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

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

_____

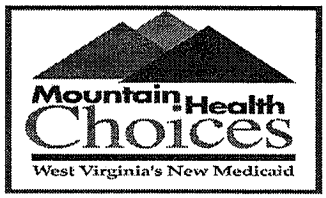
Witness: Title:

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_____	_____

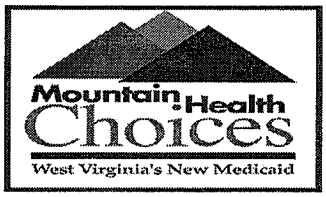
3. Health Education Classes. Please place a check mark in the appropriate box indicating if this patient needs education on any/all of the listed topics:

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.