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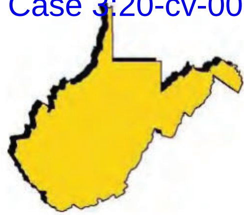

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CHAPTER–519 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRACTITIONER SERVICES – INCLUDING PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED REGISTERED NURSE PRACTITIONERS

CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment 18	Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners	01/16/12	01/16/12
Section 519.20.1	Prior Authorization for Outpatient Surgeries	01/10/06	02/15/06
Section 519.13.2.1	Immunization for Children	11/21/05	11/30/05
Section 519.19.1	Prior Authorization for Outpatient Surgeries	10/24/05	Postponed
Section 519.12.5	Medicaid Diabetes Disease State Management	10/4/05	10/15/05
Section 519.13.2.2	Immunizations for Adults	10/4/05	10/24/05
Section 519.13.2.1	Immunizations for Children	9/28/05	7/18/05
Section 519.19.1	Prior Authorization for Outpatient Surgeries	9/28/05	11/1/05
Section 519.14.3	Prior Authorization Requirements for Imaging Procedures	9/1/05	10/1/05
Section 519.7.6	Nursing Facility Visits	5/17/05	6/1/05
Section 519.11.3	Psychiatric Services	5/17/05	6/1/05
Section 519.12.1	Caloric Vestibular Testing	5/17/05	6/1/05

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

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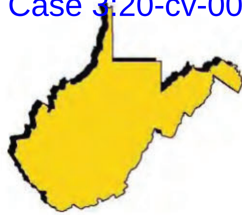

519.15 UNLISTED SERVICES, DRUGS, PROCEDURES, OR ITEMS

Unlisted services, drugs, procedures, or items (as defined by HCPCS) are used only when there is no code that describes the service, item, or procedure provided to a Medicaid member. Unlisted codes must always be billed on paper with a description of the service provided, e.g., an operative report or clinical notes.

When billing for other unlisted services, procedures, or items, the claim must be accompanied by all documentation necessary to justify reimbursement (i.e., operative reports, cost invoices, etc).

519.16 NON-COVERED ITEMS – MEDICAL SUPPLIES/DURABLE MEDICAL EQUIPMENT

Payment will not be authorized for non-covered items – medical supplies/durable medical equipment. Details of non-covered items – medical supplies/durable medical equipment are found in the Chapter 506 pertaining to durable medical equipment.

519.17 NON-COVERED SERVICES

Certain services and items are not covered by the Medicaid Program. Non-covered services include, but not limited to, the following:

- Acupressure
- Acupuncture
- Autopsy
- Cardiac rehabilitation programs, pulmonary rehabilitation programs, and other rehabilitation programs
- Chelation therapy
- Claims received more than 12 months after the date of service
- Completion of forms and reports, except for eligibility purposes as specifically requested by the Department of Human Services using ―ESRT" letters of request
- Cosmetic procedures, medical or surgical, the primary purpose of which is to improve the member's appearance. Such procedures include, but not limited to, otoplasty for protruding ears of lop ears, rhinoplasty (except to correct nasal deformity), nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathism or both, dermabrasion, certain skin grafts, malar augmentation, breast implants for other than breast cancer reconstruction, and lipectomy
- Courtesy Calls (visits in which no identifiable medical service was rendered)
- Dietary (food) supplements, except as provided in a hospital or nursing home
- Direct payments to members (payments are made to the provider of service)
- Domestic or housekeeping services, except to the extent they may be provided under a home health service plan
- Drugs and supplies dispensed by the physician which are acquired by the physician at no cost
- Educational services
- Experimental/Research/Investigational medical or surgical procedures
- Genetic testing
- Hypnosis
- Immunizations required for travel outside the Continental United States
- Incidental surgical Procedures (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, etc.) performed at the same time as a major surgical procedure
- Infertility services (i.e., artificial insemination, in vitro fertilization, etc.)
- Inhalation Therapy (chronic basis)

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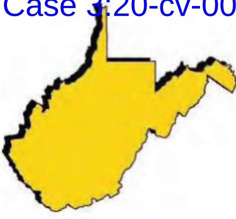

- Injections and visits solely for the administration of injections unless medically necessary and the member's inability to take appropriate oral medications are documented in the member's medical record and on the claim form
- Inpatient rehabilitation services for members over 18 years of age
- Items/Services not related to medical care that were provided for the convenience of the member, their custodian, or the provider
- Maintenance services if no progress is being made
- Mass screenings for any condition
- Massage therapy
- Meals-on-Wheels (or similar food service arrangements)
- Naturopathy
- Non-legend Drugs (over-the-counter drugs), except for the following:
  - Family planning supplies
  - Insulin
  - Diabetic syringes/Needles/Testing kits
  - End-Stage Renal Disease (ESRD) Vitamin/Vitamin mineral preparations and other medications related to ESRD services.

  NON-LEGEND DRUGS FOR MEMBERS RESIDING IN LONG-TERM CARE (LTC) FACILITIES (skilled and intermediate nursing homes) are to be furnished by the LTC and are not to be billed to the member or the Department of Health and Human Resources.

- Nutritional (dietary) counseling
- Operating surgeon may not bill for the administration of anesthesia, except epidural anesthesia
- Pain Clinics (Specific medical procedures ordered by the physician for treatment are covered)
- Payment to a physician for laboratory services as payment is made directly to the facility performing these services. (The physician may have a laboratory specifically approved for Medicaid purposes; the laboratory must have a Medicaid laboratory provider number)
- Personal comfort items (items which do not directly contribute to the treatment of an illness or injury or to the functioning of a malformed body part)
- Physician services denied by Medicare as not medically necessary, ineffective, unsafe, or without proven clinical value
- Physician services included as part of the cost of an inpatient facility or hospital outpatient department
- Pre-operative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them
- Procedures prohibited by State or Federal statute or regulations
- Pulmonary rehabilitation programs and other similar rehabilitation programs
- Referrals from one physician to another for treatment of specific member problems are not to be billed as consultations
- Reflexology
- Rehabilitation programs such as cardiac, pulmonary, dietary, weight control, etc.
- Respiratory therapy
- Routine Foot Care, except for those members having a metabolic disease such as diabetes and the metabolic disease must be documented
- Services and items under a Workers Compensation law or other payment services
- Services provided as inpatient hospital services if the service could appropriately and safely be

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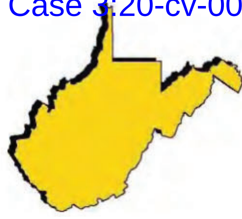

performed on an outpatient basis in an office or outpatient hospital setting unless the procedure is performed as a secondary necessary procedure

- Services provided by students
- Services provided for the purpose of relieving discomfort
- Services which are not medically justified
- Services which are provided at no charge to patients who are not Medicaid members (i.e., services provided free to the general public cannot be billed to Medicaid)
- Sex change surgery (transsexual surgery)
- Sex determination services
- Spectacle (glasses) cases
- Sterilizations when the member is under 21 years of age, institutionalized, or mentally incompetent
- Tai chi
- Telephone contacts with members or on their behalf
- Tempomandibular Joint Syndrome (TMJ) surgery or treatment
- Visits solely for one or more of the following:
  - Prescription pickup
  - Collection of specimens for laboratory procedures
  - Ascertaining members' weight.
- Weight reduction (obesity) clinics/programs.
- Yoga

519.18 BILLING AND REIMBURSEMENT

Practitioners must bill WV Medicaid directly for covered services provided to Medicaid members. However, payment may be made to a practitioner's employer when the practitioner is required as a condition of employment to turn over his/her fees to the employer or when the facility where a service is rendered has a signed contract with the practitioner that requires the facility to submit the claim. **Chapters 300 and 600** contain additional information.

As is consistent with Federal law prohibiting Medicaid providers from balance billing, (i.e., billing an amount in excess of the Medicaid fee), the practitioner may not bill the member any additional amount regardless of the setting in which a service is rendered.

519.18.1 HCPCS CODES

The Center for Medicare and Medicaid Services (CMS) of the Federal Government has mandated that all States implement the HCPCS codes to identify medical services provided to Medicaid members.

HCPCS is a coding system that uses the AMA's Current Procedural Terminology, fourth edition (CPT-4) as its base (Level I codes) and then nationalizes non-standard codes used by various states so all state and federal payers of medical claims use the same coding system (Level II codes).

In an effort to maintain uniformity with National Correct Coding Policies implemented by CMS, the BMS incorporates the National Correct Coding Initiative methodologies for the analysis of standard medical and surgical practice. These policies were developed based on coding conventions defined in the AMA's CPT-4 Manual, in national and local policies, in edits and in coding guidelines developed by national societies. They are consistent with federally and state mandated program policies. Incorporating these edits into the review process does not represent new policy or monitoring procedures by the BMS and should not be interpreted as such. These edits represent generally accepted standards of medical and surgical practice. Adherence to these policies will be monitored

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Exhibit 25

Welcome

Aetna Better Health® of West Virginia

2021-2022 Member Handbook

Mountain Health Trust – Medicaid

AetnaBetterHealth.com/WestVirginia

86.20.301.1-WV

Aetna Better Health® of West Virginia

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COURT ORDERED SERVICES

Medically necessary court ordered treatment services are covered by Aetna Better Health. Court ordered services are subject to, BMS review and determination and member appeals.

SECOND MEDICAL OPINIONS

You may need a second opinion for an illness, surgery and/or confirming a treatment of care your practitioner has told you that you need. Contact your practitioner or Member Services for help to get a second opinion. If an appropriate provider or practitioner for the second opinion is not available within the Aetna Better Health network, we will arrange for you to get the second opinion outside the network. There is no cost to you for the second opinion.

SERVICES NOT COVERED

Some services are not available through Aetna Better Health or Medicaid. If you choose to get these services, you may have to pay the entire cost of the service. Aetna Better Health is not responsible for paying for these services:

- All non-medically necessary services
- Sterilization of a mentally incompetent or institutionalized individual
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular patient's condition
- Organ transplants, except corneal transplant
- Treatment for infertility and the reversal of sterilization
- Sex transformation procedures and hormone therapy for sex transformation procedures
- All cosmetic services, except in the case of accidents or birth defects
- Christian science nurses and sanitariums
- Duplicate Services
- Service codes determined by Bureau for Medical Services as not covered
- Health services or supplies from nonparticipating practitioners, except in an emergency, for family planning or when otherwise approved by Aetna Better Health
- Health Services prohibited by law or regulation
- For adults, TMJ and other dental problems related to malocclusion unless proven to be life-threatening

This is not a complete list of the services that are not covered by Aetna Better Health. If a service is not covered, not authorized, or is provided by an out-of-

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Aetna Better Health® of West Virginia

WEST VIRGINIA MEDICAID MANAGED CARE MEMBER HANDBOOK

(July 1, 2021 – June 30, 2022)

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Behavioral Health Services Not Covered:

- Services provided to individuals under the age of 21 performed in a children's residential treatment facility
- Any services that are covered by fee-for-service
- School-based services

If there is a mental health or substance abuse emergency, please call 911 right away.

COURT ORDERED SERVICES

Medically necessary court ordered treatment services are covered by The Health Plan. Court ordered services are subject to BMS reviews and determination.

SERVICES NOT COVERED

Some services are not available through The Health Plan or Medicaid. If you choose to get these services, you may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- All non-medically necessary services.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Cosmetic/plastic surgery will be covered only to correct conditions from accidents/injuries like a car accident and birth defects like a cleft lip. Breast implants are covered only for mastectomy due to breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- Removal/replacement of breast implants must be proven medically necessary. Implants must have been inserted for reconstructive purposes due to mastectomy for breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- These conditions must have happened while you were a member of The Health Plan. If not, The Health Plan must determine an ongoing history of medically necessary cosmetic/plastic surgery to correct these conditions. The Health Plan may do so by looking at your past medical records.

- Removal of breast implants that were inserted for cosmetic reasons only will not be covered.
- Oral surgery for adults will be covered to correct conditions from accidents/injuries, like a car accident. The accident/injury must have happened *while* you were a member of The Health Plan. An oral surgeon *must* be needed to correct these conditions. These services must start within six months of the accident/injury.
- Custodial or home care, rest and respite care, or other services primarily to assist in the activities of daily living and personal comfort items (to include cleansing and luxury items) are not paid for by The Health Plan. This includes personal services and residential services.
- Health care that is for research, investigation, or experimental as determined by The Health Plan, is not paid for by The Health Plan. The Health Plan will look at standards of the AMA, FDA, NIH, Medicare, or reports of consultants to decide if a health care treatment is experimental or investigational.
- Private rooms are not paid for, except when medically needed and approved by The Health Plan. Personal or comfort items and services like guest meals, lodging, radio, television, and telephone are not paid for by The Health Plan.
- Hospital or medical care for problems that state or local law requires treatment in a public facility is not paid for by The Health Plan.
- Any injury or sickness when any benefits, settlements, awards, or damages will be received or paid will not be paid for by The Health Plan. This also includes workers' comp, employer's liability or similar law or act. This applies even if you waived your rights to workers' comp, employer's liability, or similar laws or acts. Be sure to tell The Health Plan if you will get any benefits, settlements, awards, damages, or workers' comp.
- Reversal of voluntary sterilization and associated services and/or expenses will not be paid for by The Health Plan.
- Sterilization for members under age 21 will not be paid for by The Health Plan.
- Sex change, hormone therapy for sex transformation, and gender transition procedures/expenses will not be paid for by The Health Plan. Procedures, services and supplies related to sexual dysfunction will not be paid for by The Health Plan.
- Special services not approved by The Health Plan will not be paid for.

Provider Procedural Manual

Corporate Office

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Wheeling, WV 26003

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F: 1.740.699.6169
TTY: 711

healthplan.org

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Exclusions, continued

- Sex change, hormone therapy for sex transformation, and gender transition procedures/expenses will not be paid for by The Health Plan. Procedures, services and supplies related to sexual dysfunction will not be paid for by The Health Plan.
- Special services not approved by The Health Plan will not be paid for.
- Provider and medical services outside the service area will not be paid for if you knew you would need these services before you left the service area. If you know you will need services and you may be traveling soon, tell your PCP or The Health Plan.
- Hearing aid evaluations, bone-anchored hearing aids, cochlear implants, hearing aids, hearing aid supplies, batteries and repairs will only be covered for members under the age of 21. Coverage depends on hearing loss and The Health Plan guidelines.
- Exams for insurance, sports physicals, camp physicals, or daycare physicals will not be paid for unless it is part of your yearly physical exam given by your PCP.
- Medical and surgical treatment for *all* infertility services will not be paid for by The Health Plan.
- Abortions will not be paid for by The Health Plan but are covered by FFS Medicaid. Use your medical card.
- Long-term cardiac and pulmonary, physical, respiratory, occupational or speech therapy will only be paid for in certain situations, such as for children.
- Services for acupressure, hypnosis, electrolysis, Christian Science treatment and autopsy. Any education or training classes including Lamaze and to quit tobacco use (unless under RFTS) will not be paid for by The Health Plan. Estrogen and androgen pellet implants, arch supports, massage, and paternity testing are not covered.
- Liposuction, panniculectomies or abdominoplasty, such as surgery to remove fatty tissue ("tummy tucks"), will not be covered by The Health Plan.
- Work hardening programs, including functional capacity evaluations will not be covered by The Health Plan.
- Services at non-medical weight loss clinics and diet centers, mini-gastric bypass surgery, and gastric balloon for treatment of obesity will not be covered by The Health Plan. Consideration for bariatric surgery and related services require prior authorization. Also included are wiring of the jaw, weight control programs, screening for weight control programs, and similar services.
- Organ transplants and related expenses will not be covered by The Health Plan. These are covered by FFS Medicaid through your medical card.
- Vision services for members over age 21 are limited to medical treatment only and require an approved referral to a participating ophthalmologist.
- Practitioner and medical services that are not medically necessary or appropriate as determined by The Health Plan will not be paid for.
- Other limitations specifically stated in the provider and medical benefits list in this handbook.

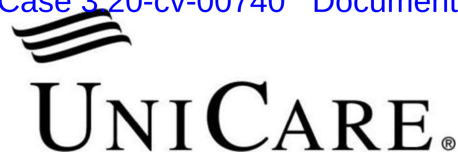
CFAIN0001861

UniCare Health Plan of West Virginia, Inc.

Member Handbook

Mountain Health Trust
West Virginia Health Bridge
West Virginia Children's Health Insurance Program

UWV-MHB-0022-20



Please note this change to your handbook.

Thank you for being a member. We have important updates to your UniCare Health Plan of West Virginia, Inc. benefits. Starting July 1, 2021, mothers and their newborns can continue to receive Medicaid benefits for up to one year postpartum. Extending coverage for you and your baby helps ensure continued access to care for your health-related needs.

It is important you provide UniCare with your newborn's name. This helps us stay up to date and provides UniCare with the right details for your health coverage. To provide a name, call your Department of Health and Human Resources (DHHR) or tell the Change Center at **877-716-1212**.

Please keep this insert with your UniCare handbook.

Questions? We're here to help. Call the Customer Care Center at **800-782-0095**, Monday through Friday from 8 a.m. to 6 p.m. Eastern time, or visit **unicare.com/wv**.

Enclosure(s): Get help in another language
HHS nondiscrimination notice

1033803WVMENUNC 06/21

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SERVICES NOT COVERED

Some services are not available through UniCare, Medicaid, or WVCHIP. If you choose to get these services, you may have to pay the entire cost of the service. UniCare is not responsible for paying for these services and others:

Medicaid non-covered services:

- All non-medically necessary services and those not listed as covered
- Autopsy and other services performed after death
- Care from a provider not in our plan when you didn't get the needed OK from us before you got the service
- Coma stimulation
- Cosmetic or reconstructive surgery when not required as a result of accidental injury or disease, or not performed to correct birth defects; services resulting from or related to these excluded services also are not covered
- Daily living skills training
- Dental services other than those listed as covered
- Duplicate testing, interpretation, or handling fees
- Education, training, and/or cognitive services, unless specifically listed as covered services
- Emergency evacuation from foreign country, even if medically necessary
- Expenses for which you are not responsible, such as patient discounts and contractual discounts
- Expenses incurred as a result of illegal action while incarcerated or while under the control of the court system
- Experimental, investigational, or unproven services
- Fertility drugs and services
- Foot care (routine, except for diabetic patients)
- Genetic testing for screening purposes — except those tests covered under the maternity benefit are not covered
- Sterilization of a mentally incompetent or institutionalized individual
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition
- Organ transplants, except in some instances
- Treatment for infertility and the reversal of sterilization
- Sex transformation procedures and hormone therapy for sex transformation procedures
- All cosmetic services, except in the case of accidents or birth defects
- Care given outside of the U.S.
- Medical equipment, prescriptions, services, and supplies that are:
  - Used only for your comfort or hygiene

  - Used for exercise
  - Personal or comfort items
  - Used for the same function as another service we have already paid for
  - Changes to your house or car, including ramps, stair glides, vehicle lifts for wheelchairs, vehicle safety devices (such as EZ Vests, transit systems, or car seats)
  - Equipment that needs replacement due to neglect or misuse
- Service animals
- Emergency room visits for routine care
- Payment for care you got for health problems that were work-related if they can be paid for by workers' compensation insurance, your employer, or by a disease law that has to do with your job
- Acupuncture
- Experimental or investigational services
- Christian science nurses and sanitariums
- Homeopathic medicine
- Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
- Hypnosis
- Incidental surgery performed during medically necessary surgery
- Orientation therapy
- Orthotripsy
- Screenings, except those specifically listed as covered benefits
- Sensory Stimulation (SS) therapy

WVCHIP non-covered services:
Some services are not covered by WVCHIP regardless of medical necessity. Specific exclusions are listed below.

- All non-medically necessary services and those not listed as covered
- Acupuncture
- All expenses incurred at a facility when a patient leaves against medical advice
- Ancillary services and/or services resulting from an office visit not covered by WVCHIP
- Aqua therapy
- Autopsy and other services performed after death
- Behavioral or functional type skills training except for applied behavior analysis (ABA) treatment
- Biofeedback
- Coma stimulation

We can translate this for you at no cost.
Call the Customer Care Center at 800-782-0095. If you have speech or hearing loss, call the TTY line at 711.

unicare.com/wv

UniCare Health Plan of West Virginia, Inc.

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