted claims that are over 12 months from dates of service must be billed on the appropriate paper claim form to the Bureau's fiscal agent with appropriate documentation. (See Chapter 300, Section 340.2).

Exceptions to the 12 month time limit are:

- Corrected claims that were billed prior to the 12 month time limit and before 24 months from the date of service with copy of remittance advice (rejections, 824 and Return to Provider (RTP) letters are not accepted as proof of timely filing).

- Medicare primary claims billed within 12 months of the Medicare pay date with a copy or the Explanation of Medicare Benefits (EOMB). Medicaid can pay said claim within 6 months after notice of disposition of the Medicare claim.
- Claims for members with backdated Medical cards billed within 12 months of the issuance of the Medical card with a copy of the Medical card.

Providers submitting excessive duplicate claims may be subject to a monetary assessment.

For additional information and requirements, please refer to Chapter 300 Provider Participation Requirements.

800.12 RESTITUTION

BMS is responsible for recovery of State and Federal Medicaid funds improperly paid as a result of overpayments, false claims, and misrepresentation or concealment of facts related to a provider's qualifications, or costs as filed with BMS.

Procedures for auditing providers may include the use of sampling and extrapolation. If sampling reveals overpayment, the provider will be required to reimburse BMS for the entire amount of overpayment.

The Bureau's procedure for auditing providers may include the use of sampling and extrapolation. If sampling reveals patterns of inappropriate coding, failure to adhere to Bureau policies, consistent patterns of overcharging, or other fiscal abuse of the medical assistance program, the provider shall be required to reimburse the Bureau an extrapolated amount.

The Bureau may in its discretion decide to conduct desk audits with non-extrapolated findings based on, but not limited to the following factors: review of a new service; new provider groups utilizing a service; or a review to validate corrective action plan.

An example of an extrapolation technique for calculating such an overpayment may be as follows:

- An error rate is calculated based on the sample records reviewed.
- This error rate is then extrapolated for the total amount paid for that procedure code for the time period of review.

The provider will be notified in writing of the method of determining any overpayment and the amount to be recovered by BMS with appropriate documentation to support the findings.

800.12.1 RECOVERY OF OVERPAYMENTS

When a provider is notified of an overpayment by the BMS, the provider must enter into a written repayment arrangement within 30 days of such notification. The provider may select one of the following optional arrangements:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12 month period, through monthly payments or the placement of a lien against future payments.

If the provider selects the monthly restitution option, BMS will charge interest on the overpayment balance after 60 days following notification of the overpayment. The interest rate on overpayments will be the higher of the rate as set by the Secretary of the Treasury after taking into consideration private consumer rates of interest prevailing on the date of demand for payment or by the current value of funds rate. These rates are published quarterly in the Federal Register by the Secretary of the Treasury, subject to quarterly revisions. Each monthly payment must include at least 1/12 of the remaining balance of the overpayment, plus applicable interest (i.e., there can be no "back ending" under the recovery schedule).

In the event that the provider fails to submit a written repayment arrangement within thirty days, a lien may be imposed on all future Medicaid payments, effective thirty days after notification of the overpayment. Interest will accrue on any remaining balances commencing thirty days after the date of notification. The lien will remain in effect until the overpayment is recovered with interest.

If the provider does not comply in full with the repayment arrangement within 1 year of notification of the overpayment, the provider is subject to all of the sanctions set forth in §870 of the Medicaid regulations.

BMS reserves the right to waive or extend the recovery provisions set forth above in extraordinary circumstances in order to prevent undue hardship. Undue hardship requests must be accompanied by 5 years of financial statements for review by BMS, prior to the decision to waive or extend the recovery provision.

If the provider seeks a document/desk review of an overpayment decision, the repayment and interest provisions set forth above will begin 5 days after the date of the document/desk review decision or 60 days after the date of notification, whichever is later.

If the provider continues an appeal through an evidentiary hearing, any monetary findings in their favor will result in a refund to the provider's account after notification of the evidentiary hearing conclusion. If there is further appeal, a refund will be made at the conclusion of the appeal process.

800.12.2 DELINQUENCIES

Debts are considered overdue and payment to the provider may be withheld from future payments up to the amount of the debt plus interest when any of the following situations exist:

- The provider does not respond within 30 days following notification of the overpayment and repayment is not made;
- Arrangements for repayment or request for document/desk reviews or conferences are not made within the 30 day time period;

- The terms of the agreed upon installment payment plan are violated;
- The determination of overpayment is upheld in the appeal process and arrangements for repayment are not made within the 30 days following notification of the overpayment
- The appeal process exceeds 120 days due to delays requested by the provider;
- The provider, or if a corporation, any of its officers, has been found guilty in any court of competent jurisdiction of fraud or abuse of the Medicaid Program.

800.13 THIRD PARTY LIABILITY (TPL)

Federal regulations mandate that States identify any potentially liable third party resource available to meet a member's medical expenses. The "third party" may be an individual, institution, corporation, or public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS/TRICARE, Medicare, etc. There is no Medicaid reimbursement for any covered service for an eligible member that is eligible for payment by a Workers Compensation Plan.

It is important to note that 42 CFR 447.20(b) states that a provider may not refuse to furnish services covered under the Medicaid Plan to an eligible individual on account of a third party's potential liability for the service.

Prior to submitting a claim to Medicaid, the provider must secure information regarding possible third party coverage. Once identified, the provider must bill the third party. All requirements of the third party insurance plan must be met before Medicaid will reimburse including use of in-network providers. After receipt of payment, the provider may then bill the claim to Medicaid. For medical claims, the provider must report the TPL payment and any member liability amounts. The provider must report the third party payment and member liability amounts. If the third party denies payment for services, the provider must submit a claim on paper along with a copy of the Explanation of Benefits denying payment by the third party. The attached copy must contain the written denial reason. If a denial code is used, a description of the code must be attached.

If a provider learns of the potential for third party liability after Medicaid has paid, the provider must first refund Medicaid using the Void/Adjustment process described in Chapter 600. A claim is then submitted to the third party payer and if necessary, the provider re-bills Medicaid along with a copy of the third party's explanation of benefits.

If the member receives the insurance payment or notice of denial, it is the member's responsibility to forward the payment or denial to the provider. The member is considered a "private pay" until such time as the member provides the needed information to the provider.

Medicaid members are not responsible for any third party related co-insurance amounts, deductible amounts, or HMO related co-pays and deductibles, even if the claim payment is zero when the claim payment has been reduced as a result of the insurance payment or capitation agreement.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and TPL related are subject to a filing deadline of 12 months from the date of the Medicare payment.

For additional TPL information and requirements, refer to Chapter 100 General Information, Chapter 300 Provider Participation Requirements, Chapter 400 Member Eligibility, and Chapter 600 Reimbursement Methodologies.

BMS, pursuant to federal and state law, recovers medical assistance payments from two sources. One is payment that is the responsibility of a member's insurance policy which pays primary to Medicaid. A provider is required to bill a member's insurance prior to billing Medicaid. The second source of third party recovery is subrogation. A member executes an assignment of benefits upon enrolling in Medicaid. If a member recovers payments from a liable third party, such as from an accident or lawsuit, Medicaid is entitled to payment of the medical assistance paid due to the accident, etc.

800.14 APPEALS

There are 2 types of appeal processes available. One addresses service denials and the other is administrative actions resulting in a negative action against a provider

800.14.1 SERVICE DENIALS

Requirements regarding who may initiate service denial appeals and the current time frames are as follows:

a. Prior Authorization Contractor Reconsideration of Medical Necessity Determination

Issues concerning medical necessity determinations may be appealed through the reconsideration process to the Utilization Management Contractor (UMC). At present, either the provider or member may initiate a request for reconsideration of any negative medical necessity determination issued by WVMI. The UMC must receive the written request and supporting documentation within 60 days of the notification of denial. Services that are initiated subsequent to the PA denial are not reimbursable unless a subsequent reconsideration or department appeal reverses the initial denial. Consequently, any provider who initiates services subsequent to the UMC denial does so at risk. A PA denial may result in either a provider appeal if a service has been provided and payment denied or a member appeal if a covered service has been denied or reduced.

b. DHHR Agency Fair Hearings Process

The Agency Fair Hearings Process provides an appeal mechanism through which applicants or members may appeal any adverse decision regarding eligibility or termination, denial, suspension, or reduction of covered services. For further information on the Fair Hearings Process, refer to Chapter 400.

800.14.2 DOCUMENT/DESK REVIEW

The provider document/desk review process involves 2 steps. The first step will be a document/desk review by BMS. If a provider disagrees with the resulting decision, a request can be made for an evidentiary hearing.

a. Request for Document/Desk Review

A provider, within 30 days after receipt of a notice of an adverse administrative action taken by the Bureau/Department which affects his/her participation in the Medicaid program or reimbursement for covered services provided to eligible Medicaid members, may request a document/desk review. The request for a document/desk review must be in writing, dated, signed and must set forth in detail the items in contention. Failure to request or late requests for prior authorizations (PA) for services are the responsibility of the providers and are not subject to document/desk review.

b. Additional Information

When information is requested from a provider, in the course of a review or audit by the Office of Quality and Program Integrity and/or the Office of Audit, Research and Analysis, or their agents or contractors, and the provider does not provide the information in a timely manner, BMS will consider that the information does not exist and proceed accordingly.

If the provider offers the information for review at a later time, BMS will charge for the staff time involved in the review. If the provider does not agree to reimburse BMS for staff time, any additional information will not be considered.

c. Decision from Document/Desk Review

The Commissioner of the Bureau or his/her designee will issue a decision from the document/desk review upholding, denying, or modifying the original decision.

800.15 EVIDENTIARY HEARING

An evidentiary hearing is a formal hearing procedure before the Commissioner of BMS or his/her designee. Only issues reviewed in reconsideration and set forth in written request for document/desk review will be considered.

800.15.1 REQUEST FOR EVIDENTIARY HEARING

The request for an evidentiary hearing must be in writing, dated, signed and received within 30 days of receipt of decision from the document/desk review. The request for an evidentiary hearing shall contain a statement as to the specific issues or findings of fact and/or conclusions of law in the preceding determination with which the provider disagrees and basis for its contention that the specific issues and/or findings and conclusions were incorrect. The request must include identification of the provider representatives who will be present at the hearing. The parties will be permitted only 2 continuances.

Any provider requesting a hearing resulting from an adverse decision of BMS shall bear the necessary and attendant costs of such hearing, including costs of transcription, court reporting, production and copying of documents and all similar costs. If a fact-finder or hearing examiner should be retained by BMS, the costs of said fact-finder or hearing examiner shall be borne by BMS.

800.15.2 RECORD OF HEARING

A complete record of proceedings at the hearing shall be made and transcribed in all cases.

800.15.3 NOTICE OF DECISION

BMS will issue a written decision based on findings of fact and conclusions of law, setting forth reasons for the decision as soon as practical after the hearing. The decision by the Commissioner of BMS or designee is final.

800.16 ACTIVITIES THAT CONSTITUTE FRAUDULENT PRACTICES OR ABUSE OF THE PROGRAM

The following is a non-inclusive sample list, of practices that constitute fraudulent practices or abuse of the West Virginia Medicaid Program:

- Billing for services, supplies, or equipment which were not rendered to or used for Medicaid members
- Billing for supplies or equipment that are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually useless
- Flagrant and persistent over-utilization of medical and paramedical services with little or no regard for results, the member’s ailments, condition, medical needs or the physician's orders
- Claiming of costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Misrepresentations of dates and descriptions of services rendered, or the identity of the member or the individual who rendered the services
- Duplicate billing - this includes billing the West Virginia Medicaid Program twice for the same services
- Arrangements with employees, independent contractors, suppliers and others, designed primarily to overcharge the West Virginia Medicaid Program with various devices (commissions, fee splitting) used to siphon off or conceal illegal payments
- Charging the West Virginia Medicaid Program, by subterfuge, costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses

- Failure to comply with State and Federal laws or the regulations of the State or Federal agencies that govern the practice of a provider's respective profession, business, or trade
- Failure to comply with West Virginia Medicaid Program regulations, or submission of false certification of Medicaid billing forms or reports
- Failure to report or perform offsetting adjustments on Medicaid claims to reflect payment by other payers
- Billing for services paid for by another entity
- Billing for services that require the approval of the PAAS PCP without the approval of the PCP, including fraudulent use of the PAAS PCP approval number on a claim.
- Upcoding is when a provider increases the bill by exaggerating or falsely representing what medical conditions were present and/or what services were provided. An example of upcoding would be when a two minutes visit for diagnosis and treatment of an upper respiratory condition is upgraded from a low reimbursement rate code to a code that indicates a more serious ailment, for example, a more severe bronchitis or sinus infection which required a one hour visit because of a nebulizer treatment. Whether or not the additional services billed were provided or not, if they were not medically necessary, there is fraud.
- Other schemes or artifices that are in violation of State and Federal law.

For additional information and requirements, please refer to Chapter 100 General Information under Fraud and Abuse and Chapter 300 Provider Participation Requirements.

800.17 PROSECUTION AND PENALTY

Fraud is a serious crime. Suspected fraud will be referred to the proper government entities for investigation and prosecution. Criminal and civil penalties are severe for fraud in the Medicaid program. You should refer to the West Virginia Code and the United States Code for likely criminal and civil sanctions and penalties.

800.17.1 FEDERAL PENALTIES

Federal criminal and civil penalties are too numerous to list. Possible penalties include prison, fines and exclusion from federal and state programs. You should refer to the United States Code for likely sanctions and penalties.

800.18 PROTECTIVE SERVICES - MANDATORY REPORTING OF INCIDENCE OF ABUSE, NEGLECT OR EMERGENCY SITUATION

West Virginia State law provides for mandatory reporting of abuse or neglect of adults and children and assesses penalties for failure to do so.

The West Virginia Codes §9-6-9; §9-6-11; §9-6-14; §49-6A-3; §49-6A-8 provide in pertinent part that any medical, dental or mental health professional, social service worker, and person, official or institution etc. are mandated to report incidence of abuse, neglect, or emergency situation of an incapacitated adult or child.

Failure to report is a misdemeanor and is punishable by not more than one hundred dollars or imprisonment in county jail for not more than 10 days or both.

A person who has control of an incapacitated adult and willfully creates an emergency situation that leads to abuse and neglect and/or who knowingly permits another to abuse and/or neglect an incapacitated adult is guilty of a felony.

800.19 MAINTENANCE OF RECORDS

Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by BMS or the U.S. Department of Health and Human Services (DHHS).

The provider must make all records and documentation available upon request to BMS and/or DHHS. Such records and documentation must include but not be limited to:

- Financial Records
- Member Information
- Description of Medicaid Service Implementation
- Identification of Service Sites
- Dates of Service for Each Service Component by Member
- Client Records
- Personnel Records
- For additional requirements, refer to Chapter 300 Provider Participation Requirements and applicable provider manuals for the specific service requirements.

CHAPTER 800(B)–QUALITY AND PROGRAM INTEGRITY
CHANGE LOG

Replace	Title	Change Date	Effective Date
XXXX	New Chapter	XXXX	December 1, 2012

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CHAPTER 800(B) – QUALITY AND PROGRAM INTEGRITY

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

800.1 DEFINITIONS

Definitions governing the policies described in this chapter will apply pursuant to Common Chapter 200, Acronyms and Definitions, of the Provider Manual. In addition, the following definitions also apply to this chapter.

Abuse - Actions that are inconsistent with acceptable business or medical practice

Civil Fraud - To knowingly submit, or cause to be submitted, a false, fictitious, or fraudulent claim for reimbursement. This could be performed by deliberate ignorance or reckless disregard of the truth related to the claim. Civil fraud is determined by a “preponderance of the evidence” standard. Penalties for civil fraud may include fines up to three times the amount of damages sustained by the government as a result of the false claims.

Criminal Fraud - To intentionally and knowingly submit, or cause to be submitted, a false, fictitious, or fraudulent claim for reimbursement. Criminal fraud is determined by a “beyond a reasonable doubt” standard. Penalties for criminal fraud may include fines, imprisonment, or both.

Decision Support System (DSS) - A computer system designed to provide assistance in determining and evaluating alternative courses of action. A DSS (1) acquires data from the mass of routine transactions of a business, (2) analyzes it with advanced statistical techniques to extract meaningful information, and (3) narrows down the range of choices by applying rules based on decision theory. Its objective is facilitation of 'what if' analyses and not replacement of human judgment.

Exception Report - A listing of abnormal or excessive services that fall outside of accepted norms based upon established medical standards/principles.

Exception Profiling - A process that compares activity for a statistical measurement against a norm for that statistic

Good Cause Exception - An exception to permit a suspected fraudulent provider to continue to provide services to Medicaid members for reasons as specified in Title 42 Code of Federal Regulations (CFR) Section 455.23

Medicaid Integrity Group (MIG) - Contractors engaged by the Centers for Medicare & Medicaid Services (CMS) to audit claims for payment for items or services under a State Plan, which identify overpayments to individuals or entities receiving Federal funds.

Partial Suspension of Payment - The process in which a provider may only receive a portion of the reimbursement for services rendered. This may occur when the suspected fraud is not believed to be system-wide throughout the provider. A partial suspension of payment may occur due to suspected fraud occurring with a specific service or product, a rendering practitioner, or another reason that may not incorporate the provider's entire reimbursement.

Payment Error Rate Measurement (PERM) - A program developed by CMS to estimate the amount of improper payments to Medicaid providers, submit those estimates to Congress, and report on actions CMS is taking to reduce the improper payments.

Recovery Audit Contractor (RAC) – A contractor West Virginia Medicaid is required by Title 42 CFR Part 455 to maintain in order to aid in Program Integrity activities.

Self-audit - A process when a review of provider records is conducted by the provider themselves

Spike Report - A report that recounts a sharp rise in the frequency for a given variable, usually immediately followed by a decrease

Suspension of Payment - A process wherein the Medicaid reimbursement to a provider is stopped

Trend Analysis - The method of collecting data in order to determine a pattern in the information

Waste - Over-utilization of services or the misuse of resources provided for which medical necessity is not present

800.2 PROGRAM DESCRIPTION

The Office of Quality and Program Integrity (OQPI) was formed in July 1995, as the result of funding by the West Virginia Legislature, to monitor the utilization of Medicaid Services.

The OQPI is charged with meeting the requirements set forth in:

- Title 42 CFR Section 455.1 Program Integrity: Medicaid – Requirements for a State fraud detection and investigation program and

- Title 42 CFR Section 456.1, Utilization Control – Requirements concerning control of the utilization of Medicaid services

Title 42 CFR Section 455.13 states, "The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;
(b) Methods for investigating these cases that—
  (1) Do not infringe on the legal rights of persons involved; and
  (2) Afford due process of law; and
(c) Procedures developed in cooperation with State legal authorities for referring suspected fraud cases to law enforcement officials."

The OQPI executes the federal requirement of Title 42 CFR Section 456.3 which states, "The Medicaid agency must implement a statewide surveillance and utilization control program that—

(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
(b) Assesses the quality of those services;
(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part."

The OQPI conducts post-payment reviews. OQPI is responsible for identifying fraud, waste, and abuse cases and uses a combination of processes and claims data systems to complete this task. The processes and claims data systems detect fraud, waste, and abuse by reviewing member and provider information including, but not limited to:

- Claims submitted for services not rendered
- Claims submitted for services that do not meet medical necessity
- Upcoding or unbundling of services
- Documentation does not support services billed
- Services violating Federal and/or State policy, procedures, and/or regulations
- Services used excessively
- Services received with another's Medicaid card
- Services received by the member falsifying their eligibility for a medical card or information to receive medical treatment
- Services received from the physician in order to abuse/misuse prescription drugs
- Services by or under contract with an enrolled provider who has been excluded or disqualified from participation and receipt of monies from a Federal program

800.3 QUALITY AND PROGRAM INTEGRITY FUNCTIONS

Quality and Program Integrity oversight includes:

1) Data Analysis and Review
2) Post Payment Review
3) Prevention versus Collection
4) Medicaid Fraud Referrals
5) Provider Eligibility

These functions are discussed in the following sections.

800.3.1 DATA ANALYSIS AND REVIEW

Data analysis and review includes analysis of management information summaries, maintenance of OQPI case files, comprehensive/limited audits, trend analysis, establishment of norms, identification of providers outside of norms, and identification of providers requiring closer examination.

Sources used in identifying providers for review include:

- Exception reports,
- Trend analysis,
- Utilization analysis,
- Spike reports,
- Participant/provider/staff complaints, and
- Referral from internal and/or external sources.

Exception profiling may be utilized as the first step for case development in detecting or controlling fraud and abuse. However, it is generally combined with information from either a data warehouse or decision support system due to the format of query results.

Once data is analyzed, a review process is designed based upon the specifics of the issue.

Reviews may identify overpayment for recoupment and underpayments. Reviews often reveal the need for OQPI to make recommendations to develop, update, and/or clarify BMS policy.

800.3.2 POST PAYMENT REVIEW

OQPI performs post payment review of claims to ensure:

- Conformance to Federal and West Virginia Medicaid rules and regulations;
- Medical necessity and appropriateness;
- Payment to an enrolled and qualified provider on behalf of an enrolled member; and
- Units and services billed match units and services documented in the providers' records.

These reviews provide a means to identify and measure fraud and abuse. Post-payment reviews are conducted on Medicaid providers and members by utilizing computer software programs/systems. These systems are used to review provider utilization by generating profiles of health care providers and members in comparison with their peers. Post payment review analyzes frequency, standard

deviations, outliers, spike reports, etc., in order to identify potential overpayments, questionable billing practices, and/or fraud, waste, and abuse.

Post payment review may include a provider site audit to evaluate records in their totality or records may be requested for submission to OQPI. Other reviews may be completed by BMS or their designee.

800.3.3 PREVENTION VERSUS COLLECTION

It is more efficient to prevent improper payments than to discover them after they transpire; therefore:

- OQPI focuses on ensuring there are review systems and controls in place to prevent improper payments. OQPI determines what improvements are necessary to claims payment systems and claims edit/controls to prevent improper payments.

- OQPI staff reviews policy chapters and makes recommendations to the policy committee members after identifying any potential weaknesses within the program policy.

- OQPI makes recommendations for service limits, billing codes, and edits to reduce improper payments from occurring.

800.3.4 MEDICAID FRAUD REFERRALS

OQPI is charged with investigating complaints and identifying potential fraud, waste, and abuse occurring within the Medicaid system. Complaints are received from various sources for development, investigation, and appropriate resolution.

OQPI investigates each case to determine if there is a credible allegation of fraud, waste, or abuse. If it is a credible allegation of fraud, waste, or abuse, the complaint is referred to the West Virginia Office of the Inspector General Medicaid Fraud Control Unit (MFCU). The provider is also subject to payment suspension, absent good cause exception as noted in Section 6402(h)(2) of the Affordable Care Act. If OQPI or their contracted agent suspects that a member or patient at a facility has been abused or neglected, a referral is made to MFCU.

MFCU has jurisdiction under federal and state law to investigate West Virginia Medicaid providers for potential fraudulent practices, and the authority to seek criminal and civil remedies when fraudulent practices are discovered.

Complaints regarding **member** fraud should be referred to the **West Virginia Office of the Inspector General Investigations and Fraud Management Unit**. The process of reporting member fraud can be found at https://www.wvdhhr.org/oig/mfcu/secRepFrd/.

800.3.5 PROVIDER ELIGIBILITY

The OQPI partners with various state and federal agencies and provider associations, some of which

include the Department of Health and Human Services, the BMS fiscal agent, internal program staff and the provider community to ensure compliance with provider eligibility requirements.

800.3.5.1 PROVIDER SCREENING

The OQPI reviews for compliance with Title 42 CFR Part 1007 relating to requirements for provider screening. This includes reviews of initial provider applications as well as random reviews of enrolled providers to ensure applications are current and reflect any substantive changes outlined in the regulations and ensure all required disclosure information is present. OQPI may review employees/contractors of the enrolled provider to determine provider compliance with required checks of public databases identifying any individuals/entities that have been excluded or disqualified via criminal conviction/license revocation or restriction from providing or being reimbursed for services paid by any federal/state program. OQPI reviews personnel records of enrolled providers' employees providing direct care or having direct access to Medicaid members to ensure there are no disqualifying criminal convictions that would prohibit these individuals from providing services. A description of these disqualifying offenses may be found in the appropriate chapter of the BMS provider manual or within applicable federal and state regulations. If upon review it is found such an individual has been employed, monies are recovered for any services provided by the individual/provider.

800.3.5.2 EXCLUSIONS

The OQPI supports other state and federal program exclusions as mandated under federal law and regulations. Program exclusions have the effect of prohibiting reimbursement by WV Medicaid for services provided by the excluded individual whether employed by or under contract with an enrolled provider. This broad prohibition applies whether the Federal reimbursement is based on itemized claims, cost reports, fee schedules or prospective payment systems. Furthermore, it should be recognized that an exclusion remains in effect until the individual or entity has been reinstated to participate in Federal health care programs in accordance with the procedures set forth in Title 42 CFR 1001.3001 through 1001.3005. Reinstatement does not occur automatically at the end of a term of exclusion, but rather an excluded party must apply for reinstatement. If the state initiates such exclusion, an appeal process will be afforded to the individual in accordance with existing policy. If however, such exclusion is already in place and published, the only appeal right would be based upon incorrect identity. Providers' right of appeal is described in West Virginia Medicaid Manual Chapter 300 (Chapter 300).

800.3.5.3 CRIMINAL INVESTIGATIVE BACKGROUND CHECKS

The OQPI will work to ensure compliance with applicable federal and state policy/regulations to ensure such checks are conducted and that no individual with a disqualifying offense provides services to Medicaid beneficiaries. If upon review it is found such disqualifying offenses exist, monies will be recovered for any services provided by the individual/provider from the date of disqualification. While the WV Medicaid program's goal is to remain current on all federal/state regulations regarding criminal background checks. It is the responsibility of the provider to determine appropriate methods for routing review of their employees/contractors to ensure compliance with current law.

800.4 IDENTIFICATION OF CASES

BMS is mandated under federal law to provide methods and procedures to review utilization and payment for care and services provided under the state plan. BMS must safeguard against unnecessary utilization of care and services. Payments are made with efficiency, economy, and quality of care considerations. BMS ensures there are sufficient providers so that care and services under the state plan are available to the general population of West Virginia.

800.4.1 METHODS USED TO IDENTIFY ISSUES AND/OR CASES

OQPI cases originate from a variety of sources.

1) Referrals – Referrals are received from many sources and come in varying degrees of completeness. Referrals are made by members, providers, BMS staff, West Virginia DHHR staff, the MFCU, and others.
2) Case Finding – Cases can also be identified by use of outlier reports utilizing resources which may include but are not limited to: Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); Current Dental Terminology (CDT); Medicare DRG Definitions Manual; Medicare Correct Coding Guide; and applicable pharmacy standards or research of manuals to identify qualifiers to services such as service limits, mutually exclusive codes, services which should be provided in a bundled rate, or services limited to certain eligibility groups.
3) Data Analysis System Process – The process that takes each claim submitted and sorts the claim data into computerized reports.

   The data analysis system is a tool that is frequently used to research information for the other two methods of case identification such as the following:

   - Compare like member and provider groups resulting in Exception Reports which identify Medicaid members whose utilization of services is aberrant when compared to members of similar age and health. These reports also identify providers whose practice patterns are aberrant when compared to their peer group.

   - Identify increases or decreases in provider activity over time resulting in Spike Reports. These reports can be generated across all categories of providers and at an individual level, and are focused to identify the appropriateness of a drug or procedure. Produced on an as-needed basis, Spike Reports are accompanied by documentation identifying the issues which cause the provider/member to be identified as an exception.

When referrals are received by OQPI, specific queries can be run on the data analysis system with specific parameters focused on the suspected fraud or abuse.

800.5 INVESTIGATING COMPLAINTS

Complaints come to the OQPI through many different sources, e.g., the Inspector General's Hotline, MFCU, telephone referrals, letters, program staff, other State or Federal agencies, etc.

The initial investigation may result in a determination of the following:

1) No outstanding issue, which results in case closure;
2) A potential fraud issue, which results in MFCU referral; and/or
3) An overpayment issue, which results in OQPI review

800.6 UTILIZATION REVIEW ACTIVITIES

Utilization review activities may be performed by requesting documentation of services being submitted for review to OQPI, or may be conducted at the provider's location. Medicaid members sign a release of information as part of the application process; therefore, no additional release of information is required for providers to make records available for review. Failure to comply with a request for records or request for a self-audit may result in a hold on all Medicaid payments until the requested documentation is received.

Records may be selected using generally accepted and approved sampling techniques. An error percentage may be calculated from the sample results and extrapolated across all claims billed during the period that services were reviewed (i.e., all claims billed in one month, quarter, year, etc.).

When the BMS has identified unnecessary and/or inappropriate practices through monitoring activity or other reviews, it may pursue one or more of the following actions which may include (but is not limited to):

1) Recoupment of inappropriately paid monies
2) Requirement of a satisfactory written plan of correction
3) Limited participation in the Medicaid program that may include:

    a) Prior authorization for all services;
    b) Prepayment review of all applicable claims;
    c) Suspension of payment until a plan of correction is filed and accepted;
    d) Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
    e) Ban on specific services based upon review findings.

4) Exclusion from participation in the West Virginia Medicaid Program through the following actions:

    a) Suspension;
    b) Disenrollment;
    c) Denial, non-renewal, or termination of provider agreements.

5) Referral to MFCU
6) Withholding of payment involving fraud or willful misrepresentation.
7) Referral to the provider's licensing and/or certifying body(ies) for appropriate action based upon the licensing and/or certifying body(ies) regulations.

The recoupments of overpayments are handled as defined in Chapter 300. When a written plan of correction is required, the provider must create and submit the plan to BMS within the time specified in

the notice. The plan shall address all deficiencies noted in the review report and identify steps to correct deficiencies and establish time lines for successful implementation of the corrective action plan. The plan is subject to the approval of BMS. If the case is under the jurisdiction of a court, the court may have authority to approve or disprove the plan for overpayment.

In cases of limited participation, as noted above, BMS will notify the provider in writing regarding the limitation placed on participation, the duration of the limitation, and the corrective action necessary to remove the restriction. In cases of prohibition from participation, BMS will notify the provider in writing in advance as to the reasons for the action and the effective date and duration.

Providers' right of appeal is described in Chapter 300.

If a provider's fiscal agent/billing company requests a copy of a letter sent from OQPI to the provider, the fiscal agent/billing company will be required to send a copy of the billing service agreement that exists between the provider and the fiscal agent/billing company before the letter will be sent. Before a copy of an OQPI letter can be sent, there must be verification of the identity of the prospective recipient.

800.6.1 ON-SITE REVIEW

On-site review refers to a review of provider records conducted by OQPI staff or contractor at the provider location(s). The review may be announced or unannounced.

When an onsite review is conducted, the provider will make available a work area which provides some privacy and guarantees the confidentiality of the records during the review process. The cost of making necessary copies to validate appropriate utilization is included in provider reimbursement for Medicaid procedures.

An error percentage may be calculated from the sample results and extrapolated across all claims billed during the period services were reviewed (i.e., all claims billed in one month, quarter, year, etc.). A draft report will be issued to the provider detailing the possible issues and amounts that might be disallowed. The draft report contains a time period in which the provider may respond with documentation in order to justify the disputed services.

When, in the opinion of OQPI, the provider's response to the draft report justifies the services disputed, there may be either a modification or no disallowance of services. OQPI will then compose a letter informing the provider there was a modification or no disallowance and the case is closed.

When, in the opinion of OQPI, the provider's response to the draft report **DOES NOT** justify all of the services disputed, OQPI will issue a Final Report with the case's final disposition and amount of disallowance. The final report details the provider's rights of appeal.

800.6.2 DESK REVIEW

Desk review refers to the instance when a review of provider records is conducted by OQPI staff at BMS. There are generally two types of Desk Review:

1) Compliance Reviews – This type of review includes, but is not limited to, a review of policy requirements, such as exceeding established service limits, or identifying claims that were paid

to an ineligible population. Requests for records from the provider are not generally required to complete this review process. The provider will receive a "Demand Letter" that details the reasons for service disallowance. They are then expected to reimburse BMS for all disallowed services. The demand letter details the provider's rights of appeal.

2) Documentation Reviews - In this type of review, a sample of records is requested from the provider and reviewed by staff to determine whether the service was billed and paid in accordance with the appropriate program regulation(s) or policies(s). An error percentage may be calculated from the sample results and extrapolated across all claims billed during the period services were reviewed (i.e., all claims billed in one month, quarter, year, etc.).

   Documents requested for a review by OQPI may be sent by the provider as electronic or paper copies.

   The outcomes of the documentation reviews are the same as an on-site review.

800.6.3 SELF-AUDIT/SELF-DISCLOSURE

Health care providers have an ethical and legal duty to ensure the integrity of their partnership with the Medicaid program. This duty includes an obligation to examine and resolve instances of noncompliance with program requirements through self-assessment and voluntary disclosures of improper use of State and Federal resources. If a provider suspects improper billing in an attempt to defraud WV Medicaid, or an ongoing fraud scheme within its organization, it should immediately contact BMS' OQPI. If a provider performs a self-disclosed self-audit, the interest will not be imposed to the reimbursement amount unless the provider's payments are not made on the BMS specified payment dates.

OQPI may request that a provider perform a self-audit as a result of a specific area of questionable billing.

When a self-audit is assigned, a self-audit letter is sent to the provider. The self-audit letter details the format in which the provider is to report their findings along with their options of repayment.

800.6.4 INFORMATIONAL REVIEW

OQPI may conduct a review to gather program data and/or additional information used for program administration. This type of review is for informational purposes only, and does not result in a monetary disallowance. It may, however, lead to further investigation.

800.7 RECOUPMENT PROCESS

This procedure outlines the recoupment process for OQPI within BMS.

When a provider receives a Demand Letter/Final Report from OQPI, they have 30 days to enter into a repayment agreement and an additional 30 days to effectuate payment if they enter into a repayment agreement. Additional information is included in the Demand Letter/Final Report.

Providers have three basic repayment options from which to select. They are as follows:

1) Check remittance within 60 days of receipt of notification
2) Placement of a lien against further Medicaid payments so that recovery is effectuated within 60 days after notification of the overpayment.
3) A recovery schedule in which the provider may make payments for up to 12 months. The payment amount and due dates are determined by BMS, and the provider is notified of the repayment schedule. .

If determined by the BMS fiscal unit, providers may be instructed to perform reversal/replacement instead of the repayment options listed above.

800.8 DOCUMENT/DESK REVIEW PROCESS

A Document/Desk Review is the first level of appeal available to West Virginia Medicaid providers. A request for a Document/Desk Review must be made to the Commissioner of the Bureau for Medical Services. Additional information on the Document/Desk Review Process may be found in Chapter 300.

1) When a provider enters into a repayment agreement, they retain their rights of appeal.
2) Document/Desk review decisions ordering the provider to refund the overpayment will become effective within five days from the date of the decision, or within 60 days from the date of the original disallowance notification, whichever is later. Interest will accrue on any portion remaining after the 60 day notification period.
3) If the overpayment determination is reversed by the Document/Desk review, BMS will refund any previous payments made by the provider down to the disallowance amount determined in the Document/Desk review.
4) Upon learning of a decision from the Document/Desk review favoring BMS, the method of repayment chosen by the provider will take effect in five days. Recoupment will begin at this time even if the provider requests an evidentiary hearing.
5) If the provider did not enter into a repayment agreement with BMS, a lien will be requested by OQPI five days from the date of the provider's receipt of the Document/Desk review decision, or within 60 days from the date of the provider's receipt of the demand letter/final report, whichever is later.
6) If the provider fails to adhere to the method of repayment chosen by them on the repayment agreement, BMS will recoup the remainder of the overpayment as well as any accumulated interest.
7) If the overpayment determination is reversed by an evidentiary hearing, BMS will refund any previous payments made by the provider down to the disallowance amount determined in the evidentiary hearing.

800.9 MEDICAID FRAUD AND ABUSE

Both fraud and abuse have the same impact: they detract valuable resources that would otherwise be used to provide care to Medicaid beneficiaries.

A) It is mandated in 42 CFR Section 456.3, "The Medicaid agency must implement a Statewide utilization program that…

- Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; and
- Assesses the quality of those services."

B) Title 42 CFR Section 455.13 states, "The Medicaid agency must have…

- Methods and criteria for identifying suspected fraud cases; and
- Methods for investigating these cases."

When fraud is suspected, a preliminary investigation will be performed by OQPI. After review of the data, and consultation with appropriate staff, a decision will be made as to whether a referral to MFCU is warranted.

800.10 SUSPENSION OF PAYMENT

A suspension of payment to a provider shall be performed when there is a credible allegation of fraud. When OQPI determines a suspension of payment is in order, the following steps will be taken:

- OQPI will determine if good cause exception exists to not suspend payment.
- A fraud referral to MFCU will be effected.
- The supervising attorney of BMS' Legal Department will be informed of the intent to suspend payment.
  * Within five business days, either MFCU or BMS' Legal Department must recommend to the OQPI Office Director for good cause exception if there is good cause not to suspend payment, or to suspend only in part. If either recommends a good cause exception, the suspension will not be placed at that time or a partial suspension will be placed.
- Five business days after the fraud referral is placed with MFCU, a notice of intent to suspend shall be sent to the provider. Their rights of appeal will be contained in the letter. The suspension will commence 30 days from receipt of the letter.

A suspension may be placed immediately if OQPI or MFCU have reason to believe the provider will cease or seriously curtail operations prior to recovery of the overpayment.

A suspension will be removed when:

- There are methods in place to recoup the entire fraudulent overpayment, or
- It is determined by OQPI and MFCU that there is no credible evidence of fraud

800.10.1 SUSPENSION OF PAYMENT APPEAL PROCEDURES

An appeal process is available to West Virginia Medicaid providers when a provider is notified of intent to suspend payment.

- Written evidence of the reason payment should not be suspended must be received by the Commissioner of BMS within five business days after receipt of the notice of intent to suspend. Upon review of submitted evidence, BMS will inform the provider whether the suspension is affirmed or reversed.
- If, after review of the provider submitted evidence, BMS affirms the suspension of payment, the provider may request an evidentiary hearing. This request for an evidentiary hearing must be received by the Commissioner of BMS within 30 calendar days of the provider's receipt of the affirmation of the suspension of payment. The evidentiary hearing will be conducted as detailed in Chapter 300, Provider Participation Requirements, §300.30.2 Request for Evidentiary Hearing.
- If a provider refuses or fails to submit written evidence within the specified time period, they shall have 30 calendar days from receipt of the notice of intent to suspend in which to request an evidentiary hearing. The evidentiary hearing will be conducted as detailed in Chapter 300, Provider Participation Requirements, §300.30.2 Request for Evidentiary Hearing.

800.11 OQPI RESPONSIBILITIES TO CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

OQPI is responsible for ensuring that all BMS Program Integrity activities are in compliance with Federal Medicaid regulations. As such, OQPI is required to coordinate its Program Integrity activities with various CMS oversight entities. Among these responsibilities are providing CMS with working details of BMS' Program Integrity activities, coordinating any CMS audits of West Virginia Medicaid providers, overseeing Recovery Audit Contractor (RAC) audits, and cooperating with CMS in periodic audits of BMS program integrity reviews.

800.11.1 MEDICAID INTEGRITY GROUP (MIG)

In accordance with the Deficit Reduction Act (DRA) of 2005, CMS is obligated to engage contractors (referred to by CMS as Audit Medicaid Integrity Contractors, or "Audit MICs") to audit claims for payment for items or services under a State Plan, and identify overpayments to individuals or entities receiving Federal funds. CMS' Medicaid Integrity Group (CMS-MIG) has engaged in a number of outreach activities to educate States about the activities it is conducting pursuant to the Medicaid Integrity Program (MIP), and about issues such as the manner in which subjects for audits under the program will be chosen, and how the overpayments identified in the course of Medicaid Integrity Program audits will be collected.

OQPI has been charged with the responsibility to deal directly with CMS-MIG and its Audit MICs in order to efficiently and accurately aid in CMS' conducting of audits of West Virginia Medicaid providers. Effective communication with CMS-MIG will minimize duplication of efforts and mitigate conflicts with the provider community. In order to facilitate those ends, the State Medicaid agency (OQPI) is responsible for:

1) Reviewing/vetting audit leads;
2) Reviewing draft audit reports provided by CMS-MIG;
3) Participating in various communications efforts with the Audit MIC;

4) Providing the Audit MIC with information regarding applicable State and Federal laws, regulations, policies, and provider contact information for audit subjects; and
5) Complying with any requirements determined by CMS-MIG to be necessary for carrying out MIC audits, pursuant to Section 1902(a)(69) of the Social Security Act, in accordance with its Medicaid State Plan Amendment regarding the Medicaid Integrity Program.

800.11.2 RECOVERY AUDIT CONTRACTOR (RAC)

As required by Title 42 CFR Part 455, West Virginia Medicaid is required to maintain a RAC to aid in Program Integrity activities. Within BMS, OQPI is charged with the responsibility to oversee all RAC activities. OQPI staff will coordinate audit activities with the RAC, provide support and validation of data review/analysis, and review all completed audits performed by the RAC prior to their release to ensure the reliability of its conclusions and adherence to all West Virginia Medicaid regulations and policies.

800.11.3 PAYMENT ERROR RATE MEASUREMENT (PERM)

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) requires the heads of Federal agencies to regularly review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review.

OQPI is responsible for assisting CMS in conducting their PERM reviews of WV Medicaid providers and ensuring that they run as efficiently as possible. In order to meet these responsibilities OQPI will:

1) Provide CMS with all requested data from its medical payments system (MMIS);
2) Assist CMS in educating WV Medicaid providers about PERM requirements;
3) Aid CMS in ensuring WV Medicaid providers respond to records requests within stated time frames;
4) Educating CMS about specific WV Medicaid policies and regulations;
5) Evaluate any PERM error decisions affecting WV Medicaid providers to ensure accuracy;
6) Recover dollars identified as errors from the provider; and
7) Complete a Corrective Action Plan (if necessary) to address any payment error deficiencies identified by PERM.

800.11.4 FEDERAL OFFICE OF THE INSPECTOR GENERAL (OIG) AUDITS

It is the responsibility of OQPI to assist the Federal Health and Human Services OIG with any audits/reviews they undertake regarding WV Medicaid providers. The Office of Evaluation and

Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.

800.12 FEDERAL FALSE CLAIMS REQUIREMENT

Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires that any provider who meets a threshold of $5 million in net Medicaid reimbursement during the Federal fiscal year (October 1 through September 30 of the following year) must establish and maintain written policies which provide detailed information about the Federal laws imposing civil and criminal penalties for submitting false Medicaid clams. In addition, the provider must have written policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, i.e. Medicaid. A copy of these policies must be provided to all of its employees, contractors, and agents. These policies must include an explanation of the False Claims act; the entity's policies and procedures for detecting and preventing waste, fraud, and abuse; the rights of employees to be protected as whistle blowers; and telephone numbers and/or addresses for reporting fraud and abuse.

To ensure compliance with the DRA, OQPI will annually request copies of required information (electronic or paper) for providers meeting the $5 million threshold, and conduct desk reviews of providers' written policies, procedures, and employee handbooks as they relate to the requirements of the DRA.

OQPI will provide written response of approval or denial of the entity's policies along with any suggestions to ensure they conform to the requirements of the DRA. Thereafter, OQPI will conduct a review of affected entities who continue to meet the $5 million threshold on a yearly basis for any updates or changes to its written policies. In addition, BMS may also review the entity's DRA policies during any regular on-site review of Medicaid billings.

CHAPTER 900—ESTATE RECOVERY

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CHAPTER 900—ESTATE RECOVERY

900.1 SCOPE

This rule establishes State standards and procedures for recovery of medical assistance payments from the estates of certain deceased recipients and from property sold by permanently institutionalized recipients of such assistance. This recovery is limited in scope to medical assistance payments for nursing facility services, home and community-based services and related hospital and prescription drug services and will not exceed the amount actually paid for such services.

900.2 AUTHORITY

W.Va. Code § 9-5-11c

900.3 APPLICATION AND ENFORCEMENT

900.3.1 APPLICATION

This rule applies to payments made by the Department of Health and Human Resources, Bureau for Medical Services, or any successor agency responsible for administering the State's Medicaid program for nursing facility services, home and community-based services and related hospital and prescription drug services provided to individuals fifty-five years of age or older or to individuals who, after notice and an opportunity for hearing, have been deemed to be permanently institutionalized.

900.3.2 ENFORCEMENT

This rule is enforced by the Secretary of the Department of Health and Human Resources.

900.4 DEFINITIONS

Adult Child - means a natural child, legally adopted child or step child.

Bureau - The Bureau for Medical Services or any successor agency or its authorized representative or agent responsible for administration of the Medicaid Program in the State.

Estate - The real and personal property belonging to a decedent at the time of his/her death, including any intangible interests therein. The term "estate" includes all property identified in W.Va. Code §11-11-2(b)(4).

Home and Community-based Services - Those services provided by Medicaid pursuant to Section 1915C Waivers No. 0133 and 0134, as approved by the Health Care Financing Administration of the United States Department of Health and Human Services.

Nursing Facility Services - Those services provided in nursing facilities or in a distinct part of a larger facility which is set aside for the provision of nursing services. This term also includes services in an intermediate care facility for the mentally retarded (ICF/MR).

Related Hospital and Prescription Drug Services - Those hospital and prescription drug services which are rendered in conjunction with nursing facility and/or home and community-based services whether or not they are billed by the nursing facility or home and community-based service provider.

Other necessities are defined as utilities, major home repairs, real estate taxes, real estate insurance and normal upkeep and maintenance.

Permanently Institutionalized - An individual who:

- Is an inpatient in a nursing facility, ICF/MR facility or other medical institution;
- Is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimal amount of his/her income required for personal needs; and,
- After notice and opportunity for a hearing, has been deemed permanently disabled to such an extent that he or she cannot reasonably be expected to be discharged from the medical institution and returned to a non-institutional home environment prior to death.

Recipient - An individual who receives nursing facility services, or home and community-based services paid for by Medicaid.

Secretary - The Secretary of the West Virginia Department of Health and Human Resources or his or her lawful designee.

900.5 DETERMINATION OF PERMANENT INSTITUTIONALIZATION

Upon admission of a Medicaid recipient to a nursing facility or other institution which provides twenty-four hour a day nursing and custodial care, the facility will notify the local Department of Health and Human Resources office of the recipient's admission, legal guardian, physician, and discharge prognosis.

The discharge prognosis shall be determined by the admitting physician.

The discharge prognosis will state, to a reasonable degree of medical probability and given the state of medical science at the time of admission, whether the recipient can reasonably be expected to be discharged from the medical institution and returned to a non-institutional home environment prior to death.

If, in the opinion of the admitting physician, it is not reasonable to expect the recipient to be discharged from the medical institution and returned to a non-institutional, home environment prior to death, the nursing home or institution will forward the information to the Bureau and/or the Bureau’s agent.

The Bureau will determine whether, based upon the information supplied, the recipient may be permanently institutionalized. There shall be a rebuttable presumption that the recipient is permanently institutionalized. The presumption of permanent institutionalization after six (6)

months of residence can be rebutted by documentation of the personal physician that the individual will be discharged within a reasonable period of time not to exceed three (3) months and that the individual has a place to which he/she can return. If said individual is not discharged within this three (3) month period, the nursing facility will notify the Bureau and a presumption of permanent institutionalization will be instituted.

If it is determined that the recipient is permanently institutionalized, the recipient and his/her legal guardian will be advised in writing of this determination and the right to a hearing before the Bureau should this determination be disputed.

The recipient and his/her legal guardian shall have thirty (30) days from the date of receipt of the Bureau determination in which to request a hearing.

No lien shall be placed upon property belonging to a recipient until a final determination is made regarding whether the individual is permanently institutionalized.

Any lien imposed shall dissolve within thirty (30) days upon that individual's discharge from the medical institution and return home. The individual shall provide written documentation of the return home and request that the lien be dissolved.

900.6 IDENTIFICATION OF ESTATES SUBJECT TO RECOVERY

All local Department of Health and Human Resources case managers will advise the Bureau when any recipient in their case load age fifty-five or older is admitted to a nursing facility, ICF/MR or becomes a recipient of home and community-based services pursuant to a 1915C waiver. Nursing facilities, ICF/MR facilities and case managers will also advise the Bureau on a monthly basis, of those individuals in their case load who are in nursing facilities or receiving home and community-based services and have attained the age of fifty-five.

900.7 RECOVERY FROM ESTATES

Pursuant to 42 USC ¶ 1396p (2)(A) recovery will be made against an estate of a recipient and a lien imposed only after:

- The death of the individual's spouse
- No surviving child under age 21, or
- The individual's blind or permanently and totally disabled child, who are lawfully residing in the home.

Pursuant to 42 USC ¶ 1396p (2)(b) recovery will be made against an estate of a recipient and a lien imposed only after:

- The death of the individual's spouse
- No surviving child under age 21, or
- The individual's blind or permanently and totally disabled child, who are lawfully residing

in the home, or

- The recipient's sibling:

- Who was residing on the real property for a period of at least one year immediately before the date of the recipient's admission to a medical institution on a continual basis since the date of the recipient's admission, or

- A son or daughter of the recipient who was residing in the recipient's home for a period of at least two years immediately before the date of the recipients' admission to the medical institution, and who establishes, to the satisfaction of the Department that he or she provided care.

900.7.1 DELAYED RECOVERY

Recovery from estates may occur when the condition upon which the delay was based no longer exists. The Department may impose a recovery property lien to be executed only when the condition no longer exists and the property is to be sold.

If property subject to delayed recovery is sold, only that portion of the proceeds which represents the recipient's interest in the property is subject to a recovery lien.

900.8 UNDUE HARDSHIP WAIVERS

No lien will be placed nor recovery made from the estates of recipients when:

(a.) An adult child who has resided continuously in the home for a two year period of time prior to the date the parent became a recipient and continued to reside in the home until the parent's death, if that child can establish that he/she provided care to the recipient which permitted the parent to remain at home without Medicaid assistance for at least that two year period;

(b.) A beneficiary or heir in intestacy, who maintains continuous employment in the family business for a period of time beginning at least one year before the recipient became a Medicaid recipient until the time of the recipient's death, if the property which would otherwise be subject to an estate recovery lien is an integral part of the business and is required for the continued viability of the business.

(c.) An adult child maintains continuous employment in the family business for a period of time beginning at least three (3) years before the parent became a recipient until the time of the parent's death if the property which would otherwise is be subject to an estate recovery lien is an integral part of the business and is required for the continued viability of the business.

(d.) An adult child regardless of whether he/she was living in the family home, is able to present proof of monetary support to his/her parent for medical care and other necessities including upkeep, utilities and repairs prior to the date the parent became a recipient and continued said upkeep in order to maintain the recipient's property. Such support will reduce the medical assistance lien on a dollar-for-dollar basis.

(e.) An adult grandchild, whose is the recipient's beneficiary or heir in intestacy and whose parents are both deceased prior to the date the grandparent became a recipient is able to present proof of monetary support to his/her grandparent for medical care and other necessities prior to the date the grandparent became a recipient. Such support will reduce the medical assistance lien on a dollar-for-dollar basis.

(f.) A sibling who is able to present proof of monetary support to his/her sibling for medical care and other necessities prior to the date the sibling became a recipient. Such support will reduce the medical assistance lien on a dollar-for-dollar basis.

(g.) Beneficiaries may apply for a hardship waiver by presenting evidence that recovery from the estate will jeopardize the survival of the family unit or severely disrupt the family's income or business unless the circumstances which caused the disruption were created by the recipient's use of estate planning methods to avoid estate recovery.

An application for an undue hardship waiver shall be submitted to the Bureau within forty-five (45) days of the placement of the lien or filing of the proof of claim. The Bureau will have ninety (90) days from receipt in which to issue an approval or denial of a request for a hardship waiver or to advise the applicant that additional time is necessary to consider the request. The presence of a will that bequests specific property to beneficiaries cannot be used as evidence of an undue hardship. Documentation of an inter vivos gift cannot be used as evidence of an undue hardship unless the gift would not have been considered an uncompensated transfer and resulted in the imposition of a penalty period.

900.9 ESTATES OF $5,000.00 VALUE

The Department will impose no recovery on estates with a value of $5,000.00 or less at the time the estate is admitted to probate.

No undue hardship waiver will be granted if the recipient had a long term insurance policy and because Medicaid eligible by virtue of disregarding assets because of payments or entitlement to payments under such policy. [See 42 USC §1396p(b)(C)(ii) (I)]

900.10 SPECIAL TREATMENT TRUST

For any special treatment trust established under 42 USC 1396p the trustee must assure that the Department of Health and Human Resources is the primary beneficiary of the trust after the recipient's death. The Department is to be reimbursed up to the amount of medical assistance paid on behalf of recipient since June 9, 1995 or the balance of the trust whichever is less.

The trustee shall account to the Department and forward payment within thirty (30) days of the recipient's death.

900.11 ADMINISTRATIVE DUE PROCESS

Those persons adversely affected by the enforcement of this rule desiring an administrative review or appeal the issue of permanently institutionalized or to contest the failure to grant an undue hardship waiver only shall do so in conformance with the following:

Administrative Review

The administrative review procedure provides an informal conference to allow the recipient, administrator, executor, the beneficiary or heir in intestacy an opportunity to present his/her case, to provide additional information bearing on the adverse administrative action. Through this procedure, the Bureau is afforded an opportunity to receive additional information that could affect its decision or impending action on permanent institution or undue hardship.

Request for Administrative Review

A recipient, administrator, executor, beneficiary or heir in intestacy may, within thirty (30) days after receipt of a notice of an adverse administrative action taken by the Bureau request an administrative review. The request for an administrative review must be in writing, dated, signed and must set forth in detail the items in contention, and identify the representatives who will be present for the conference. Upon receipt of the request for an administrative review conference, the Bureau will establish a mutually agreeable date and time for the review.

Notice of Decision

A written decision based on findings and setting forth the reasons for the conclusions will be issued within thirty (30) to sixty (60) days after the administrative review hearing. The decision may nullify, modify, or uphold the original administrative action and will establish an effective date for any further action to be taken. In the case where the decision is disputed, the recipient, beneficiary or heir in intestacy may/must request an evidentiary hearing within thirty (30) days after receipt of the notice of decision.

Evidentiary Hearing

An evidentiary hearing is a formal hearing procedure before the Commissioner of the Bureau or his/her designee. The recipient, beneficiary or heir in intestacy may present evidence and argument and cross examine adverse witnesses. Only those issues presented in the administrative review will be considered in the evidentiary hearing.

Request for Evidentiary Hearing

The request for an evidentiary shall be in writing, dated, signed and filed within thirty (30) days of the date on the notice of decision from the administrative review conference or other adverse ruling. The request for an evidentiary hearing shall contain a statement as to the specific issues or findings of fact and/or conclusions of law in the preceding determination with which the recipient, administrator, executor, beneficiary or heir disagrees and basis for his/her contention that the specific issues and/or findings and conclusions were incorrect. The request shall include identification of the representatives who will be present at the hearing.

Any recipient, beneficiary, administrator, executor, or heir in intestacy requesting a hearing resulting from an adverse decision of the Bureau shall bear the necessary and attendant costs of such hearing, including costs of transcription, court reporting, production and copying of documents and all similar costs. If a fact-finder or hearing examiner should be designated by the Bureau shall bear the costs of said fact-finder or hearing examiner.

Record of Hearing

A complete record of proceedings at the hearing shall be made and transcribed in all cases.

Notice of Decision

A written decision based on findings and setting forth reasons for the decision will be issued as soon as practical after the hearing. The decision by the Commissioner is final. The recipient, beneficiary, heir, administrator, or executor in intestacy may pursue further recourse through judicial review.