1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
3 HUNTINGTON DIVISION
4 ---
5 Christopher Fain, individually and on behalf of all
6 others similarly situated, et al.,
7 Plaintiffs,
8 vs. CIVIL ACTION NO. 3:20-cv-00740
9 William Crouch, et al.,
10 Defendants.
11 ---
12
13
14 REMOTE DEPOSITION OF SARAH YOUNG
15
16
17 DATE: March 11, 2022
18 TIME: 8:00 a.m. CST
19 PLACE: Veritext Virtual Videoconference
20
21
22
23
24 REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
25 JOB NUMBER: 5096099

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12 NOTE: The original deposition transcript will be
13 delivered to Carl Charles, Esq., as the taking attorney.
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1 SARAH YOUNG,
2 duly sworn, was examined and testified as follows:
3 EXAMINATION
4 BY MR. CHARLES:
5 Q. Good morning, Ms. Young. My name is Carl
6 Charles, I'm an attorney for the plaintiffs and I'm with
7 Lambda Legal. My pronouns are he/him. Can I just
8 confirm your pronouns are she/her, I just want to make
9 sure to address you properly.
10 A. Sure. Thank you.
11 Q. Okay. And I'll be referring to you as Ms. Young
12 throughout the deposition this morning. Just for my
13 note, have you been deposed before?
14 A. No, I have not.
15 Q. Okay. So let me just go through a few very
16 quick ground rules. Because you're here as an
17 organizational witness and not in your personal
18 capacity, the ground rules will be different and won't
19 take us long.
20 So for the deposition today it's important that
21 both of us engage in verbal responses. So when I ask
22 you a question, please, even if it's a yes or no
23 question, do say yes or no instead of nodding your head
24 or, you know, sort of common yes, no answers like mm-hmm
25 or huh-un. Those are just harder for the court reporter

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1 to note in the record. Does that make sense?
2 A. It does, yes.
3 Q. Okay. If you could, please, wait until I'm
4 finished with the question and I will in kind wait until
5 you are finished with your response before asking
6 another question. That would just, again, try to make
7 Kelley's life as easy as possible here, so that will
8 help her record what we're saying and not have to go
9 back and ask us to repeat.
10 Throughout the day if you need a break, please
11 don't hesitate to let me know. The only thing I would
12 ask is that if there's a question pending if you could
13 provide a response and sort of if we could finish that
14 segment of dialogue before we take a break, then I'm
15 happy to then take a break. Does that make sense?
16 A. It does. Thank you.
17 Q. Okay. And then finally, you just took an oath
18 to tell the truth. Is there anything today that would
19 prevent you today from giving truthful or honest
20 testimony?
21 A. No.
22 Q. Okay, great. So that's it, that's the ground
23 rules. Any questions from you about those?
24 A. No, I don't believe so.
25 Q. Okay. So are you aware that you are here today

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1 to give testimony in a lawsuit entitled Fain versus
2 Crouch?
3 A. Yes.
4 Q. Okay. And are you familiar with what that
5 lawsuit is about?
6 A. Yes, I am.
7 Q. Okay. And what's your understanding of what the
8 lawsuit is about?
9 A. My understanding is that the lawsuit is about
10 coverage of transsexual services including surgery.
11 Q. Anything else?
12 A. I'm sorry, not that I'm aware.
13 Q. Okay. So before we get too far into things
14 today, I do want to make sure we are using some common
15 vocabulary and just so we understand one another when
16 we're using terms, so that's where I'll start.
17 So first, we'll be talking today extensively
18 about the West Virginia Department of Health and Human
19 Resources, specifically the Bureau of Medical Services
20 where you work. If I refer to that entity as BMS, will
21 you know what I am referring to?
22 A. Yes.
23 Q. Okay. Thank you. We will also be discussing
24 managed care organizations today. First of all, are you
25 familiar with what a managed care organization is?

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1 A. Yes, I am.
2 Q. Okay. And can you just tell me what your
3 understanding of what a managed care organization is,
4 please?
5 A. In a managed care model we pay the organization
6 a capitation payment, a per member per month payment,
7 and they are responsible for coverage of services for
8 the members that are assigned to them out of that
9 capitation payment.
10 Q. Thank you. And so if in the course of today I
11 refer to those managed care organizations by the
12 abbreviation MCO or MCO's, will you understand what I'm
13 referring to?
14 A. Yes.
15 Q. Okay. And we'll also be talking in large part
16 today about certain exclusions of care in West
17 Virginia's Medicaid coverage for transgender people, and
18 so I just want to go over those briefly with you at the
19 outset so that you're familiar with what I'll be
20 referring to. So let me, I should have asked at the
21 outset, Ms. Young, do you have the Veritext Exhibit
22 Share visible on a screen?
23 A. Yes, I do.
24 Q. Okay. I'm just going to introduce an exhibit
25 here, if you'll just give me one moment.

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1 (Exhibit 1 marked for identification.)
2 Q. Okay. So hopefully you can see there in the
3 marked exhibits folder what has been marked as Exhibit
4 PL0001. Do you see that there?
5 A. I do, yes.
6 Q. Okay.
7 MR. CHARLES: Kelley, I'm showing the
8 witness what has been marked as Exhibit 0001, it's a
9 copy of a document entitled, "Bureau for Medical
10 Services policy manual, Chapter 100."
11 Q. Please take as much time as you need to look at
12 the document and I will wait until you tell me you've
13 sufficiently reviewed it.
14 A. I am familiar with the document.
15 Q. Okay. Thank you, thank you. I just don't want
16 to, throughout the day I will say take a moment, but
17 what I mean by that is take the sufficient moments you
18 need to review it.
19 A. Thank you.
20 Q. Okay. Do you recognize this document?
21 A. I do, yes.
22 Q. And what is this document?
23 A. This is a chapter of our provider manual, it's
24 available on our Website, and it is a guiding document
25 for services that we cover and billing instructions for

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1 providers. It is not all inclusive and I believe
2 there's a disclaimer at the bottom that says to that
3 effect, but this is our general information chapter.
4 Q. Thank you. Do you have any reason to believe
5 this is not a true and correct copy of that document?
6 A. It appears to be the same one that we have on
7 our Website.
8 Q. Thank you. Okay. So now if you would, please,
9 turn to Page 10 of this document. The page numbers are
10 in blue at the bottom right-hand corner, the text is a
11 little bit, it's kind of small there in the bottom
12 right-hand corner.
13 A. Okay, sorry.
14 Q. No, no, take your time.
15 MS. BANDY: Is there a Bates number on
16 that? That might be helpful.
17 MR. CHARLES: Yes, sorry. So it's
18 CFAIN001661.
19 MS. BANDY: Okay, we got it.
20 BY MR. CHARLES:
21 Q. Okay. Ms. Young, do you see in the middle of
22 the page the numbers 1661?
23 A. Yes.
24 Q. And the title, "General noncovered services"?
25 A. Yes.

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1 Q. Okay. So if you would just read along with me,
2 I'm going to read aloud, but if you'll just follow
3 along, please. Underneath that heading, "The West
4 Virginia Medicaid program does not cover certain
5 services and items regardless of medical necessity."
6 Did I read that correctly?
7 A. Yes.
8 Q. Okay. And then some examples are identified
9 below. I'm not going to read all of those examples, I'm
10 going to continue to the next page where that list
11 continues. Just let me know when you're on the next
12 page.
13 A. I am.
14 Q. Okay. And then the third bullet from the top,
15 do you see what that bullet is?
16 A. I do.
17 Q. And could you just read that out loud for me?
18 A. "Transsexual surgery."
19 Q. Okay. Thank you very much. So I'm going to put
20 that document away for a moment and introduce another
21 document.
22 (Exhibit 2 marked for identification.)
23 Q. Okay. Do you see what has been marked as
24 Exhibit PL0002?
25 A. Yes.

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1 Q. Okay.
2 MR. CHARLES: So I'm showing the witness
3 what has been marked as Exhibit PL0002.
4 Q. Are you familiar with this document as well, Ms.
5 Young?
6 A. I am, but this looks like the archived version
7 rather than the current version.
8 Q. Okay. And can you tell me what you mean by
9 archived versus current?
10 A. The format. And I'm just looking at the first
11 page. So at some point, I want to say it was 2013,
12 2014, we reformatted almost all of our chapters and any
13 time that we update a chapter we put the old chapter
14 into archive so that it's there for reference, but not
15 currently on our provider manual page.
16 Q. So am I understanding correctly that the
17 difference between this document based on your, based on
18 the first page here is that the difference between this
19 and what's currently available is just formatting?
20 A. It would also be the effective date. I think
21 this one says 12, and I apologize, I believe that the
22 current version is in a different format and would have
23 a different effective date.
24 Q. Okay. Would it be fair to say that the content
25 as far as you know is not different?

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1 A. I honestly couldn't say without comparing them
2 side-by-side.
3 Q. Okay.
4 A. It looks like it's dated 2012, so there may have
5 been changes in the current version since then.
6 Q. Okay. Thank you. Let's go ahead and take a
7 look at this document and then I may come back to an
8 updated version of this per your comments. So if you
9 would, please, I know I'm asking you, but whomever it is
10 running the Exhibit Share, if you could, please, turn to
11 Page 75. This document is quite a bit more lengthy than
12 the previous, so.
13 MS. BANDY: And are you referring to the
14 page number that's printed on the bottom of the page?
15 MR. CHARLES: Yes, it is. If you could,
16 before you do that, I'm sorry, I realized that I didn't
17 ask the witness, I just asked her if she recognized it
18 and not what it was. So if we can just pause for a
19 moment so I can ask her.
20 MS. BANDY: Sure.
21 MR. CHARLES: Thank you.
22 BY MR. CHARLES:
23 Q. Ms. Young, I started asking you sort of, you
24 shared the information about the document. Can you just
25 tell me what you recognize this document to be, a

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1 description?
2 A. Sure. This looks like, like I said, an archived
3 or an older version of Chapter 519 as part of our
4 provider manual.
5 Q. And 519 specifically is the part of the manual
6 that is there describing the title, "Covered services,
7 limitations and exclusions for practitioner services"?
8 A. Correct, yes.
9 Q. Okay.
10 MR. CHARLES: So Page 75 is going to be in
11 the bottom right corner under the blue line footer bar
12 there.
13 MS. BANDY: Okay. I think we've got it.
14 MR. CHARLES: Thank you.
15 BY MR. CHARLES:
16 Q. Okay. So, Ms. Young, are you seeing at the top
17 of Page 75 there 519.15, "Unlisted services, drugs,
18 procedures or items"?
19 A. Yes.
20 Q. Okay. So then just two headings down, do you
21 see 519.17, "Noncovered services"?
22 A. Yes.
23 Q. Okay. And then about --
24 MR. CHARLES: Actually, Kim, if you could
25 go ahead and scroll to Page 77, so just two pages below

Page 20

1 where we are.
2 MS. BANDY: Okay.
3 Q. So then on Page 77, Ms. Young, there's no
4 heading, there's just a continuation of that bulleted
5 list?
6 A. Yes.
7 Q. Okay. And then do you see the bullet, it would
8 be the fifth bullet down the page, "Sex change surgery"?
9 A. Yes.
10 Q. Okay. And then in parentheses, what is in
11 parentheses next to that phrase?
12 A. "Transsexual surgery."
13 Q. Okay. Thank you. Are you aware, Ms. Young, of
14 anywhere else in BMS's official documents where this
15 specific exclusion is spelled out in this way, either as
16 transsexual surgery or sex change surgery?
17 A. Not that I'm aware of.
18 Q. Okay.
19 MR. CHARLES: Okay. There's another
20 exhibit in the marked exhibit folder, Kim.
21 MS. BANDY: Okay.
22 (Exhibit 3 marked for identification.)
23 MR. CHARLES: So I'm showing the witness
24 what has been marked as Exhibit PL0003, a copy of a
25 document entitled, "UniCare Health Plan of West Virginia

Page 21

1 Inc. member handbook."
2 BY MR. CHARLES:
3 Q. Ms. Young, please take as much time as you need
4 to look at this document, if you need any time at all.
5 A. Is there a certain section?
6 Q. Yeah, we'll turn to it. Generally do you
7 recognize this document?
8 A. I do, yes.
9 Q. Okay. And what is it, based on your
10 understanding?
11 A. So this is the, each of our managed care
12 organizations are required to have a member handbook, so
13 it is their communication to members to the covered
14 services, and this appears to be UniCare Health Plan
15 West Virginia member handbook.
16 Q. Thank you, Ms. Young. And I don't see a plan
17 year listed anywhere on here, are you seeing that?
18 A. Not on what I'm seeing, I don't see that.
19 Q. No problem. Do you know, is it a requirement
20 that MCO handbooks have plan years listed on them?
21 A. Not that I'm aware of.
22 Q. Okay. So if you'll please turn to Page 61.
23 MR. CHARLES: And that's going to be Bates
24 stamp DHHRBMS000081, Kim, if that helps get you there
25 faster.

Page 22

1 MS. BANDY: Yes, that's helpful.
2 MR. CHARLES: Okay.
3 MS. BANDY: All right.
4 BY MR. CHARLES:
5 Q. So, Ms. Young, at the top of that page do you
6 see the title there, "Services not covered"?
7 A. Yes.
8 Q. So I'm going to read aloud and if you'll just
9 follow along the couple of sentences there, "Some
10 services are not available through UniCare, Medicaid or
11 WVCHIP." Very quickly, Ms. Young, what is WVCHIP?
12 A. It's the West Virginia Children's Health
13 Insurance Program, we refer to it as CHIP.
14 Q. Okay. So if it will work for you, that's how
15 I'll refer to it today, to the extent we discuss it.
16 A. Yes.
17 Q. So then starting up again at that sentence, "If
18 you choose to get these services, you may have to pay
19 the entire cost of the service. UniCare is not
20 responsible for paying for these services and others."
21 And then the heading there, can you just read that for
22 me, Ms. Young?
23 A. "Medicaid noncovered services."
24 Q. Great. And then looking at the fourth bullet
25 from the bottom of that page, do you see that there?

Page 23

1 A. Yes.
2 Q. Okay. And can you just read that for me, it
3 begins with, "Sex transformation"?
4 A. "Sex transformation procedures and hormone
5 therapy for sex transformation procedures."
6 Q. Great. Thank you.
7 (Exhibit 4 marked for identification.)
8 MR. CHARLES: Okay. So I've marked another
9 exhibit there in the marked exhibit folder, Kim. So,
10 Kelley, I'm showing the witness what has been marked as
11 Exhibit PL00004.
12 MS. BANDY: We've got it.
13 MR. CHARLES: Great. Thank you.
14 BY MR. CHARLES:
15 Q. Ms. Young, have you seen this document before?
16 A. I don't recall this specific document.
17 Q. Okay. Are you familiar with the health plan as
18 an entity?
19 A. Yes.
20 Q. Okay. Is that another MCO?
21 A. Yes, it is.
22 Q. Okay. And even though you don't recognize this
23 document, does it appear generally to be what it says on
24 that title page, the provider procedural manual?
25 A. Yes, it does.

Page 24

1 Q. Okay. And what is a, do you know what a
2 provider procedural manual is?
3 A. I would assume that it is, instead of the member
4 handbook that we viewed earlier, this is the handbook
5 for the manual that is geared towards the providers,
6 towards their billing practices or deadlines, their
7 procedures for billing.
8 Q. Do you know if other MCO's have a provider
9 procedural manual?
10 A. I do not know if they have it in this exact
11 format.
12 Q. Okay. Fair enough. Let's turn to --
13 MR. CHARLES: And I'm sorry, Kim, there's
14 not a Bates stamp on these pages. So if we could turn
15 to Page 66, and the page number is in the lower
16 right-hand corner.
17 MS. BANDY: Okay.
18 MR. CHARLES: Thank you.
19 BY MR. CHARLES:
20 Q. Okay. Ms. Young, do you see at sort of the
21 bottom third of Page 66 there's a green, in green
22 lettering a title there, "Exclusions," do you see that?
23 A. Yes.
24 Q. Okay. So again if you could follow along as
25 I'll read the sentences underneath that title, "Some

Page 25

1 services are not available through the health plan or
2 Medicaid. If you choose to get these services, you may
3 have to pay the entire cost of the service. The health
4 plan is not responsible for paying for these services
5 and others." Did I read that correctly?
6 A. Yes.
7 Q. Okay. Thank you.
8 MR. CHARLES: So then, Kim, going down to
9 Page 68.
10 MS. BANDY: Okay.
11 Q. And so, Ms. Young, do you see at the top of
12 Page 68, it says, "Exclusions continued"?
13 A. Yes.
14 Q. Okay. And then if you would, please, just read
15 that first bullet in its entirety for me.
16 A. "Sex change, hormone therapy for sex
17 transformation and gender transition procedure/expenses
18 will not be paid for by the health plan. Procedures,
19 services and supplies related to sexual dysfunction will
20 not be paid for by the health plan."
21 Q. Okay. Thank you. Okay. Just a couple more of
22 these, we're almost through them. Thank you for your
23 patience.
24 (Exhibit 5 marked for identification.)
25 MR. CHARLES: Kim, do you see what's been

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1 marked as Exhibit PL0005?
2 MS. BANDY: Yes.
3 MR. CHARLES: Okay. So I'm showing the
4 witness what has been marked as Exhibit PL0005.
5 BY MR. CHARLES:
6 Q. Ms. Young, please take the time you need to
7 review this document. And have you seen this document
8 before, Ms. Young?
9 A. No, I don't believe I have.
10 Q. Okay. Do you know what it is?
11 A. It appears to be the Aetna Better Health member
12 handbook.
13 Q. And this handbook has a year on it, can you just
14 tell me the year?
15 A. Yes, 2019 to 2020.
16 Q. Great. And is this again a plan that West
17 Virginia Medicaid recipients can choose from amongst the
18 available MCO's for benefit year 2019 to 2020?
19 A. It is, yes.
20 Q. Okay.
21 MR. CHARLES: So, Kim, if you would,
22 Page 31.
23 MS. BANDY: We're there.
24 MR. CHARLES: Thank you.
25 BY MR. CHARLES:

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1 Q. Ms. Young, do you see the heading, "Services not
2 covered" about a third of the way down the page there?
3 A. Yes.
4 Q. Okay. So reading aloud again, if you'll follow
5 along, please, "Some services are not available through
6 Aetna Better Health or Medicaid. If you choose to get
7 these services you may have to pay the entire cost of
8 the service. Aetna Better Health is not responsible for
9 paying for these services and others." Did I read that
10 correctly?
11 A. Yes.
12 Q. Thank you. And then looking at the sixth bullet
13 there, sixth bullet from the top that is. Can you read
14 that bullet for me that begins again, "Sex
15 transformation"?
16 A. "Sex transformation procedures and hormone
17 therapy for sex transformation procedures."
18 Q. Great. Thank you.
19 MR. CHARLES: Okay. Again, Kim, in the
20 marked exhibit folder I'm showing the witness what has
21 been marked as Exhibit PL0006.
22 (Exhibit 6 marked for identification.)
23 BY MR. CHARLES:
24 Q. Have you seen this document before, Ms. Young?
25 A. No, I have not.

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1 Q. Okay. Can you just tell me what it -- well,
2 sorry. Take a minute to look at it, please, first.
3 A. Okay.
4 Q. Thank you. And then can you just tell me what
5 this document is?
6 A. It appears to be the Aetna Better Health of West
7 Virginia member handbook.
8 Q. And for which plan year, please?
9 A. 2020 to 2021.
10 Q. Okay. And can you tell me what, to the extent
11 you know, what Mountain Health Trust - Medicaid means
12 there at the bottom?
13 A. Mountain Health Trust is the name of our managed
14 care program.
15 Q. Okay. So the managed care program oversees the
16 managed care organizations, is that right?
17 A. Yeah, it's an all encompassing term. You'll
18 hear it referred to as the Mountain Health Trust plan
19 or, it's to differentiate between fee for service and
20 managed care.
21 Q. Oh, that's helpful. Okay. So fee for service
22 does not fall under the Mountain Health Trust?
23 A. Correct.
24 Q. Okay. Thank you for that.
25 MR. CHARLES: Again, Kim, turning to

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1 Page 32, if you would, please.
2 MS. BANDY: Okay.
3 MR. CHARLES: Thank you.
4 BY MR. CHARLES:
5 Q. So at the bottom of Page 32, Ms. Young, do you
6 see the heading, "Services not covered"?
7 A. Yes.
8 Q. Okay. And then I'll read those introductory
9 sentences, if you'll follow along again, please, "Some
10 services are not available through Aetna Better Health
11 or Medicaid. If you choose to get these services you
12 may have to pay the entire cost of the service. Aetna
13 Better Health is not responsible for paying these
14 services." Did I read that correctly?
15 A. Yes.
16 Q. Okay.
17 MR. CHARLES: And then scrolling to
18 Page 33, please.
19 MS. BANDY: Okay.
20 Q. The third bullet from the top there, Ms. Young,
21 could you just read that bullet for me, please.
22 A. "Sex transformation procedures and hormone
23 therapy for sex transformation procedures."
24 Q. Great. Thank you.
25 (Exhibit 7 marked for identification.)

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1 MR. CHARLES: Okay. And again, in the
2 marked exhibit folder I'm showing the witness what has
3 been marked as Exhibit PL0007.
4 BY MR. CHARLES:
5 Q. And if you could again just take a minute to
6 look at this, Ms. Young.
7 A. Okay.
8 Q. And have you seen this document before?
9 A. I have not, no.
10 Q. Okay. And what does it appear to be?
11 A. It appears to be the Aetna Better Health of West
12 Virginia member handbook for the years 2021 to 2022.
13 Q. So just an updated member handbook from the one
14 we just looked at?
15 A. I believe so, yes.
16 Q. Okay. And following under that same umbrella,
17 we just discussed the Mountain Health Trust managed care
18 program?
19 A. (Nodding head.)
20 Q. Okay. Thank you.
21 MR. CHARLES: And then, Kim, please,
22 turning to Page 31.
23 MS. BANDY: I don't see page numbers.
24 MR. CHARLES: Yeah, I am not either. All
25 right.

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1 MS. BANDY: Do you see like at the bottom
2 of the screen there's something that will pop up that
3 says page --
4 MR. CHARLES: Oh, I do see that, yes.
5 Thank you for that. Let me try to find where I need to
6 go here. So when that toggle appears, Kim, it's Page 33
7 of 52.
8 MS. BANDY: Okay. Thank you.
9 MR. CHARLES: No, thank you. I don't know
10 how I would have found it had you not pointed that out,
11 so.
12 MS. BANDY: All right. We're there.
13 MR. CHARLES: Thank you so much.
14 BY MR. CHARLES:
15 Q. Ms. Young, do you see, "Services not covered"
16 about a third of the way down the page?
17 A. Yes.
18 Q. Okay. And then again I'll read aloud, so please
19 follow along, "Some services are not available through
20 Aetna Better Health or Medicaid. If you choose to get
21 these services you may have to pay the entire cost of
22 the service. Aetna Better Health is not responsible for
23 paying for these services." Did I read that correctly?
24 A. Yes.
25 Q. Thank you. And then again the sixth bullet

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1 down, if you could just read that for me.
2 A. "Sex transformation procedures and hormone
3 therapy for sex transformation procedures."
4 Q. Okay. Thank you very much. So to your
5 knowledge, Ms. Young, are there other MCO plans besides
6 the ones we've just, besides the handbooks for the ones
7 we've just reviewed and discussed?
8 A. There are no current plans, no.
9 Q. Okay. I'm sorry, you mean no additional the
10 ones?
11 A. Correct. Sorry.
12 Q. No, no problem. And to your knowledge are there
13 other instances of language like this in other West
14 Virginia Medicaid materials that you have seen?
15 A. None that I have seen.
16 Q. Okay. How about Bureau for Medical Services
17 materials that you have seen or are aware of?
18 A. None that I have seen.
19 Q. Okay.
20 A. None that I'm aware of.
21 Q. Okay. And what about are there other instances
22 of language like this in any fee for service materials
23 that you're aware of?
24 A. Not that I'm aware of.
25 Q. Okay. So keeping in mind the exhibits and

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1 documents we just looked at, if today as we're talking I
2 generally refer to those exclusions of coverage as thee
3 exclusion or exclusions, will you generally know to what
4 I am referring?
5 A. Yes.
6 Q. Okay. Thank you. And if as a part of our
7 discussion you need to distinguish amongst those various
8 exclusions we just reviewed in order to give accurate
9 testimony, will you let me know?
10 A. Yes.
11 Q. Okay. Thank you. And again, to your knowledge
12 are you aware of any other exclusions of gender
13 confirming care in the West Virginia Medicaid program?
14 A. Not that I'm aware of.
15 Q. Okay. And then last sort of term I just want to
16 come to an understanding about for the purposes of
17 today's deposition, we'll be talking about medical
18 treatment that transgender people need for the purpose
19 of treating gender dysphoria. Plaintiffs and us, their
20 counsel, refer to that as gender confirming care. So if
21 I use that during the course of today's deposition, will
22 you understand what I'm referring to?
23 A. Yes.
24 Q. Okay. Thank you. So just a little bit of
25 background questions about your position with the

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1 organization, Ms. Young. Can you tell me what your job
2 title is, please?
3 A. Deputy commissioner of policy and operations.
4 Q. Okay. And what responsibilities fall under your
5 role within BMS?
6 A. Under the policy side I have staff who oversee
7 all of the coverage policies that we have, that also
8 includes our eligibility policy. And on the operation
9 side I have oversight of all of the technical systems
10 that we use to manage the program.
11 Q. Can you tell me what technical systems you
12 oversee, that seems like a big bucket of work, can you
13 just say a little bit more of what you mean by that?
14 A. It is. We have the Medicaid managed information
15 system, you may see it referred to as MMIS, that is our
16 claims processing system. Within that we have our
17 provider enrollment documents or files as well. I do
18 not see the, oversee the member eligibility system, but
19 our staff do have input into the Medicaid portion of
20 that system. There are various other systems that we
21 oversee that touch on member eligibility as well.
22 Q. So there's another individual who specifically
23 oversees eligibility, right, that formally falls under
24 someone else, is that correct?
25 A. The policy for member eligibility falls under?

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1 Q. No, I'm sorry, not the policy. I'm looking
2 at -- sorry. There's a director of Medicaid
3 eligibility, so I guess what I'm asking is like what is
4 the difference between what you just said and that
5 person's role?
6 A. So the employee at BMS who is the director of
7 member eligibility, she reports to me.
8 Q. Oh, I see. Okay. And can you just tell me who
9 that is so I don't have to keep referring to them by
10 their title?
11 A. Anita Hayes.
12 Q. Thank you. Okay. So she reports to you?
13 A. Correct.
14 Q. Are there, can you tell me the other directors
15 that you oversee?
16 A. Sure. Do you want names and titles?
17 Q. Yeah, please.
18 A. Okay. Anita is my director of Member
19 Eligibility; Jennifer Myers is the director of Provider
20 Services -- oh, I'm sorry, we change our titles often.
21 Q. I think she's Professional Services, right?
22 A. Thank you, yes, yes. And I have Brandon Lewis
23 is our Medicaid Enterprise Systems director; I have
24 Marcus Canaday who is the director of our Money Follows
25 the Person program; Randall Hill who is director of our

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1 Home and Community Services Based program, and Cynthia
2 Parsons who was director of our Behavioral Health and
3 Long-Term Care Services. I believe that is everyone.
4 Q. That's quite the list. Okay. Thank you very
5 much for that. So then who do you directly report to?
6 A. Commissioner Cindy Beane.
7 Q. Okay. And just in a sort of general way, do you
8 have a formal structure for how often you report to
9 Commissioner Beane, you know, I'm not referring here to
10 informal communications you might have with her, I'm
11 just speaking, you know, do you have a monthly, you
12 know, formal reporting structure or a quarterly
13 structure, something of that nature?
14 A. We have a weekly leadership team meeting to
15 which we escalate issues that the commissioner or the
16 other deputies are not already aware of, but there is a
17 lot of informal escalation of issues.
18 Q. That makes sense. Thank you. How long have you
19 been in your role as deputy commissioner for policy and
20 operations?
21 A. Officially I was interim for a number of years,
22 I believe official was 2016 or 2017.
23 Q. If you had to ballpark your interim years, could
24 you give me just a rough estimate?
25 A. I believe it started in 2014.

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1 Q. That works. Thank you. And were you employed
2 with BMS before you started as the interim director?
3 A. Yes, I was.
4 Q. And what was your position within BMS before
5 that?
6 A. I came to BMS in 2012 and at that time I was in
7 the position of assistant to the commissioner, and then
8 at some point I was promoted to a director position
9 before becoming interim deputy.
10 Q. Okay. So you were assistant to the commissioner
11 beginning in 2012. Can you just tell me briefly what
12 that, what your duties were therein?
13 A. Sure. I ensured that the commissioner was aware
14 of issues that were not escalated to her in other ways.
15 And at that time I also oversaw the Medicaid expansion
16 duties, the state plan amendments and the policies
17 around that.
18 Q. And before your position as assistant to the
19 commissioner, were you also employed in some capacity
20 with BMS or were you with a different organization?
21 A. I was still with DHHR, but not with BMS, I was
22 with a different Bureau.
23 Q. And what Bureau was that?
24 A. At the time it was called Bureau For Children &
25 Families.

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1 Q. And what was your role there, just the most
2 immediate one before you, I don't want to keep going all
3 the way back, but just before you became the assistant
4 to the director?
5 A. Sure. I was director of client services.
6 Q. Okay. And was that another administrator role
7 within the Department of Children & Families?
8 A. It was, yes.
9 Q. Okay. So then turning to your education, Ms.
10 Young. Just confirming, did you attend university or
11 college?
12 A. Yes.
13 Q. And where did you?
14 A. West Virginia University.
15 Q. Okay. And approximately what years were you a
16 student there?
17 A. '92 through '97.
18 Q. Okay. And did you receive a degree from West
19 Virginia University?
20 A. Yes.
21 Q. And what was that degree in?
22 A. A bachelor in secondary education.
23 Q. Were you ever a teacher?
24 A. No.
25 Q. Okay. Just curious. And do you have any

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1 additional schooling beyond your bachelor degree?
2 A. I do have hours towards a master degree, but I
3 have not completed the master's.
4 Q. And when you complete those hours do you have to
5 do it through a particular institution or how is that
6 credentialed, if you can just say briefly?
7 A. It's not through my employment, but I was taking
8 hours remotely through West Virginia University.
9 Q. Okay, I see. And at some point it could be that
10 you'll acquire sufficient hours to confer a master's
11 degree, is that how that would work?
12 A. Generally, yes.
13 Q. Okay. So as you sort of likely put together,
14 because I just jumped right into things, your deposition
15 is that of an organizational representative for BMS. Do
16 you understand that?
17 A. I do, yes.
18 Q. Okay. So I'm, you know, not asking you the
19 person, Ms. Young, I'm asking you the BMS representative
20 questions today. And so your counsel has designated you
21 to give testimony as the organizational representative
22 for BMS on certain topics, do you understand that?
23 A. Yes.
24 Q. Okay. Do you recall when you were notified that
25 you'd be giving this testimony today as an

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1 organizational representative on various topics? Just a
2 ballpark is fine, it doesn't have to be the exact date.
3 A. Yeah, I can't say exactly. I know that it was
4 prior to November of last year.
5 Q. Okay. So can you tell me, please, Ms. Young,
6 what did you do to prepare to testify today as BMS's
7 organizational representative?
8 A. I reviewed the documents that were, that were
9 sent to me by email and I believe met with counsel just
10 to make sure that I was aware of the topics that I'd be
11 covering.
12 Q. Great. And what were those documents that were
13 sent to you to review?
14 A. I don't know that I could list them all. They
15 were -- I don't have the words to describe it. So it
16 was the exhibits and the interrogatory documents.
17 Q. It sounds like you're referring to discovery
18 requests?
19 A. I believe so, yes.
20 Q. Okay. Were you sent other filings from this
21 case to review that you remember?
22 A. Not that I remember specifically.
23 Q. Okay. And you said you spoke to counsel. Did
24 you speak to anyone besides your attorneys to prepare
25 for today's deposition?

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1 A. I met with my staff to go over what documents
2 they had prepared.
3 Q. Thank you. And when you say your staff, does
4 that sort of generally refer to the list of directors
5 that we just went through?
6 A. It does, yes.
7 Q. Okay. And what documents did your staff prepare
8 for you in anticipation of this deposition?
9 A. I have a document that's the list of diagnosis
10 codes, I don't know those off the top of my head, in
11 case that was asked, and it has some procedure codes on
12 it as well. That's the only document that was prepared
13 for me.
14 Q. Okay. And is it accurate to say that you spoke
15 with each of those directors that we just went through
16 in preparation for your testimony today?
17 A. I did not speak with all of them as they were
18 not, not all were named.
19 Q. Okay.
20 A. I did meet with Jennifer Myers specifically,
21 there was I believe a claims document that she provided,
22 and I've spoken with Brandon Lewis as well about his
23 system documents.
24 Q. Okay. With Jennifer Myers, you said you spoke
25 with her about a claims document, is that what you just

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1 said?
2 A. Correct, yes.
3 Q. Okay. And when did you speak with her
4 approximately?
5 A. Earlier this week.
6 Q. Okay. And how long was that conversation?
7 A. Just a few minutes. I wanted to make sure I
8 understood how the document was set up.
9 Q. Okay. Were there any notes from that
10 conversation?
11 A. No.
12 Q. Okay. And so Ms. Myers was just explaining to
13 you how that document is set up?
14 A. Yes.
15 Q. And do you have that document with you?
16 A. I don't have it with me, no.
17 Q. Okay. So it sounds like it was just in
18 preparation for any questions that we might ask about
19 that document?
20 A. Correct, yes.
21 Q. Okay. And then you said, I believe you said
22 Brandon Lewis?
23 A. Yes.
24 Q. And when did you speak with him?
25 A. I spoke with him I believe it was last week.

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1 Q. Okay. And how long was that meeting?
2 A. Just a few minutes.
3 Q. And can you just say again the nature of that in
4 preparation for today?
5 A. Just in case there were any questions of how the
6 claims were processed, generally speaking, and the prior
7 authorization process as well since those are handled
8 through different systems.
9 Q. And remind me again why he would know the answer
10 to those questions you had for him, his role again?
11 A. He's the Medicaid enterprise systems director,
12 he oversees those systems.
13 Q. That's helpful. Thank you. The enterprise just
14 threw me off, that could mean a lot of very interesting
15 things. Okay. So Medicaid enterprise systems director?
16 A. Yes.
17 Q. Okay. So did he go over any documents with you?
18 A. No.
19 Q. Okay. And so you were just asking him questions
20 about how claims were processed essentially?
21 A. Generally, yes.
22 Q. And then were there any other people that you
23 met with on your team either individually or as a group
24 to prepare for your testimony today?
25 A. No, I don't believe so.

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1 Q. Okay. Ms. Young, we've been going for about an
2 hour, would it be all right if we took a quick break?
3 A. Yes.
4 Q. Okay.
5 MR. CHARLES: And Kim and Lou Ann, just
6 confirming that works for you too?
7 MS. CYRUS: Yes.
8 MS. BANDY: Sure. Do you want to do just
9 five minutes?
10 MR. CHARLES: Actually, why don't we make
11 it seven minutes and come back at 10:10.
12 MS. BANDY: All right. Thank you.
13 (A break was taken at 9:03 a.m.)
14 MR. CHARLES: So we're back on the record
15 at 10:41. And if you could, Ms. Bandy, make your
16 appearance today as counsel.
17 MS. BANDY: Yes, thank you. Kimberly Bandy
18 on behalf of the West Virginia DHHR, Bureau of Medical
19 Services.
20 MR. CHARLES: Thank you, so much.
21 BY MR. CHARLES:
22 Q. Okay. Ms. Young, thank you again for your
23 patience and understanding. We were discussing before
24 we left off who you had spoken with in preparation for
25 your deposition today and you noted that you had spoken

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1 with Mr. Brandon Lewis and Ms. Jennifer Myers, right?
2 A. Yes.
3 Q. Okay, great. And so you also confirmed I
4 believe right before we took the break that those were
5 the only two individuals that you had met with in
6 preparation for your testimony today, is that correct?
7 A. Correct.
8 Q. Okay. To your knowledge did you review any
9 other notes from previous meetings or conversations in
10 preparation for this testimony today?
11 A. No, I have not.
12 Q. Okay. So we're going to, I'm going to introduce
13 another exhibit here, Ms. Young, and you should see that
14 appear in the marked exhibit folder in just a moment.
15 (Exhibit 8 marked for identification.)
16 Q. All right. Do you see what I have marked as
17 Exhibit PL0008?
18 A. Yes, I do.
19 Q. Okay.
20 MR. CHARLES: So I'm showing the witness
21 what I've marked as Exhibit PL0008, the plaintiffs'
22 second amended notice of 30(b)(6) deposition.
23 Q. Do you recognize this document, Ms. Young?
24 A. I do. I believe I've only reviewed the
25 original, not the amended.

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1 Q. Okay. So why don't you please then, it's not a
2 very long document, will you just take a moment and
3 review it so that we can confirm you've had the
4 opportunity to do so.
5 A. Okay.
6 Q. All right. Thank you so much. And you have
7 been designated to speak as a representative of BMS in
8 response to topics contained in this document. We'll
9 return to that later as we get to each topic, but I'm
10 not going to have us read through all the topics right
11 now since they don't all pertain to your testimony.
12 A. Okay.
13 Q. So a few more questions before we get to those
14 topics. Did you in preparation for your testimony
15 today, did you meet with any, that you know of, any
16 transgender West Virginia Medicaid recipients?
17 A. No.
18 Q. Okay. As an organizational representative did
19 you meet with any mental health providers who are, who
20 provide services to transgender West Virginia Medicaid
21 recipients?
22 A. Not in preparation for this.
23 Q. Okay. Have you met with any of those providers
24 under other circumstances?
25 A. Yeah, we regularly meet with providers or, you

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1 know, on any number of topics and we have provider
2 workshops, we have other communications with providers
3 on any number of topics.
4 Q. Thank you. So the providers don't necessarily
5 have to go through the MCO's in order to get to, in
6 order to get to you, and by you I mean the deputy
7 commissioner for policy and operations?
8 A. That's correct.
9 Q. Okay. And did you meet in preparation for today
10 as an organizational representative, did you meet with
11 any medical, medical health providers who specialize in
12 care for transgender people?
13 A. No, I have not.
14 Q. Okay. So you didn't meet, for example, with any
15 endocrinologists?
16 A. No.
17 Q. Or any surgeons?
18 A. No.
19 Q. Okay. And in preparation for your testimony
20 today did you meet with any of the medical directors at
21 BMS charged with making clinical coverage decisions for
22 West Virginia Medicaid?
23 A. Our medical director, Dr. Becker, is part of our
24 leadership team, I have not met with him specifically in
25 preparation for this though.

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1 Q. But is it accurate to say that you do meet with
2 him in those weekly senior, I believe you called them
3 senior team meetings?
4 A. Leadership team.
5 Q. Leadership team, thank you. So Dr. Becker is
6 present for those meetings?
7 A. He is, yes.
8 Q. Okay. All right. Thank you. So if you still
9 have the exhibit we just looked at, PL0008, up on the
10 screen, I'm going to return to that now. So if you
11 would look at Page 2 of that exhibit.
12 A. Okay.
13 Q. And about at the bottom third, the paragraph
14 starting with, "Pursuant to Rule 30(b)(6)," do you see
15 that?
16 A. I do.
17 Q. Okay. So I'll just read briefly that paragraph,
18 "Pursuant to Rule 30(b)(6) deponents provided by
19 defendants West Virginia Department of Health and Human
20 Resources, Bureau for Medical Services shall be
21 knowledgeable officers, directors, managing agents or
22 persons who consent to testify on their behalf
23 concerning the above captioned matter regarding the
24 following." So you've been designated as one of your
25 topics to testify as to topic 1 there. Could you just

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1 read topic 1 for me, please, Ms. Young.
2 A. "Your authority to and/or role in establishing
3 eligibility standards for Medicaid providers,
4 determining benefits and reimbursing providers."
5 Q. Great. Thank you. So with respect to that
6 topic, can you please tell me what you did to prepare to
7 testify today?
8 A. Sure. So to prepare for this I considered the
9 question and what that, what I interpret that to mean,
10 our provider enrollment standards, the contracts we have
11 with the providers and our reimbursement methodology.
12 Q. Great. And is it accurate to say that that
13 question from your perspective falls within your
14 responsibility and role at BMS?
15 A. It does, yes.
16 Q. Okay. Thank you. So talking about the
17 eligibility standards for providers, who determines the
18 eligibility standards for providers to participate in
19 the West Virginia Medicaid program?
20 A. There's a lot of input into those provider
21 enrollment standards. There is national and local
22 requirements as to the scope of practice for individual
23 providers, and then there are some West Virginia
24 specific standards based on state code, you know, there
25 are checks and balances and we have to check for, to

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1 ensure that it's a safe provider, we check against
2 criminal background and exclusions from the Medicaid,
3 from participating in the Medicaid program.
4 Q. Thank you for that. Let me start with your
5 comment about you said there were state and local
6 requirements. Can you just tell me more specifically
7 what you mean by that?
8 A. Sure. So the federal requirements might be that
9 they are, like a physician can provide a certain number
10 of services, certain type of services. And then West
11 Virginia state code may further limit that to say that
12 in West Virginia they can provide X number of services
13 where they have to have a certain type of license or a
14 lot of paperwork related issues.
15 Q. That makes sense. Would it be accurate to say
16 that in some instances West Virginia's requirements are
17 more specific than what might be required from say the
18 federal requirements?
19 A. I think generally speaking that would be
20 correct.
21 Q. Okay. So the standards for providers to
22 participate as it pertains to West Virginia Medicaid, do
23 you know how those standards are developed specific to
24 BMS, not thinking about the West Virginia code you
25 mentioned?

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1 A. Sure. So if I understand what you're asking, I
2 mean, we take all of that into consideration when we are
3 developing the standards for our provider enrollment.
4 There may be other things that we add based on our
5 policies and there are certain services that we might
6 only cover if the provider is physically located in West
7 Virginia, and that would be a more state specific role
8 than a federal role, if that helps.
9 Q. It does. Can you give me an example of
10 something like that where the provider needs to be
11 physically located in West Virginia in order to meet the
12 criteria?
13 A. Yes. We only cover long-term services, skilled
14 nursing or what you call nursing home services by
15 providers that are physically located in West Virginia.
16 Q. Thank you. To your knowledge do providers as
17 part of the standards for eligibility have to agree to
18 any non-discrimination provisions?
19 A. I would have to review the provider agreement
20 that they sign. If it's there, it would be in that
21 agreement.
22 Q. Okay. But just based on your knowledge today,
23 you're not sure if there is a non-discrimination
24 requirement or some kind of language to that effect in
25 those agreements?

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1 A. I couldn't say 100 percent without looking at
2 the document.
3 Q. Okay. No problem. Are providers audited on any
4 kind of routine basis by BMS, either in your department
5 or some other department, for their continued
6 eligibility within West Virginia Medicaid?
7 A. They are. So if they have to have a certain
8 type of license that has an expiration date, that is
9 monitored, if they've undergone a background check that
10 has a, like a look-back period or an expiration date,
11 that's monitored. And that's tracked usually through
12 our claims processing system, our provider enrollment
13 system.
14 Q. Okay. And that, that system falls under your
15 purview, right?
16 A. It does, yes.
17 Q. Okay. Sorry, I'm thinking about it as being
18 under Brandon Lewis, but Brandon Lewis is part of your
19 team?
20 A. Correct, yes.
21 Q. Okay. What happens if in -- I'm sorry, could
22 you, I don't know that you said this, how often do those
23 audits happen? You said on some level it depends on
24 what the specific inquiry is, but are there sort of like
25 just general like yearly audits that happen to BMS?

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1 A. All providers have to revalidate their
2 enrollment. It's not a complete re-enrollment, it may
3 feel like it, but it's a reassessment of all the
4 information that they've provided. There are regular
5 checks that are triggered by other events, including
6 like if a payment is returned then they reassess their
7 EFT information. And there's also checks that are done
8 by a different office in the Bureau, the Office of
9 Program Integrity. I'm not over that office, but they
10 may have a scheduled review of certain provider types.
11 Q. That's helpful. Thank you. And then are there
12 things a provider could do in the course of providing
13 services to West Virginia Medicaid recipients that would
14 make them ineligible?
15 A. Absolutely. There is, you know, we're always
16 looking for fraud, waste and abuse, any complaint from
17 the member or from anyone is investigated. And
18 obviously any type of exclusion from participating in
19 Medicaid, that there may be providers that are licensed
20 in different states and so they've been excluded in
21 another state, and so if we find out about that then we
22 would have to take similar action as well.
23 Q. I see. Okay. Could a documented history of
24 seeking reimbursement from BMS for noncovered services
25 result in the exclusion of a provider?

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1 A. I don't believe so. I can't think of an edit or
2 a trigger that would alert us of continued non-billing.
3 It may trigger some provider education because sometimes
4 it's just, it transposed a number or, and billing is
5 very complicated, but not that I'm aware of, no.
6 Q. Okay. So it sounds like that would be
7 attributed more to error than deliberate, some kind of
8 deliberate and disqualifying action?
9 A. Correct, yes.
10 Q. Okay. So again, just another hypothetical. If
11 a provider is, say there's a surgeon who performs
12 mastectomies for West Virginia Medicaid recipients who
13 are women with a diagnostic code of breast cancer and
14 that same surgeon is also, is performing that same
15 surgery but for a different diagnostic code, for
16 transgender West Virginia Medicaid recipients and billed
17 Medicaid for it repeatedly, it sounds like that would
18 not be grounds to disqualify them as a provider within
19 the system?
20 A. Let me see if I understand you correctly.
21 Q. Sorry, let me back up, that was unusually
22 complicated and compound. So if a provider is billing
23 for the same procedure, right, a mastectomy, but under
24 two different diagnostic codes, one that is included,
25 one that is excluded, would that surgeon's billing for

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1 something that's excluded necessarily mean they couldn't
2 participate in West Virginia Medicaid?
3 A. No, it would not.
4 Q. Okay. Thanks for bearing with me while I
5 reformulated that question. So thinking about benefits
6 and how benefit offerings are determined, how are those
7 benefit offerings determined year-to-year within the
8 West Virginia Medicaid program?
9 A. In the context of this topic, I interpreted that
10 to be provider related. Is that what you're asking
11 about?
12 Q. Tell me the difference between provider related
13 benefits versus benefits available to enrollees?
14 A. Again, in the context of how this was written, I
15 interpreted that to be the, we have a contract, what we
16 call a contract, which is a list of services that are in
17 the scope of practice for that provider type, like a
18 podiatrist would have codes on their contract that would
19 be specific to covered podiatry services. I interpreted
20 that to be determining the benefits for, again, in this
21 context it seemed to be about providers.
22 Q. I see. So you are reading topic 1 as
23 eligibility standards for Medicaid providers and then
24 you're reading the clause determining benefits as
25 benefits provided to providers?

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1 A. I am. It's not a term or terminology that we
2 normally use.
3 Q. Okay.
4 A. Again, and then the last part of it is also
5 pertaining to providers. So I may have misinterpreted
6 that, I apologize.
7 Q. No, nothing to apologize for. What would be the
8 terminology you'd use for the benefits as they are
9 available to enrollees in West Virginia Medicaid?
10 A. Sure. So we do typically use the word benefits
11 or covered services when we talk about the member
12 portion of this.
13 Q. Okay. All right. Give me just a moment here.
14 All right. So let's talk a little bit about
15 reimbursement to providers. What is your role, or I
16 should say what is BMS's role regarding the
17 reimbursement process to providers enrolled with the
18 Medicaid program?
19 A. Sure. So BMS in conjunction with DHHR, Office
20 of Accountability and, I'm sorry, it's OARM, it's a
21 finance division within DHHR, we set the rates for
22 certain, for the codes. We also have methodology in our
23 state plan that dictates whether something is paid at a
24 certain percentage of a Medicare rate, or if it's a rate
25 that we develop ourselves, those rates are established

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1 and they're updated on certain schedules. And then that
2 reimbursement methodology or the limits is then entered
3 into our payment system, the MMIS that I spoke of, and
4 it's maintained in that system for accurate payment.
5 Q. Okay. And are providers always reimbursed for
6 included services under the West Virginia Medicaid plan?
7 A. There's a lot of factors. If it's billed
8 correctly and it's a provider type that's eligible to be
9 paid for that service, generally speaking, you know, if
10 it's in their scope of practice and it's in their
11 contract, yes, they are.
12 Q. Okay. So then you sort of answered this, but
13 are there instances where included services are not
14 reimbursed?
15 A. Correct. Again, if it's billed by a provider
16 that is not authorized to provide that service, if they
17 did not get, if it requires a prior authorization and
18 they did not obtain that, if it's not billed correctly
19 or timely, we also have timely filing requirements.
20 Q. Can you give me an example of the timely filing
21 requirement?
22 A. Sure. The federal requirement that we follow is
23 essentially two years complete. So the provider has a
24 year from the date of service to bill us and then
25 another year in case there's correction, something was

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1 billed wrong or not, you know, done correctly.
2 Q. Okay. Thank you. And then the converse of
3 that, are providers not reimbursed for excluded services
4 even if they submit a reimbursement?
5 A. Correct. Noncovered services are not covered,
6 are not reimbursed.
7 Q. Can you think of instances where an excluded
8 service could be reimbursed?
9 A. Not with Medicaid funds. The managed care
10 organization has latitude with their non-Medicaid funds,
11 they could choose to cover a service, but it's not in
12 the Medicaid benefit or reimbursed with Medicaid funds.
13 Q. I appreciate the degree of your technical
14 knowledge of this. So the MCO's could theoretically
15 maintain some separate pot of money, if you'll allow me
16 that watering down of what you just said, that they
17 could cover non-West Virginia Medicaid covered services?
18 A. They could. And an example might be that for,
19 they'll have what they call like baby showers, basically
20 a public event and they may give gift cards for
21 incentives to achieve health initiatives or meet certain
22 goals, that's outside of the Medicaid reimbursement.
23 Q. I see. And that, that just comes out of like
24 the managed care organization's budget, is that sort of
25 where that money would come from?

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1 A. That's my understanding, yes.
2 Q. Okay. Thank you. And are you aware of, as of
3 right now of any managed care organizations doing that
4 for gender confirming care, so using a bucket not, not
5 West Virginia Medicaid designated funds for the coverage
6 of gender confirming care?
7 A. Not that I'm aware of, no.
8 Q. Okay. Will providers who are contracted and
9 eligible within the requirements we talked about for
10 West Virginia Medicaid receive reimbursement for gender
11 confirming care that they provide to West Virginia
12 Medicaid recipients who are transgender?
13 A. Let me make sure I understand. They will be
14 reimbursed for covered services. If they are billing
15 for a gender confirming procedure that is not covered,
16 they will not be reimbursed for that procedure.
17 Q. Okay. So as a specific example, would a
18 provider who submits for reimbursement be reimbursed for
19 billing for counseling, for example, for gender
20 dysphoria for someone who receives West Virginia
21 Medicaid coverage?
22 A. Yes, they would, that is a covered service.
23 Q. Okay. And what about gender confirming
24 hormones?
25 A. Hormone therapy is a covered service.

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1 Q. Okay. And what about gender confirming surgical
2 procedures?
3 A. That is not a covered service.
4 Q. Okay. So then just backing up a little bit, Ms.
5 Young. So on the provider side of determining benefits,
6 how does BMS or West Virginia Medicaid, I guess I can,
7 sorry, I can just say BMS, how does BMS determine
8 benefits on the provider side year-to-year?
9 A. So big picture speaking, it's based on the
10 covered services for members. And then based on the
11 covered service we drill down to the codes that are
12 specific to those individual services, and then further
13 drill down to the type of practitioner or provider that
14 is eligible to provide that in West Virginia. Or based
15 on, I'm sorry, based on our West Virginia policies, we
16 do have out of state providers, but we do drill down to
17 that specific type of provider. And then there are, so
18 there's different codes that come out each year and
19 they're evaluated to see if it falls within that process
20 that I explained.
21 Q. Okay. And do those determinations reflect
22 consideration of Center for Medicare and Medicaid
23 Services requirements?
24 A. Yes. So the Center for Medicare, Medicaid
25 Services dictates, which are mandatory services, and we

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1 base it big picture on those services, yes.
2 Q. Perfect. Okay. So to your knowledge are there
3 changes from year-to-year based on those criteria you
4 just discussed for the provider side of benefits?
5 A. Yes, there are.
6 Q. Okay. Can you off the top of your head give me
7 an example maybe from a change from last year to this
8 year?
9 A. Sure. If I could go back one year it might be
10 easier.
11 Q. Of course, sure.
12 A. The state legislature mandated that we cover
13 adult dental services. We had always covered emergency
14 extractions, anything to do with an accident or injury
15 to the mouth, but we had not covered cleanings and
16 preventative care. That was put into the state code and
17 effective January 1st of last year. We rolled out a
18 thousand dollar limit on those services for eligible
19 members.
20 Q. Great. And can you think of a change that was
21 not mandated by the state legislature that BMS took on
22 based on its own internal evaluations of some of those
23 various criteria you listed?
24 A. I can't think of a specific instance, but we do
25 have a procedure code team that meets I believe it may

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1 be weekly to go over as new codes are introduced or new,
2 if there's a change in a scope of practice for a
3 practitioner then they would evaluate the codes that are
4 associated with that additional scope of practice if
5 it's within our confines of covered services.
6 Q. Okay. And let me zoom out from the specific and
7 just say, or just rather ask, does BMS make changes
8 without the West Virginia legislature necessarily
9 mandating it to do so?
10 A. Yes, we do.
11 Q. Okay, okay. And those changes that BMS makes
12 independent of the legislature, does CMS have to approve
13 those, so do those changes necessarily, if they include
14 the required, if those changes include what CMS mandates
15 for coverage, does CMS necessarily have to approve those
16 changes?
17 A. Depending on the scope I guess of the change,
18 yes. If we added a service that was not previously
19 covered, if we added it or added limitations to a
20 service that we currently cover, they would have to
21 review and possibly approve the act. There may be a
22 much minor scale change that we've made that doesn't
23 require their approval. I think it depends on the scope
24 and how substantial of a service change it is.
25 Q. Okay. And then on the enrollee side of

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1 benefits, how are benefits determined year-to-year
2 within the Medicaid program?
3 A. Assuming all of covered services for the
4 members?
5 Q. Mm-hmm.
6 A. It depends on changes that are made at the
7 provider level, if that makes sense. So if we've added
8 a new service, then we would add that to the scope of
9 what's in the member covered services as well.
10 Q. I see. So if I were to imagine sort of a
11 flowchart, it would be a change that happened at the
12 provider level that then sort of filtered down to those
13 benefits provided to the enrollees?
14 A. Right. And that might be more how we
15 operationalize it with the dental example. So it was
16 widely known that we would provide the service, once we
17 got it operational on the provider side then we made it
18 available to members to utilize.
19 Q. I see. So it can be, it can be that a change is
20 initiated or sort of BMS starts considering a change by
21 first thinking about the change to the benefits for the
22 members, but the operational, how did you say that, the
23 operationalizing of that happens at the provider level
24 first and then proceeds to the enrollees?
25 A. Yeah, I think that's a good summary.

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1 Q. Okay. I think the dental example is a very good
2 one. Are you aware of other changes that BMS has
3 undertaken in let's say the last five years that have
4 come about, not operationally, but thinking about things
5 that have come to the attention of the organization from
6 the, first from the enrollee vantage point and enrollee
7 benefit vantage point and then was operationalized from
8 that top down?
9 A. Sure. We have what's technically referred to as
10 an 1115 demonstration waiver for substance use disorder,
11 that was in direct response to the opioid epidemic in
12 West Virginia and in adding additional services that
13 were not previously covered in order to address that
14 epidemic.
15 Q. Okay. Thank you for that example. And in terms
16 of, and thinking about that example specifically, I'm
17 not suggesting by my question that you folks internal to
18 BMS were not aware of the opioid epidemic in West
19 Virginia, but more so in terms of the organization, how
20 did that, how did that specific benefit that's available
21 to enrollees come about, was it enrollees were asking or
22 was it their constituent advocates were asking? Does
23 that make sense? How did it come to the awareness of
24 BMS as the organization, not you the individual who were
25 likely aware of that happening?

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1 A. Yeah, it's a big question because I think we
2 were aware on a personal and a professional level as to
3 what was going on and we were approached by a number of
4 state providers, members, different advocacy groups or
5 different interested parties. There was specific
6 funding that was made available around that time as
7 well, so it was getting a lot of attention and obviously
8 we were being asked to do what we could to address it as
9 well.
10 Q. Thank you for that. So for a change like that
11 which, I mean, tell me if this is right, you said that
12 was a larger system change in the benefit structure for
13 both enrollees and providers. Do you recall that CMS
14 had to be consulted about that change?
15 A. Yes.
16 Q. Okay.
17 A. Yeah, specifically this type of authorization.
18 We were aware of at least one other state at the time
19 that had requested for the authority to do something
20 like this. This demonstration waiver is a very lengthy
21 process and CMS was involved from the very beginning of
22 conceptualizing it through public comment and approving
23 the actual application for the waiver.
24 Q. I see. And so thinking about CMS's role
25 specifically as it relates to gender confirming care, to

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1 your knowledge does CMS require that gender confirming
2 care be excluded from any state Medicaid plan?
3 A. Not that I'm aware of.
4 Q. Okay. And are you aware of any other state
5 Medicaid plans that include or provide coverage for
6 gender confirming care? And I should say, I know this
7 is tricky, but you the representative of BMS, not you,
8 Ms. Sarah Young, in your personal capacity.
9 A. And I apologize, I don't, I have not done
10 research on what other states cover and the degree to
11 which they do cover.
12 Q. Okay. And have you seen any discussion of that
13 specific nature come through emails from other members
14 in the leadership team?
15 A. Regarding other states?
16 Q. Other states, yes, yes, mm-hmm.
17 A. Not that I recall.
18 Q. Okay. And then when the Bureau for Medical
19 Services undertook the change to cover hormone therapy,
20 do you know if CMS was consulted in that change?
21 A. My understanding of that is that we had always
22 covered the hormone therapy until a change was made at
23 some point, and I don't know when that was, that change
24 was made that we didn't cover it. So then when the
25 change was made it was basically reverting back to the

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1 original policy to cover hormone therapy. I'm not aware
2 of contacting CMS since it was, since we had previously
3 covered it prior to the change being made.
4 Q. Okay. Sorry, let me just track the timeline
5 here. So your testimony is that hormone therapy for the
6 treatment of gender dysphoria hadn't always been covered
7 by West Virginia Medicaid, or I should say by BMS as the
8 administrator of West Virginia Medicaid, and that there
9 was a change at some point to not cover it, am I
10 understanding your statement there correctly?
11 A. If I can clarify.
12 Q. Sure.
13 A. My understanding is that there were no gender
14 specific edits on hormone therapy, so I don't know that
15 we were aware of the condition or the reason that it was
16 being prescribed, but we had at some point added a
17 gender edit that was then removed.
18 Q. Okay. So hormone therapy was covered without a
19 gender restriction which would allow it to be prescribed
20 for the treatment of gender dysphoria and then at some
21 point, do you know that point at which those edits were
22 added?
23 A. I don't. I know generally when it was removed,
24 but I'm not aware of when it was specifically added.
25 Q. Sure. Sorry, if you don't mind, just tell me

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1 when you know it was, when approximately that date was
2 that the edits were removed?
3 A. I don't know the date. I believe it may have
4 been in around 2017.
5 Q. Okay. A couple more questions about
6 reimbursement for providers. In the course of BMS's
7 what sounds like annual calculation of reimbursement
8 rates, are those generally submitted to CMS for
9 approval?
10 A. Some of them are. I apologize, I don't know the
11 difference in which ones are and which ones aren't, but
12 there are fee schedules that are specifically called out
13 in our state Medicaid plan and there are, you know,
14 obviously the rates that we pay the managed care
15 organizations, those are very closely monitored by CMS.
16 But there are other rate changes that we have to submit,
17 again, if they're in our state plan we have to submit a
18 state plan amendment if we were to make a change to the
19 rate or the methodology by which it's calculated.
20 Q. I see. So generally what you're saying is there
21 are some things which require an amendment be submitted
22 to CMS and essentially their approval, but again, not
23 expecting you would know the full breadth of all of
24 those things, you do know though that some do require
25 CMS approval?

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1 A. That's correct, yes.
2 Q. Okay. And so does that, would you say generally
3 that that kind of approval happens on an annual basis or
4 is it more -- well, sorry, let me stop there. Does that
5 happen on an annual basis?
6 A. It depends on the fee schedule or what the rate
7 is. The managed care organizations, I believe their
8 rates are updated once or twice a year and they're
9 reviewed at that point. There are others that are
10 updated, you know, on an annual basis.
11 Q. Gotcha. Okay. I don't think I asked this, if I
12 did I apologize for asking you to repeat your answer,
13 but how does BMS determine those reimbursement rates,
14 generally?
15 A. Generally speaking it depends on what the rate
16 is.
17 Q. Okay.
18 A. There's a, I'm losing the word, there's a whole
19 huge calculation for the managed care rates and there
20 are others that are based on a percentage of Medicare's
21 rates and there are others that are based on maybe a
22 percentage increase of what the previous rate was if
23 there's not another schedule that it follows.
24 Q. Okay. Are you aware of any proposed rate
25 changes that have been rejected by CMS in your tenure?

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1 A. I can't think offhand of any that have been
2 rejected. I know there are several that have been
3 renegotiated.
4 Q. So CMS maybe said no thank you and you said
5 okay, we'll try again, is that --
6 A. Yes, yes.
7 Q. Okay. Have you observed in your tenure that
8 reimbursement rates fluctuate significantly
9 year-over-year?
10 A. I wouldn't say significantly. There have been
11 rates that were not on a schedule to be updated that,
12 you know, we realize they hadn't been updated on X
13 number of years and the providers reached out to say
14 that this is no longer a sustainable rate and so we
15 would reevaluate it at that point. There are others
16 that are on a fixed schedule and there are some that
17 are, whether they're state specific or they just don't
18 have a schedule to be updated that kind of will lag.
19 Q. I see. Okay. So it sounds like really the
20 great fluctuations would result in a, would be more the
21 exception to the rule rather than the general rule?
22 A. I believe so. You know, with the pandemic there
23 were other rates that we were able to increase in order
24 to alleviate all the concerns, but those are, again,
25 event specific as well.

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1 Q. That makes sense. Thank you. So is it fair to
2 say that generally, which I'm asking a lot of
3 generalizations I realize, but generally BMS will have
4 an idea year-to-year about the reimbursement rates of
5 most of the procedures or billing codes that are within
6 its purview?
7 A. Generally speaking, yes.
8 Q. Okay. And then does the, does the reimbursement
9 rate for a particular procedure change based on the
10 diagnostic code associated with that procedure?
11 A. I don't believe so because the procedure, the
12 procedure code is for the just, you know, very basically
13 it's for the procedure that's being done, regardless of
14 the reason, so the rate would be based on the difficulty
15 or what's involved in that procedure.
16 Q. Okay. Thank you. So the procedure used to
17 treat, the reimbursement rate for a procedure used to
18 treat one, you know, particular diagnosis isn't, to your
19 knowledge isn't different than a procedure used to treat
20 like a different diagnosis, it's the same procedure?
21 A. At the procedure code level, yes.
22 Q. Okay.
23 A. So I don't know what all might be involved in
24 the treatment or there may be various codes that are
25 included, but at that procedure code level it's the same

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1 regardless.
2 Q. Got it. Okay. Thank you. And then sort of
3 zooming out again, if BMS excludes a particular service,
4 are the MCO's required to abide by that exclusion?
5 A. Yes, if they are reimbursing out of their
6 Medicaid money.
7 Q. Okay. Sorry, Ms. Young, give me just a second.
8 How are you doing, Ms. Young, would you like a break now
9 or would you like to continue for about another
10 20 minutes and then we break for lunch?
11 A. I can continue.
12 Q. Okay. Thank you. So if you would look back
13 again at the marked exhibits, the most recent one that
14 we had open there, the second amended notice of
15 deposition. We're still on Page 2. Oh, no, I'm sorry,
16 we're on Page 3, if you would, and I'm looking at topic
17 No. 5. Do you see it up there?
18 A. Yes, it begins with, "Your efforts to
19 administer."
20 Q. It does. Could you just finish reading the rest
21 of that topic for me, please.
22 A. "Your efforts to administer the Medicaid program
23 in West Virginia and/or affirm your compliance with the
24 Medicaid Act and the Patient Protection and Affordable
25 Care Act."

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1 Q. Okay. Thank you. And are you prepared to
2 testify about this topic today?
3 A. Yes, I am.
4 Q. Okay. And with regard specifically to this
5 topic, what did you do to prepare to testify today?
6 A. I reviewed how we administer the program and the
7 various regulations, not specifically, but just
8 considered all the various rules and regulations that
9 were, you know, have to be in compliance with.
10 Q. Okay. Did you, you may have sort of answered
11 this, but did you review any section or clause -- well,
12 sorry, let me zoom out a little bit. Did you review the
13 Medicaid Act or any portion of the Medicaid Act?
14 A. Not specifically in preparation, no.
15 Q. Okay. And did you review the Patient Protection
16 and Affordable Care Act in any part?
17 A. Not in direct preparation, no.
18 Q. Okay. Are you generally familiar with BMS's
19 obligations under the Medicaid Act?
20 A. Generally speaking, yes.
21 Q. Okay. And would you say you're also generally
22 familiar with BMS's obligations under the -- okay. The
23 Patient Protection and Affordable Care Act is commonly
24 called the ACA, if I refer to the ACA would you know
25 what I'm speaking about?

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1 A. Yes. I think we've called it the PPACA, but I
2 believe it's the same thing, yes.
3 Q. That's a new one, I have not heard that one. We
4 use ACA and I know, you know, often the general public
5 it's ObamaCare, but tell me again what you call it?
6 A. The PPACA, just add the P's in there.
7 Q. Okay. I'll go with the ACA for today, if you'll
8 indulge me, but that's a good one, I'm going to remember
9 that. So returning to this topic, is it correct to say
10 that BMS is the entity that administers the Medicaid
11 program in West Virginia?
12 A. Yes, we are the single state authorized to,
13 single state agency authorized to administer the
14 program.
15 Q. And is that authorization, does that originate
16 in the state code of West Virginia, to your knowledge?
17 A. I believe it's in the state code and it's also
18 designated in our state Medicaid plan.
19 Q. Okay. Thank you. How would you describe what
20 BMS does to administer the West Virginia Medicaid
21 program?
22 A. Sure. So we base all of our policies and
23 procedures within the confines of the federal
24 regulation, the state code, state laws, and we ensure
25 that the covered services are available to members and

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1 that reimbursement is available to providers who provide
2 those services to our members. We provide member
3 education, provider education, we have a number of
4 documents on our Website to guide those policies and
5 procedures, and we contract with a number of systems and
6 vendors that help us operationalize those policies.
7 Q. That was a nice succinct job for what I
8 understand to be a very large undertaking. So it's fair
9 to say then that BMS oversees all matters pertaining to
10 Medicaid recipients' access to West Virginia Medicaid
11 services?
12 A. Yes.
13 Q. Okay. Does BMS establish a process for
14 individuals to apply for West Virginia Medicaid
15 eligibility?
16 A. We do in partnership with a sister Bureau who
17 actually does the application processing.
18 Q. Oh, I think you mentioned that earlier. What is
19 the name of that Bureau?
20 A. The original name was Bureau For Children &
21 Families, I believe their current name is Bureau for
22 Family Assistance.
23 Q. Okay. And that is not housed within BMS?
24 A. No, it is under the umbrella of DHHR, it is
25 separate and distinct from BMS.

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1 Q. Okay. So in conjunction with that sister
2 Bureau, BMS reviews applications for West Virginia
3 Medicaid coverage and either grants or denies them, is
4 that accurate?
5 A. In conjunction with the sister Bureau, yes.
6 Q. Okay. And does BMS maintain a list of West
7 Virginia Medicaid recipients to track enrollment numbers
8 in the program?
9 A. The eligibility system provides those reports
10 and we have a number of reports that are available on
11 our Website to track enrollment, yes.
12 Q. Okay. Does BMS disseminate plan benefit and
13 enrollment information to West Virginia Medicaid
14 recipients?
15 A. We have a guide, it's called "Your Guide to
16 Medicaid" that's available on our Website. Again, with
17 there being a fee for service population and a managed
18 care population, that guide is very general for both.
19 And then the managed care organizations are responsible
20 for disseminating information to their members.
21 Q. So who disseminates that information to West
22 Virginia Medicaid recipients who are fee for service
23 rather than MCO, rather than managed care members?
24 A. The Bureau does.
25 Q. Okay.

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1 A. Through that guide to Medicaid, yes.
2 Q. So it has separate information available for the
3 fee for service recipients?
4 A. It does, yes.
5 Q. Okay. And does BMS oversee all matters relating
6 to providers who accept West Virginia Medicaid
7 recipients as patients? Or I should say -- well, let me
8 see what you say to that question and then I can
9 rephrase it if I need to.
10 A. Within our purview. So we would oversee
11 everything regarding our rules and regulations and our
12 conditions for reimbursement, yes.
13 Q. Okay. Right. So you said BMS does cover
14 establishing provider reimbursement rates?
15 A. Yes.
16 Q. Okay. Does BMS oversee all of the fiduciary
17 responsibilities related to the West Virginia Medicaid
18 program?
19 A. Yes. In conjunction with DHHR, like I said
20 earlier, there's a separate finance division under DHHR
21 that assists with that as well. But yes, under that
22 umbrella agency and within BMS we are responsible for
23 that.
24 Q. Okay. How much of the state, how much of the
25 budgetary responsibilities for the administration of

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1 West Virginia Medicaid falls in BMS's bucket of work?
2 A. I can only ballpark it.
3 Q. That's completely fine.
4 A. It would be at least 75 to 80 percent I would
5 assume. I'm not day-to-day in the financial part of
6 that, that's not under my division, but it is the bulk
7 of the work.
8 Q. Okay. So the bulk of the work would fall to BMS
9 for constructing budgets and sort of understanding how
10 the various earmarked monies are distributed, is that
11 fair to say?
12 A. Yes, I believe so.
13 Q. Okay. And is BMS the agency responsible for
14 managing the amount of federal dollars, so that would be
15 monies coming from CMS to the various programs and
16 constituents within West Virginia Medicaid?
17 A. Yes. We are responsible for claiming of the
18 federal dollars that comes into the Bureau, yes.
19 Q. Okay. And does BMS oversee benefits for
20 providers and enrollees that are both included and
21 excluded?
22 A. Let me make sure I understand. So we oversee
23 all covered services and we maintain noncovered, the
24 services that are not covered are not reimbursed. Does
25 that answer?

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1 Q. I think so. But I guess what I mean is, there's
2 no other agency making those determinations or
3 maintaining that information, right, that is BMS's sole
4 purview?
5 A. Yes, correct. And again, unless dictated by
6 another entity to add a service or to recover something,
7 those decisions are at our level.
8 Q. Okay. Perfect. And then we touched on this,
9 but let me just understand or just ask more
10 specifically, BMS also determines which benefits to
11 enrollees are available under the MCO, that is the
12 Mountain Health Trust, and which benefits are available
13 under the fee for service coverage, right?
14 A. Correct, yes.
15 Q. Okay. So let's talk a little bit about BMS's
16 efforts to ensure compliance with the Medicaid Act.
17 What do you generally understand that the Medicaid Act
18 requires of BMS in its administration of West Virginia
19 Medicaid?
20 A. My understanding is the Act requires certain
21 services to be covered, it requires certain individuals,
22 meaning certain circumstances to be eligible for the
23 program, and it may also dictate which type of providers
24 are able to do certain services. Generally speaking, I
25 think that's what it covers.

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1 Q. Okay. Are you aware of any annual compliance
2 obligations for BMS with regard to the Medicaid Act?
3 A. Again, our Medicaid state plan forms our basis
4 for the program. There are, like I said, there are some
5 annual rate changes, I'm not aware of an annual review
6 of that whole plan though.
7 Q. Okay. Are you aware or has anyone communicated
8 to you what might happen if BMS is found to not be in
9 compliance with the Medicaid Act?
10 A. Sure. If there is something that's been brought
11 to our attention usually CMS will either contact us for
12 more information or there will be what they call our
13 state health officer letter that is sent from CMS to the
14 various state Medicaid agencies that will either clarify
15 how something is to be done or will provide a change
16 that needs to be made.
17 Q. So it's fair to say that CMS will give you all a
18 heads-up before any adverse action is taken against the
19 plan?
20 A. Correct, yes.
21 Q. Okay. And can you think of a time that's
22 happened in your tenure where you've gotten a notice
23 from CMS that an adjustment needs to be made?
24 A. Sure. As I said earlier, we have the 1115
25 demonstration waiver, and so we added some medication

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1 assisted treatment coverage of that and it was an
2 optional service and it was authorized through that
3 waiver. Within the last, I believe the last year or so
4 CMS made that a mandatory service. So they sent out a
5 state health officer letter to all the states and each
6 state had to review their state plan coverage of that
7 service and they dictated what information needed to be
8 included, how the service was to be covered, and then we
9 had to submit a state plan amendment to come into
10 compliance with that requirement.
11 Q. All right. And then in your tenure have things
12 ever moved beyond the state health officer letter
13 posture? So I guess what I mean by that is, have you
14 ever gotten, has BMS ever received a state health
15 officer letter that they have ignored or not complied
16 with, in your tenure?
17 A. Not intentionally that I'm aware of.
18 Q. Okay.
19 A. There may be things that we've missed, but
20 again, I'm not aware of that.
21 Q. Sure. Are you aware of the comparability
22 requirement within the Medicaid Act?
23 A. Are you referring to like parity?
24 Q. It's a related provision, yeah. Let me
25 rephrase, sorry, let me rephrase. What do you

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1 understand to be a comparability requirement of the
2 Medicaid Act as it relates to BMS's administration of
3 West Virginia Medicaid?
4 A. I'm afraid I might need a little more context,
5 comparability to?
6 Q. So I'm referring to a provision within the
7 Medicaid Act that's referred to as the comparability
8 requirement, and my question is just do you have an
9 understanding of that requirement, and if so, what is
10 it?
11 A. I apologize, not off the top of my head, I don't
12 recall what that states.
13 Q. Nothing to apologize for. And then how about
14 are you aware of the availability requirement within the
15 Medicaid Act, and if so, what is your awareness or
16 understanding of that requirement?
17 A. Again, without reviewing the document, I'm
18 sorry, I can't speak to that.
19 Q. All right. No problem. To your knowledge has
20 BMS ever been audited for its compliance with either of
21 those provisions?
22 A. Generally speaking, there have been times when
23 we have been asked to confirm that we have a certain
24 type of policy or coverage, I believe that would fall
25 under the, loosely under an audit. I think that, I'm

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1 not aware of an official audit that I've been involved
2 in.
3 Q. Okay. And then moving over to the PPACA, see, I
4 got it, okay, moving over to the Patient Protection and
5 Affordable Care Act, can you just tell me generally what
6 you understand to be BMS's obligations under that act as
7 it relates to the administration of West Virginia
8 Medicaid?
9 A. Sure. So our largest portion of that was the
10 Medicaid expansion, that was a huge undertaking that
11 expanded Medicaid coverage to previously uncovered or
12 noncovered childless adults of certain ages. And with
13 that states had to come up with an alternative benefit
14 plan for that coverage group. Ours very closely
15 resembles our what might be referred to as regular or
16 nonexpansion benefit group. There were a few
17 differences in, you know, service limits on a
18 chiropractic benefit, but the Act dictated coverage of I
19 believe it was eight or nine essential health benefits
20 that had to be in that alternative benefit plan.
21 Q. I don't suppose you recall what those eight or
22 nine essential benefits are? If not, I'm sorry, I know
23 it probably sounds like you're back in school, but any
24 of them that you recall would be fine.
25 A. Yeah, in our state plan it specifically called

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1 out each one of them, that there are what, by name what
2 you'd consider essential health benefits. So coverage
3 to medical services, coverage, I believe, like I said,
4 there's chiropractic services, there's, you know, any
5 number of basic health services.
6 Q. Okay. So thinking about what the Act requires
7 of BMS, are there things that the Bureau does on an
8 annual basis to ensure compliance with its understanding
9 of its obligations under the Act?
10 A. So I wouldn't say that there's a specific
11 activity on an annual basis that is geared towards this,
12 but we have oversight by, you know, CMS and by any
13 number of agencies that are, that have a vested interest
14 in the administration of the plan. So anything that is,
15 obviously you mentioned earlier an audit, anything that
16 is brought to our attention as being out of compliance
17 we would take action to correct.
18 Q. Have you, again, referring to BMS, to your
19 knowledge has BMS received any communications from the
20 Federal Department of Health and Human Services about
21 its administration of West Virginia Medicaid?
22 A. I can't think of anything specifically.
23 Q. Okay. Are you aware of Section 1557 of the
24 Affordable Care Act?
25 A. Without seeing it, I don't know what that

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1 section is.
2 Q. Okay. So then is it, let me ask then, does
3 anything jump out at you in your tenure in your current
4 role as specific actions BMS has taken to comply with
5 Section 1557 of the ACA?
6 A. Without seeing that section, I couldn't respond
7 to that.
8 Q. Okay. All right. Let me pause here briefly.
9 (Discussion held off the record.)
10 (Lunch break taken from 10:59 a.m. to
11 11:35 a.m.)
12 AFTERNOON SESSION
13 BY MR. CHARLES:
14 Q. So when we left off speaking before the lunch
15 break we were talking about topic No. 5 and we had just
16 started discussing what you understand to be BMS's
17 obligations and efforts to comply with the Patient
18 Protection and Affordable Care Act. So I'm going to
19 introduce an exhibit here.
20 (Exhibit 9 marked for identification.)
21 Q. So you should see that populate in the marked
22 exhibit folder. Just let me know when you see that, Ms.
23 Young.
24 A. It's 0009?
25 Q. Yes, I apologize, it's marked PL0009, yes.

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1 Thank you.
2 MR. CHARLES: So, Kelley, I'm showing the
3 witness what has been marked as Plaintiff's
4 Exhibit 0009.
5 Q. Just very quickly, Ms. Young, do you know if
6 you've seen this before?
7 A. Yes, I have.
8 Q. Okay. Do you need to take a minute to review
9 it?
10 A. If you would speak to any specifics I would.
11 Q. Sure. I'll call your attention to a couple of
12 sections, but if you say you recall seeing it, then
13 we'll leave it there and I can just direct you to the
14 sections. So can you just tell me the title of this
15 document, please?
16 A. Sure. Section 1557 of the Affordable Care Act.
17 MR. CHARLES: And so the witness is
18 reviewing Plaintiff's Exhibit 0009, which is a slide
19 deck of, "State operations technical assistance call."
20 Q. And, Ms. Young, can you just read me the date
21 there at the bottom of the first slide.
22 A. July 19, 2016.
23 Q. Great. Was this the point in time where you
24 were still an interim director or were you formally the
25 director or deputy director at this point in time?

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1 A. I believe this was still when I was in an
2 interim position.
3 Q. Okay. But just for the benefit of the record,
4 even as an interim deputy director -- well, sorry, let
5 me back up. As an interim deputy director were your
6 responsibilities virtually the same as they are now in
7 your formal role?
8 A. They are, yes.
9 Q. Okay. Thank you. Okay. So do you recall, Ms.
10 Young, if you were on the state operations technical
11 assistance call?
12 A. I do not recall this one specifically. There
13 were a series of, again, we abbreviated it to SOTA
14 calls, we like to do that, but I don't specifically
15 recall this one.
16 Q. Okay. But is it fair to say that you do attend
17 SOTA calls regularly in your duties?
18 A. I did. They've stopped this particular series,
19 but yes, it's something I would do when available or I
20 would have specific staff attend for me.
21 Q. And what was the purpose or benefit behind
22 having a member of your staff or you yourself attend
23 these briefings?
24 A. So this was one of the ways that the federal
25 government communicates the specific requirements to us

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1 in a better method than maybe the federal regulations
2 have things stated in, you know, generally how to
3 operationalize things or call attention to specific
4 parts of the Act.
5 Q. Okay. So let's turn quickly to, it doesn't have
6 to be quickly, but if you would please scroll down, and
7 the page numbers are located in the lower right-hand
8 corner, so let's just start at Page No. 2.
9 A. Okay.
10 Q. And that first bullet point, can you just read
11 that to me, please.
12 A. Sure. "Section 1557 prohibits discrimination
13 based on race, color, national origin, sex, age or
14 disability in health programs and activities that
15 receive federal funds."
16 Q. Thank you. And now that, I mean, does this
17 description of Section 1557, does this sufficiently
18 recall to your mind what that section of the ACA is
19 about?
20 A. It does. Earlier out of context I didn't
21 recognize it by the name, but the summary does, yes.
22 Q. Okay. So would you then say having, you know,
23 having this material in front of you now, can you recall
24 other times in your tenure as deputy commissioner that
25 you may have come across this Section 1557 referenced in

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1 materials or communications?
2 A. Yeah, I mean, I think in our planning for the
3 ACA provisions I would imagine it would have been
4 involved in or included in a lot of the material.
5 Q. Okay. Thank you. So let's if you would please
6 scroll to Page 4. And that first bullet, I'll read it
7 aloud this time, if you'll just follow along,
8 "Section 1557 was effective upon the enactment of the
9 Affordable Care Act, March 2010, and OCR has been
10 enforcing it since then." Are you familiar with that
11 abbreviation OCR?
12 A. No, I'm not.
13 Q. Okay. To your knowledge has BMS ever had any
14 communications with the Federal Department of Health and
15 Human Services Office of Civil Rights?
16 A. Nothing that comes to mind.
17 Q. Okay. And then if you would please scroll to
18 Page 6. And the title there, "Who must comply with
19 Section 1557," do you see the first bullet that starts,
20 "All health programs"?
21 A. Yes.
22 Q. Okay. I'll read it aloud, if you'll follow
23 along, "All health programs and activities that receive
24 federal financial assistance from HHS." And then
25 skipping down to the third bullet, would you go ahead

1 and read that aloud for me, please.
2 A. Sure. "All health programs and activities
3 administered by HHS, the Centers for Medicare and
4 Medicaid Services, National Institutes of Health,
5 Substance Abuse and Mental Health Services
6 Administration, Health Resources and Services
7 Administration."
8 Q. Okay. Thank you. And then Page 7, please.
9 There's the definition of health program or activity and
10 the first bullet there, if you'll just follow along
11 while I read, "Health program or activity is broadly
12 defined in Section 92.4 in the regulation and includes,"
13 and then I'm looking at the second bullet, it starts
14 with, "State agencies." Can you just read that bullet
15 for me, please.
16 A. "State agencies including Medicaid, CHIP, basic
17 health programs."
18 Q. Okay. And would it be, if you were reading this
19 material would you assume that the use of CHIP in that
20 bullet point refers to the state agency you mentioned
21 earlier that West Virginia has by the same acronym?
22 A. Yes.
23 Q. Okay. And can you just remind me what that
24 stands for again?
25 A. Children's Health Insurance Program.

1 Q. Thank you. Okay. And then let's scroll to Page
2 9. And the title there is, "What state Medicaid, CHIP
3 and basic health agencies must do by when." Do you see
4 the effective date there?
5 A. Yes.
6 Q. Okay. Could you just read that for me, please.
7 A. July 18, 2016.
8 Q. And the first bullet, if you'll just follow
9 along while I read, "Designate an employee to serve as
10 the compliance coordinator." And then the second under
11 the two bullets underneath, "Responsible for
12 coordinating compliance, responsible for investigating
13 complaints." Did I read those correctly?
14 A. Yes.
15 Q. Okay. Thank you. And so as to that designation
16 that HHS was advising should be completed by July 2016,
17 do you recall BMS so designating a compliance
18 coordinator from either the existing employees or hiring
19 a new employee to fill that role?
20 A. I do not recall a specific employee that was
21 designated for this. We had a number of staff working
22 on compliance of all aspects of the Act and DHHR as the
23 umbrella agency has designated personnel that deal with
24 compliance of various regulations that would apply to a
25 lot of different agencies.

1 Q. Okay. So is it accurate then to say that DHHR
2 might have designated someone as the compliance officer
3 for BMS in its administration of West Virginia Medicaid?
4 A. I think to act on behalf of BMS if there were
5 complaints or concerns, yes.
6 Q. Okay. But to your knowledge there wasn't an
7 interior to BMS person designated or hired for that
8 purpose?
9 A. Not that I recall, no.
10 Q. Okay. And then if you would scroll to Page 17,
11 please. Oh, I'm sorry, that would actually be Page 18.
12 A. Okay.
13 Q. And the title there, if you'll just follow
14 along, "Sex discrimination provisions in Section 1557
15 regulation, Section 92.206. Sex discrimination
16 prohibited under Section 1557 includes discrimination
17 based on," and let me pause there. Did I read all of
18 that correctly?
19 A. Yes.
20 Q. And then would you please, Ms. Young, read each
21 of those bullet points for me, please.
22 A. "An individual's sex, pregnancy, childbirth and
23 related medical conditions, gender identity, sex
24 stereotyping."
25 Q. Okay. Thank you. And then the following page,

1 Page 19. Starting with, "Definition on the basis of
2 sex," if you'll just, I'll read this section, if you'll
3 just follow along, please, "Includes, but is not limited
4 to, discrimination on the basis of sex stereotyping and
5 gender identity. Definition of gender identity means an
6 individual's internal sense of gender, which may be
7 male, female, neither, or a combination of male and
8 female and may be different from one's sex assigned at
9 birth." Did I read those sections correctly?
10 A. Yes.
11 Q. Okay. Thank you. And then moving on to
12 Page 20, please. And then if you could go ahead and
13 just read, not including the title on this slide, but if
14 you could just read each of the bullets on this page,
15 please.
16 A. Okay. "Under Section 1557 covered entities
17 including state Medicaid agencies must provide equal
18 access to healthcare and insurance coverage regardless
19 of an individual's sex, including gender identity and
20 sex stereotypes, treat individuals consistent with their
21 gender identity, including with respect to access to
22 facilities, but cannot deny or limit sex specific health
23 services based solely on the fact that the gender
24 recorded for the individual does not align with the sex
25 that usually receives those types of sex specific

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1 services."
2 Q. Okay. Thank you. And in relation to the
3 content of that slide in particular, did BMS do anything
4 to change or update its policies based on that
5 information, as far as you're aware?
6 A. I think that we looked at any gender specific
7 edits that may, that may have not been compliant with
8 this. That's all that I recall.
9 Q. Okay. The gender edits that we were discussing
10 earlier as tied to hormone therapy, those gender edits?
11 A. I think we also had a gender edit on pregnancy
12 services.
13 Q. Okay.
14 A. To overcome any, honestly, a human error in
15 coding, if that makes sense.
16 Q. So in the instance that, for example, there was
17 a West Virginia Medicaid recipient whose gender marker
18 in the system was M, but they were submitting for
19 reimbursement for services related to pregnancy or
20 childbirth, you're saying that BMS undertook to address
21 that conflict?
22 A. Correct, yes.
23 Q. Okay. But as far as you are aware, that was the
24 extent of the changes that BMS made to their policies
25 and included coverages?

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1 A. As far as I recall, yes.
2 Q. Okay. So that's to say there were not any
3 changes made to any of the exclusions that we went over
4 at the beginning of today's deposition?
5 A. Not that I'm aware of, no.
6 Q. Okay. I'm going to introduce another exhibit
7 here.
8 (Exhibit 10 marked for identification.)
9 MR. CHARLES: Hopefully you're seeing that
10 in the marked exhibits folder. Okay. So I'm showing
11 the witness what has been marked as Exhibit PL0010.
12 BY MR. CHARLES:
13 Q. Just off the top, Ms. Young, do you know if
14 you've seen this bulletin?
15 A. No, I don't believe so.
16 Q. I believe it's only three pages. Will you just
17 take a moment, you're welcome to read the whole thing,
18 you're welcome to skim it, but I do want to give you
19 some time to review it since you have not seen it
20 before.
21 A. Okay. I've not read the whole thing, but I've
22 skimmed it.
23 Q. Okay. So what does this, can you just tell me
24 what this document is based on your review, please?
25 A. Sure. It looks like it's a notice from the

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1 Office for Civil Rights from the DHHS, it's dated
2 March 2nd of this year, and it looks like it's a notice
3 and guidance on gender affirming care, civil rights and
4 patient privacy.
5 Q. And you said you haven't seen this. Do you know
6 if anyone on the leadership team within BMS has received
7 this bulletin?
8 A. It's not been mentioned, no.
9 Q. Okay. So then -- well, let me ask one more
10 question. Do you recall a similar notice being received
11 by BMS in the last five years?
12 A. I do not, no.
13 Q. Okay. Would it be, would this typically be
14 something that you in your position though as deputy
15 commissioner would receive? Deputy commissioner for
16 policy and operations, sorry, I'm not trying to truncate
17 your title there.
18 A. That's okay. The content would be. I honestly
19 don't recall a similar document of this format. We
20 typically receive notices by email.
21 Q. Okay.
22 A. CMS, they would have sent it on, you know, on
23 behalf, but I don't recall anything that resembles this
24 same format.
25 Q. Okay. So if you would turn to Page 2 of this

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1 document please and look at the paragraph that starts
2 with, "Section 1557."
3 A. Okay.
4 Q. And then if you could just read the first four
5 sentences of that paragraph.
6 A. "Section 1557 protects the right of individuals
7 to access the health programs and activities of
8 recipients of federal financial assistance without
9 facing discrimination on the basis of sex, which
10 includes discrimination on the basis of gender identity.
11 Categorically refusing to provide treatment to an
12 individual based on their gender identity is prohibited
13 discrimination. Similarly, federally funded covered
14 entities restricting an individual's ability to receive
15 medically necessary care including gender affirming care
16 from their healthcare provider solely on the basis of
17 their sex assigned at birth or gender identity likely
18 violates Section 1557."
19 Q. Great. Thank you. Sorry, I know there was a
20 lot of tongue twisters in there, but I promise I'll read
21 the next paragraph.
22 A. Okay.
23 Q. Okay. So you said this is generally content
24 that in your role as deputy commissioner you would
25 receive in some kind of format from the federal

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1 government?
2 A. Yes. I would have expected it to be in that
3 state health officer format, the letter.
4 Q. Okay.
5 A. Maybe as an attachment, but with some more
6 guiding information for the state agencies.
7 Q. I see. Okay. And is this the kind of
8 information that BMS would consider in its efforts to
9 ensure compliance with PPACA and other federal laws
10 regarding healthcare?
11 A. Yes. We would consult with CMS for guidance on
12 how to ensure that we are in compliance with this, but
13 yes.
14 Q. Okay, great. All right. Give me just a moment
15 here. So, Ms. Young, if you would in the marked exhibit
16 folder please return to that deposition notice again,
17 it's two exhibits previous, so it's 08 is the number.
18 Just let me know when you've toggled to that.
19 A. Okay.
20 Q. So then on Page 3 of that notice you'll see
21 topic 8 about a third from the bottom of the page. Do
22 you see topic 8 there?
23 A. I do, yes.
24 Q. Okay. And go ahead, would you please, and read
25 topic 8.

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1 A. "Healthcare coverage and/or denials through
2 Medicaid for transgender West Virginians generally and
3 Christopher Fain and Shauntae Anderson specifically."
4 Q. Okay. Thank you. So you have been designated
5 to testify about topic 8, which you just read into the
6 record, but only as to medical claims and not
7 pharmaceutical claims, is that your understanding for
8 today's testimony?
9 A. Yes.
10 Q. Okay. And are you prepared to testify about
11 this topic today?
12 A. Yes.
13 Q. Okay. And with respect to this topic
14 specifically, how did you prepare to testify about this
15 topic today?
16 A. I reviewed our policies and when I spoke with
17 Jennifer Myers we spoke to what information was
18 available in the member file in our claims processing
19 system.
20 Q. Great. Did that discussion with Jennifer Myers
21 happen in the same discussion that we talked about
22 earlier today in your preparation generally for your
23 testimony?
24 A. Yes.
25 Q. Okay. Thank you. Because counsel has not

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1 designated you as the witness to talk about
2 pharmaceutical care, my questions won't be oriented to
3 that, so that's why I'm reformulating my question here.
4 So does BMS provide coverage for gender confirming
5 medical care for transgender people who are West
6 Virginia Medicaid participants?
7 A. We do not cover gender confirming surgery. We
8 do cover counseling for any reason.
9 Q. Okay. Do you know if BMS provides coverage for
10 other medical care for transgender West Virginia
11 Medicaid recipients which is not surgery or counseling?
12 A. Are you asking about general services?
13 Q. Yeah.
14 A. Yeah, our system does not designate whether an
15 individual is transgender, so all services that are
16 available to all members are available to all members.
17 There's no designation as a specific benefit or package
18 for transgender versus non-transgender, it's not in our
19 system or policies.
20 Q. I see. Okay. So let me clarify a little bit.
21 To your knowledge do non-transgender members access
22 coverage through West Virginia Medicaid for gender
23 affirming care?
24 MS. BANDY: I'm just going to object to the
25 extent that's, I mean, gender confirming care could

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1 mean any number of, you know, specific care. It might
2 help to be more specific instead of just using that
3 category.
4 MR. CHARLES: Okay. So we discussed at the
5 top of the call that when I'm using gender confirming
6 care today it will be referring to medical treatment
7 that transgender people need for their treatment of
8 gender dysphoria. So when I say gender confirming care,
9 that's what I'm referring to. I understand the
10 objection, but that, I guess what I'm trying to say,
11 Kim, is I'm asking the witness if she knows as a
12 representative of BMS if non-transgender recipients
13 access treatment for the purposes of treating gender
14 dysphoria.
15 MS. BANDY: Okay. And I'll just note the
16 objection and I'll let you go ahead and ask it.
17 MR. CHARLES: Okay.
18 BY MR. CHARLES:
19 Q. So go ahead, Ms. Young, you can answer to the
20 extent you know. Are you aware of non-transgender West
21 Virginia Medicaid recipients who receive gender
22 confirming care, so that would be treatment for gender
23 dysphoria?
24 A. I can first answer from this angle and let me
25 know if that helps.

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1 Q. Sure.
2 A. For the specific diagnosis of, there's a series
3 of codes that are F codes under diagnosis, gender
4 confirming services with that sole diagnosis are not
5 covered.
6 Q. Okay.
7 A. There is a secondary diagnosis, for example,
8 cancer, injury, some other reason that would be a
9 coverage service, then that procedure is available for
10 any number of other diagnosis codes, if that helps.
11 Q. It does. Thank you. Give me just a minute
12 here, I need to mark another exhibit.
13 (Exhibit 11 marked for identification.)
14 Q. Okay. Ms. Young, can you see what has been
15 marked as Exhibit PL0011?
16 A. Yes.
17 Q. Okay, great. Do you know if you've seen this
18 document before?
19 A. Yes, I've seen a document like this, assuming
20 it's the same one.
21 Q. Okay. And I'm sorry, can you just state for the
22 record -- well, I tell you what, I will read the title
23 of this document and you just let me know, I will ask
24 you afterwards to confirm I've read it accurately. This
25 is "Defendants' response to plaintiffs' second set of

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1 interrogatories to Defendants William Crouch, Cynthia
2 Beane and West Virginia Department of Health and Human
3 Resources, Bureau for Medical Services interrogatories."
4 Did I read that correctly?
5 A. Yes.
6 Q. Okay. So if you'll scroll down to what is
7 numbered Page 3, please.
8 A. Okay.
9 Q. I'm looking at No. 11 there. If you'll just
10 follow along, I'll read this one, although I suspect
11 you're going to be better at knowing codes than I am,
12 but I'll give it a shot. "Taking necessary steps to
13 comply with applicable privacy laws for each year since
14 2016 through the present, identify the number of health
15 plan participants who have submitted one or more claims
16 with a diagnosis code for gender dysphoria or gender
17 incongruence. This includes, but is not limited to, the
18 following diagnoses: F64.0, transsexualism (ICD-10-CM);
19 F64.2, gender identity disorder of childhood
20 (ICD-10-CM); F64.8, other gender identity disorders
21 (ICD-10-CM); F64.9, gender identity disorder,
22 unspecified (ICD-10-CM); HA60, gender incongruence of
23 adolescence or adulthood (ICD-11); and HA61, gender
24 incongruence of childhood (ICD-11)." Did I read that
25 mostly correctly?

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1 A. You did, yes.
2 Q. I'm sorry, I need to technically ask you, did I
3 read that completely correctly?
4 A. Yes.
5 Q. Okay. Thank you. So the response begins on
6 Page 3 and says there, "Upon information and belief,"
7 and then continues to Page 4 there at the top. Can you
8 just read to me the years and the corresponding number
9 of members, please.
10 A. 2016, 30 members; 2017, 50 members; 2018, 243
11 members; 2019, 439 members; 2020, 602 members; 2021
12 through 9/30, 686 members."
13 Q. Thank you. So quickly, let me go back to this
14 request here. I just want to make sure we have a shared
15 understanding. So this is, plaintiffs asked defendants
16 to identify the number of health plan participants who
17 have submitted one or more claims with a diagnosis code
18 for gender dysphoria or gender incongruence, do you
19 understand that part of the request?
20 A. I do, yes.
21 Q. Good, thank you. So then let's just look at the
22 number for 2021, please, and that's through September, I
23 understand that to be September 30th of 2021. Is that
24 how you understand that date reference there?
25 A. Yes, I would too, yes.

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1 Q. Okay. So there are listed 686 members who have
2 at least one claim for reimbursement with a gender
3 dysphoria or gender incongruence code. Do you know the
4 breakdown of the number of claims submitted in total by
5 these 686 members?
6 A. I do not.
7 Q. Okay. Do you have any sense of what kinds of
8 gender confirming medical care the claims were for?
9 A. Without any context, it would, it could be
10 anything.
11 Q. Okay. And then do you have, do you have any
12 sense of how many claims each one of these individuals,
13 686 people might have submitted?
14 A. I don't.
15 Q. Okay. Do you have an understanding of how
16 coverage determinations are made for transgender West
17 Virginia Medicaid recipients who are seeking
18 reimbursement for gender affirming care?
19 A. I'm sorry, could you state that again.
20 Q. Sure. So when a person is seeking reimbursement
21 for a medical claim that is for the treatment of gender
22 dysphoria, how would a coverage determination be made
23 for that claim? I guess what I'm asking is, how would
24 it actually be processed? Does that make sense?
25 A. It does, yes.

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1 Q. Okay.
2 A. All claims are submitted either electronically
3 or by paper to our claims processing system and it would
4 usually list a diagnosis code and they list a procedure
5 code. If it's a service that requires a prior
6 authorization that is requested, for fee for service
7 it's requested through our vendor Kepro. Managed care
8 organizations have a different process. And I
9 apologize, I should say I'm speaking from the fee for
10 service aspect.
11 So for a fee for service member, this is the
12 process. The claims are submitted again with the
13 information on the claim and then it is put through a
14 series of processes and checks and, you know, edits to
15 determine if it's a covered service and if it has a
16 prior authorization that's required, if it meets the
17 diagnosis that's related to coverage for those
18 procedures as well. I'm sorry, that's very basic.
19 Q. No, that's fine. Keep going.
20 A. I was just going to say, that's the fee for
21 service process. Managed care organizations have a
22 similar process, but they handle that on their side. So
23 they would receive claims, you know, put it through
24 their own system and it would I assume, you know, hit up
25 against different checks and balances and edits.

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1 Q. Okay. Thank you for that explanation. I know
2 it's very basic for somebody outside, but very helpful
3 for me to understand as sort of not being immersed in
4 this. So as a general question, I forgot to ask, are
5 there more, are there more members, generally West
6 Virginia Medicaid recipients, who use MCO's as opposed
7 to fee for service, do you have a sense of the like
8 relative ratios of those who use MCO's versus fee for
9 service?
10 A. Yes, of our total Medicaid population
11 approximately 80 to 85 percent are in a managed care
12 plan.
13 Q. Okay. And do you have a sense of why a person
14 might choose a fee for service plan versus an MCO?
15 A. Yes. So in our contracts and in our policies we
16 designated certain coverage groups of individuals who
17 are eligible to enroll in a managed care plan and there
18 are certain categories that are carved out of managed
19 care. For example, our home and community based waiver
20 services, those members are not eligible to enroll with
21 a managed care organization because it's not a service
22 that they are covering.
23 Q. I'm sorry, Ms. Young, did you say home and
24 something else?
25 A. Home and community based waivers. You may have

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1 heard of, we have an age and disabled waiver, we have an
2 intellectual developmental disability waiver, traumatic
3 brain injury waiver.
4 Q. And does waiver refer to the ways that people
5 are eligible for Medicaid so, for example, like there
6 are people eligible based on their income and then
7 you're referring to people who would be eligible based
8 on maybe a disability or an injury, am I understanding
9 that right?
10 A. Yeah, at a very basic level the waivers
11 literally allow us to waive certain standard Medicaid
12 requirements, like you said, either incoming assets or
13 by virtue of a medical condition as well, yes.
14 Q. I see. So a person might not meet the income
15 requirement, but they might be eligible for a waiver to
16 access West Virginia Medicaid on another basis
17 essentially?
18 A. Correct, yes.
19 Q. Okay. Thank you. So you mentioned the Kepro
20 processing, claims processing service, is that correct?
21 A. Kepro is our utilization management contractor.
22 Q. Okay.
23 A. They handle the prior authorizations.
24 Q. Okay.
25 A. The vendor for the claims processing is Gainwell

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1 Technologies.
2 Q. Okay. And does BMS have, does BMS have access
3 to Gainwell and Kepro? I guess what I mean is, the way
4 you described the MCO's is that they have their own
5 similar process, but it's separate and run through their
6 systems. Is it accurate then to say that fee for
7 service is under BMS and BMS does sort of provide
8 oversight and management and can access both Gainwell
9 and Kepro as necessary?
10 A. Yes, that's correct.
11 Q. Okay. All right. As far as you're aware, are
12 there other vendors that BMS works with to understand
13 and utilize accurate criteria in evaluating costs for
14 reimbursement?
15 A. I believe that there are other vendors on the
16 pharmacy side.
17 Q. Okay.
18 A. And they may have another person to speak to
19 that. On the medical side we do engage consultants from
20 time to time, we have a project management contract, so
21 they might do research for us and help us with
22 researching various topics. But offhand, I can't think
23 of another contracted entity that helps with the medical
24 evaluation.
25 Q. Sure. Let me just ask you about the one I'm

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1 aware of. Are you familiar with InterQual?
2 A. Yes.
3 Q. And is that, what is InterQual, as you
4 understand it?
5 A. As I understand at a very high level, InterQual
6 criteria is a nationally accredited criteria for
7 determining medical necessity for procedures and that is
8 the criteria that our contractor Kepro uses.
9 Q. Oh, okay. And do you know if the MCO's use
10 InterQual as well for those criteria for assessing
11 medical necessity?
12 A. I don't know which specific criteria they use.
13 I would believe that their contract states that they
14 must use a nationally accredited criteria.
15 Q. Okay. What's the importance of using a
16 nationally accredited criteria for those indicia?
17 A. I think it speaks to the validity and the
18 quality of the product that it is nationally accredited.
19 It's not a homegrown made-up process, it's something
20 that is readily available and has been peer reviewed and
21 all the things that might go into their accreditation.
22 Q. Thank you. Do you know how long, again,
23 estimate, ballpark is fine, do you have a sense of how
24 long Kepro has been using InterQual? And let's focus,
25 I'm sorry, just on your tenure, I don't expect you to

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1 answer beyond that.
2 A. Sure. I'm not aware of them using another
3 criteria.
4 Q. Okay.
5 A. I've only ever heard of the InterQual criteria.
6 Q. Okay. Let me, I'm just going to introduce
7 another exhibit here, if you'll give me just one moment.
8 (Exhibit 12 marked for identification.)
9 Q. So, Ms. Young, there should be an exhibit now in
10 the marked exhibits folder labeled PL0012.
11 A. I can see it.
12 Q. Okay. I'm guessing not, but have you seen this
13 document before?
14 A. No, I don't believe so.
15 Q. Okay. If you would please just take a, it's
16 only, it's basically three pages, if you'll take just a
17 quick minute and just review it to your satisfaction and
18 then I've just got a couple of questions.
19 MS. CYRUS: Are there Bates numbers on
20 that?
21 MR. CHARLES: No. I think it was in the
22 production that came -- it is not Bates stamped, no.
23 MS. CYRUS: Okay. Thank you.
24 A. Okay.
25 Q. Okay. So what is this document?

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1 A. So it appears that Jennifer Myers had reached
2 out to Kepro and asked them criteria for a number of
3 services and they have provided the, it looks like,
4 yeah, at the top it says this is the InterQual criteria,
5 or it's got the trademark.
6 Q. Right. Okay. Have you seen, do you see in the
7 blue text there there's six different SmartSheets
8 listed, do you know what a SmartSheet is?
9 A. I do not.
10 Q. Okay. So then scrolling down here, on the first
11 page there's a sentence that begins, "This criteria
12 subset," do you see that sentence? It's a quarter of
13 the way up from the bottom of the page.
14 A. I do, yes.
15 Q. Okay. So I'm just going to read this aloud, if
16 you'll follow along, "This criteria subset covers
17 primary genital and chest procedures for patients
18 undergoing gender affirmation surgery, or GAS, including
19 single and multistage procedures. The criteria set does
20 not cover revisional procedures for GAS." Did I read
21 that correctly, Ms. Young?
22 A. Yes.
23 Q. Okay. Thank you. On the second page there, the
24 fourth paragraph on Page 2 begins, "Delaying treatment
25 for." Let me know when you found that paragraph.

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1 A. Okay.
2 Q. So I'll read it aloud again, "Delaying treatment
3 for those with gender dysphoria is not a reasonable
4 treatment option. This can lead to negative
5 consequences such as delay or arrest in emotional,
6 social or intellectual development. Isolating one's
7 self from family and friends, being excluded from
8 society, becoming a victim of bullying and self-harm all
9 may be seen when there's an impediment or interruption
10 in care. Some individuals, notably adolescents, may
11 develop psychiatric issues including anxiety, depression
12 and suicidal ideation." And sorry, let me pause here.
13 Did I read that correctly?
14 A. Yes.
15 Q. Okay. And then the subsequent paragraph
16 beginning with, "Guidelines agree." It says,
17 "Guidelines agree that gender affirmation surgical
18 intervention is appropriate for individuals 18 years of
19 age or older as the procedures are irreversible.
20 However, behavioral health counseling and hormone
21 therapy may be used to treat individuals who have been
22 diagnosed with gender dysphoria at an earlier age. The
23 sooner the diagnosis is made and treatment options are
24 discussed, the more successful the individual is when
25 transitioning." Did I read that paragraph correctly as

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1 well?
2 A. Yes.
3 Q. Okay. And then beginning with the paragraph
4 beginning with, "InterQual," and it has a little
5 trademark mark. It says, "InterQual content contains,"
6 do you do see that paragraph?
7 A. Yes.
8 Q. Okay. "InterQual content contains numerous
9 references to gender. Depending on the context, these
10 references may refer to either genotypic or phenotypic
11 gender. At the individual patient level a variety of
12 factors including, but not limited to, gender identity
13 and gender affirmation via surgery or hormonal
14 manipulation may affect the applicability of some
15 InterQual criteria. This is most often the case with
16 genetic testing and procedures that assume the presence
17 of gender specific anatomy. With these considerations
18 in mind, all references to gender and InterQual have
19 been reviewed and modified where appropriate. InterQual
20 users should carefully consider issues related to
21 patient genotype and anatomy, especially for transgender
22 individuals when appropriate." Did I read that
23 paragraph correctly?
24 A. Yes.
25 Q. Okay. And then finally, I'm just going to read

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1 a couple parts of this last paragraph, so bear with me.
2 "InterQual procedures criteria," do you see that there?
3 A. Yes.
4 Q. Okay. "InterQual procedures criteria are
5 derived from the systematic continuous review and
6 critical appraisal of the most current evidence based
7 literature and include input from our independent panel
8 of clinical experts. To generate the most appropriate
9 recommendations, a comprehensive literature review of
10 the clinical evidence was conducted." Did I read those
11 two sentences accurately?
12 A. Yes.
13 Q. Okay. Thank you. I'm going to introduce a
14 couple more exhibits here related to InterQual, if you'd
15 just give me one moment. Okay. So looking at this
16 information from InterQual and in the context of what
17 you shared about what Kepro contracts with InterQual
18 for, did BMS consider the recommendations included in
19 InterQual's medical necessity criteria when determining
20 that coverage for transsexual surgery or for sex
21 transformation were not included in West Virginia
22 Medicaid?
23 A. I can't speak to the practice when the decision
24 was put in policy in 2004, but I can say that since then
25 we would have not, we would have not reviewed the

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1 criteria for noncovered services.
2 Q. Okay.
3 A. So I would imagine InterQual criteria includes
4 every single possible procedure that could be performed
5 and we would only have contracted with Kepro to review
6 the criteria for covered services.
7 Q. Okay. So in terms of the scope of this topic as
8 it refers to denials of coverage, I know we've talked a
9 number of times about what coverage isn't provided under
10 the West Virginia Medicaid plan. Do you know or are you
11 aware of any instances where BMS has ever communicated
12 with a managed care organization regarding denials for
13 surgical procedures for the treatment of gender
14 dysphoria when it's otherwise medically indicated? Let
15 me rephrase, I'm sorry, I made that a little
16 complicated.
17 So are you aware of a time where an MCO or, I
18 mean, obviously a person working for the managed care
19 organization has reached out to BMS to say, you know, we
20 have this person, this procedure is medically indicated
21 for them, we understand this limitation in the coverage,
22 what should we do, are you aware of any instances of
23 that kind of request coming from an MCO?
24 A. Not off the top of my head. I mean, we do
25 receive a number of inquiries, you know, to confirm what

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1 the policy is, I don't recall a specific conversation
2 though.
3 Q. Okay. And excluding hormone therapy, are you
4 aware of BMS providing coverage for gender confirming
5 medical care for Mr. Fain? He's one of the plaintiffs
6 in this case.
7 A. I've seen the claims that have been collected
8 and provided as part of our evidence and that's what I'm
9 aware of.
10 Q. And in what you've seen have there been, have
11 there been payment or reimbursement I guess is what I
12 mean for, you know, some of his claims related to gender
13 confirming medical care?
14 A. Not anything related to surgery.
15 Q. Okay.
16 A. Nothing related to surgery that I'm aware of.
17 Q. Okay. Anything related to counseling that
18 you're aware of?
19 A. I'd have to see the list of claims, but it is a
20 covered service, so if it was requested, then it would
21 be covered.
22 Q. Okay. And then are you aware of any denials of
23 medical claims for reimbursement for Mr. Fain for gender
24 confirming medical care?
25 A. Not for surgery, I'm not aware of any denials.

1 Q. Okay. I'm guessing the answer is the same, it
2 would be helpful to see the list, but in the knowledge
3 you have presently, has BMS provided coverage for Mr.
4 Fain's preventative medical care?
5 A. Again, to the extent that it's a covered
6 service.
7 Q. Okay. That's fine. Thank you. That you are
8 aware of, has BMS provided coverage for any gender
9 confirming medical care for Ms. Anderson, she's the
10 other purported class representative and named plaintiff
11 in this case, we haven't talked about her yet, but are
12 you aware of any coverage for gender affirming medical
13 care for her?
14 A. There hasn't been any surgery covered, if this
15 is an ongoing service. If there are counseling claims
16 for that reason it would have been covered.
17 Q. Would BMS cover a medical visit associated with
18 gender confirming care? So, for example, if a
19 transgender West Virginia Medicaid recipient went to see
20 their endocrinologist for blood work, lab work related
21 to, you know, regular maintenance of hormonal levels,
22 would such a medical visit be included in coverage in
23 West Virginia Medicaid?
24 A. Yes, I believe it would.
25 Q. Okay. And to your knowledge has BMS as the

1 administrator of West Virginia Medicaid denied any
2 medical claims for Ms. Anderson related to gender
3 confirming care?
4 A. Not that I'm aware of.
5 MR. CHARLES: Kelley, can we go off the
6 record.
7 (A break was taken at 12:53 p.m.)
8 BY MR. CHARLES:
9 Q. Ms. Young, if you would, let's return again to
10 marked Exhibit 8. That's again the second amended
11 notice of the 30(b)(6) deposition. And let me know when
12 you're there.
13 A. Okay.
14 Q. And we'll be on Page 3, at the bottom of Page 3,
15 No. 10. Just let me know when you see that.
16 A. Okay.
17 Q. All right. And if you would please just read
18 No. 10, and there's just one sentence of No. 10 that
19 goes onto the next page.
20 A. "Your policies, practices and procedures related
21 to the exclusion including, but not limited to, how the
22 exclusion is developed, approved and maintained."
23 Q. Thank you. And so do you understand that you've
24 been designated to testify as to this topic today?
25 A. Yes.

1 Q. And are you prepared to do so?
2 A. Yes.
3 Q. Okay. And again, with respect to this topic
4 specifically, can you please tell me what you did to
5 prepare for today?
6 A. Sure. So I considered what might all fall into
7 the policies, practices and procedures and reviewed the
8 policies.
9 Q. So in those preparations can you tell me what
10 you, what did you determine to be policies related to
11 the exclusion?
12 A. The policy that we reviewed in Chapter 100
13 simply states the exclusion.
14 Q. Okay. Thank you. And what about practices,
15 what did you, based on your expertise and knowledge what
16 qualifies as practices related to the exclusion?
17 A. Yeah. So in my conversations with Jennifer
18 Myers we identified the diagnosis codes that would be
19 related and some of the procedure codes that could be
20 related to that as far as practices and procedures
21 because that would be the basis for it.
22 Q. And I don't think I've asked you yet, although
23 you've mentioned it, so let's, what are the, what codes
24 specifically did you review with Ms. Myers?
25 A. The diagnosis codes in the F64 series. And I

1 had, when I reviewed the claims that, the claim records
2 that we provided, those diagnosis codes appeared, so I
3 familiarized myself with that.
4 Q. Do you know how many codes are in the F64
5 series?
6 A. Not in total. I reviewed it looks like I have
7 .0, .1, .2, .8 and .9. So obviously I assumed that
8 there would be the missing numbers as they're usually
9 sequential.
10 Q. Sure. Can you just read that list again?
11 A. Sure. So it's F64.0, .1, .2, .8 and .9.
12 Q. And do you have any corresponding terminology
13 that's associated with those codes?
14 A. Yes. So these are, these are national codes. I
15 apologize, I can't think of the source offhand, but I
16 was provided with the definition that goes along with
17 those diagnosis codes.
18 Q. And would you go ahead and tell me what you have
19 for that information, please.
20 A. Sure. For .0 the definition is transsexualism;
21 for .1 dual role transvestism, for .2 gender identity
22 disorder of childhood, .8 other gender identity
23 disorders, .9 gender identity disorder unspecified.
24 Q. Okay. Was that the total of the codes you
25 reviewed with Ms. Myers?

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1 A. It is, yes.
2 Q. Okay. Thank you. Let me back up a little bit.
3 Are there written policies about what BMS does in
4 relation to the exclusion for transsexual surgery?
5 A. Sorry, can you say that again.
6 Q. Sure. So we've talked about what happens when a
7 provider submits a reimbursement claim that has perhaps
8 one of the F64 family of codes or otherwise falls under
9 the exclusion. Does BMS as far as you're aware have
10 like a written policy about what should be done when
11 those claims are submitted?
12 A. In general we have a policy for how to handle
13 noncovered services. I don't believe there is one
14 specific to this topic as all noncovered services would
15 be handled in the same manner.
16 Q. I see. Can you tell me what that noncovered
17 services policy is, please?
18 A. I mean, generally speaking that provider
19 reimbursement is not available, it's spelled out in the
20 various chapters that reimbursement is not available for
21 noncovered services.
22 Q. I see. So it's not like a, there's not some
23 four-page document that outlines here's what BMS does
24 when we receive this, it's more so reimbursement is not
25 available through noncovered services?

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1 A. That's the overarching policy. Each vendor may
2 have their own individual processes for how their system
3 actually processes a claim for noncovered service or a
4 prior authorization request for a noncovered service,
5 but the Bureau doesn't maintain a lengthy document
6 pertaining to that.
7 Q. Since BMS oversees the fee for service coverage,
8 are you aware of any policy for that specifically as it
9 relates to this, as it relates to the exclusion of
10 generally in West Virginia Medicaid of gender confirming
11 care?
12 A. I'm only aware of the policies that we have in
13 the provider manual.
14 Q. Okay. So, sorry, I'm just trying to understand
15 sort of the flow of information. If in the course of
16 providing service -- or sorry, let me back up further
17 than that. In the day-to-day operations, right, a
18 provider provides a service to a member, includes it in
19 the F64 family, sends it away for reimbursement through,
20 let's pick an MCO, Aetna. Is that the kind of thing
21 that you would typically even be made aware of in your
22 role, would BMS even be aware of that? I guess what I'm
23 asking is, what is the point at which a question about
24 what is excluded or included would make its way to you?
25 A. So generally speaking when a policy is developed

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1 there's communications among the managed care, among fee
2 for service processes and managed care organizations as
3 to all the nuances of what that means and how to
4 operationalize it. To the extent that requests for
5 reimbursement of noncovered services, it is submitted,
6 it's not generally, I can't think of an instance that we
7 would discuss it. Does that answer your question?
8 Q. I think so, yeah, yeah. I'm just trying to
9 figure out the, you know, it sounds like the sort of
10 modus operandi is this is excluded, and so in the
11 day-to-day operations those requests are, there's not,
12 if I'm understanding you correctly, there's not a policy
13 or a practice system where those requests are ever
14 funneled up above the claim processing level, is that
15 accurate?
16 A. Not the sourcing the claims. So like I said
17 earlier, we don't have any mechanism to track how many
18 claims for noncovered services we have. But if a
19 provider specifically reaches out to make a request to
20 discuss a noncovered or a covered service, that is
21 escalated up through either our procedure code team or
22 to the medical director.
23 Q. Okay. So it's possible I suppose that, or not I
24 suppose, based on what you're saying it's possible that
25 a provider initiated query could come to the leadership

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1 team level, come to your desk or, you know, your
2 computer screen, as it were, for consideration, does
3 that sound right?
4 A. Correct, yes.
5 Q. So let me see here. I'm going to put another
6 exhibit in the folder for you here in just a moment.
7 (Exhibit 13 marked for identification.)
8 Q. Okay. Let me know when you see in the marked
9 Exhibits folder Plaintiff's 0013.
10 A. I see it.
11 Q. Okay. Have you seen this document before?
12 A. I have.
13 Q. Can you just for the record tell me what this
14 is?
15 A. This is an email conversation from 2016 that was
16 originated from one of our managed care organizations.
17 MR. CHARLES: Just for the record, I'm
18 showing the witness what has been marked as Plaintiff's
19 Exhibit 0013.
20 Q. We talked about some of these individuals
21 already today. Is James B. Becker Dr. Becker who we
22 discussed earlier?
23 A. Correct, yes.
24 Q. And there are two emails listed for Dr. Becker.
25 Do you know what marshall.edu is?

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1 A. Yes. So we have Dr. Becker on contract, he is a
2 Marshall physician and I believe he may be a professor
3 as well.
4 Q. Okay.
5 A. So it's sometimes easier to reach him if you hit
6 both email addresses.
7 Q. Understood. I have colleagues like that as
8 well. Okay. And so we've talked about Cynthia Beane is
9 the commissioner who you report to?
10 A. (Witness nodding).
11 Q. Is that right?
12 A. Correct, yes.
13 Q. Thank you. Sorry, I'm trying to correct myself.
14 Sometimes I'm accepting when you nod as a yes, and I
15 need to make sure, and that's on me, so that's why I'm
16 coming back to get a verbal. Thank you. And who is
17 Jeff A. Wiseman?
18 A. Jeff Wiseman at this point in time was a state
19 employee, I believe his title was something like
20 assistant to the deputy secretary.
21 Q. Okay.
22 A. And he helped us a lot with managed care
23 policies and contracts. He is no longer with the
24 Bureau.
25 Q. Okay.

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1 A. Or I'm sorry, with the Department.
2 Q. Okay. So he was, he was with the Department of
3 Health -- why have I now forgotten that. Sorry, can you
4 remind me?
5 A. Department of Health and Human Resources.
6 Q. Human Resources, okay. So he was not with BMS?
7 A. No, no.
8 Q. Okay.
9 A. He was with the umbrella agency of DHHR and he
10 reported to Deputy Secretary Samples who has several
11 agencies under him, yeah.
12 Q. Okay. So as you said, the email originates
13 there from a Todd White. Do you know who Mr. White is?
14 A. I do.
15 Q. Okay. And what is his role?
16 A. I don't know his title. I know he is the point
17 of contact for Aetna, he is definitely one of the higher
18 ranking individuals at that agency.
19 Q. Okay. So would it generally be the case that
20 Mr. White would be the person reaching out about an
21 inquiry from a covered member?
22 A. Yes.
23 Q. Okay. So if you would, please, Ms. Young, read
24 the email from Mr. White starting with, "Jeff," it's at
25 the bottom of Page 1.

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1 A. Okay. "Jeff, below is the information from a
2 specific member case developing here at CCWV. Does BMS
3 have guidance for the MCO's regarding what services are
4 covered for West Virginia Medicaid members and what the
5 limitation of those services would be?"
6 Q. Okay. And do you know what CCWV is?
7 A. I'm struggling with it. I believe it refers to
8 their managed care program.
9 Q. Okay.
10 A. I don't recall what the, it could be -- I'm
11 sorry, so Aetna used to be, used to go under the name of
12 Coventry Care of West Virginia.
13 Q. Okay.
14 A. And I believe that Coventry is referenced in the
15 paragraph below.
16 Q. Okay. Yeah, actually, I meant to start there.
17 So let me read that paragraph there at the bottom, and
18 just please read along and then I'll ask you if I read
19 it accurately. "One of our members who is a transgender
20 female is receiving medical care for the diagnosis of
21 trans-sex, heterosexual. This member received Medicaid
22 through the ACA expansion. The physician's office has
23 said when the member had straight Medicaid their office
24 visit charges were reimbursed, but when the member
25 received Coventry the charge was denied. The member has

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1 also been denied pharmacy coverage by both Medicaid and
2 Coventry for hormone therapy. The pharmacist stated it
3 was denied or kicked out of the system because it was
4 female hormones and it was kicked out because the member
5 is listed as male. This member has been told that the
6 use of federal money used for Medicaid through ACA
7 prohibits discrimination because of gender identity and
8 was referred to these sites among others." Did I read
9 those sentences accurately?
10 A. Yes.
11 Q. Okay. So getting back to my question, you were
12 saying that you recall that at one time Aetna was called
13 Coventry Care of West Virginia?
14 A. Correct, yes.
15 Q. Okay. So in the email chain, Jeff Wiseman sent
16 that email to you and Cynthia Beane, is that right?
17 A. Yes.
18 Q. His question to you is, "Thoughts?"
19 A. Yes.
20 Q. Okay. And then you replied on Tuesday, March 29
21 at 5:57 p.m., do you see that segment of the thread?
22 A. Yes.
23 Q. And could you just read your reply for me,
24 please.
25 A. "I know that we do have a gender restriction on

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1 hormone therapy, but I don't know the basis for it.
2 I've attached a discussion on this from last year, but I
3 don't recall the outcome. Dr. Becker, can you please
4 fill in the gaps. Thanks."
5 Q. Thank you. Do you recall what the discussion
6 was that you attached to this email?
7 A. I don't.
8 Q. And you said in that email, "I know that we do
9 have a gender restriction on the hormone therapy, but I
10 don't know the basis for it." Did you ever learn the
11 basis for that restriction?
12 A. Not that I recall. As we've said, I've learned
13 recently we had covered it with our restriction, a
14 restriction was placed on it, and then it was lifted
15 again.
16 Q. Okay. And then what prompted you to cc Dr.
17 Becker on the email and ask for him to fill in the gaps?
18 A. In his role as the medical director he would
19 have been involved in, likely involved in discussions
20 around that.
21 Q. Got it. And then you also added at the top of
22 the email, "Member will be 22 in November." Do you
23 recall why you added that information?
24 A. I don't. I will say that there are certain
25 services that are age specific to children up to age 21,

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1 that may have been part of the reason.
2 Q. Understood. Do you recall if Dr. Becker ever
3 responded to your question to fill in the gaps?
4 A. I don't. Sometimes conversations go offline and
5 they're discussed in meetings. I don't recall.
6 Q. Makes sense. Let me switch exhibits here.
7 (Exhibit 14 marked for identification.)
8 Q. Okay. Let me know when you can see in the
9 marked exhibit folder what I've marked as Plaintiff's
10 Exhibit 0014.
11 A. Okay.
12 Q. All right. Do you recognize this document?
13 A. I'm sorry, the text is really small. I'm not
14 sure, is there a --
15 Q. If you bring your cursor down, do you see that
16 toggle?
17 A. Yeah, I see. Thank you.
18 Q. So do you know after reviewing this if you've
19 seen this before?
20 A. It looks like I received it in 2015. I don't
21 recall the discussion or seeing it since then.
22 Q. Fair enough. So can you just tell me based on
23 your review what this series of three documents looks
24 like? And actually, before you do, Ms. Young.
25 MR. CHARLES: Kim, this does have a Bates

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1 stamp, DHHRBMS014232.
2 MS. BANDY: Thank you.
3 Q. Okay. Go ahead, Ms. Young. Sorry.
4 A. I apologize, what was the question?
5 Q. Oh, yeah. It was after your review what does
6 this, what is this document, or documents rather?
7 A. It looks like a conversation that was sent to
8 one of my staff and then sent to myself and the
9 commissioner. At some point it must have been sent to
10 Dr. Becker, I don't see him copied. I see his name at
11 the top.
12 Q. Okay. Do you know who Richard D. Ernest is?
13 A. Yes.
14 Q. And who is he?
15 A. He's a member of my staff.
16 Q. Oh, currently?
17 A. Yes.
18 Q. Okay. And can you tell me his role, please?
19 A. His current role is transportation director. I
20 believe in the past his role was, I'm getting acronyms
21 wrong, but he was over some of our children's policies
22 and he may have worked with this RFTS, which is Right
23 From the Start, which is managed by another Bureau, a
24 sister Bureau.
25 Q. So you said RFTS stands for Right From the

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1 Start, what kind of program is that?
2 A. It's a program that I believe it's managed by
3 the Bureau For Public Health, which is under the DHHR
4 umbrella, but it's not a BMS program, and they serve
5 children with certain conditions up until age three.
6 Q. Okay. And so that, that sort of contextualizes
7 this person's question to Richard acknowledging this had
8 nothing to do with the program that he may have been
9 running at the time?
10 A. Yeah. I think he may have been his contact for
11 any number of other reasons with the Bureau, that may
12 have been why he sent it to him.
13 Q. Gotcha, okay. And just quickly, you said he was
14 the director of transportation, what is the scope of
15 that role?
16 A. We have a service that's nonemergency medical
17 transportation that helps Medicaid eligible individuals
18 get to their appointments and get to their services.
19 He's also over our coverage of ambulance services and
20 anything in that transportation realm.
21 Q. Gotcha. Thank you. Okay. So starting at the
22 bottom there, I'll read the paragraph, if you'll just
23 follow along and ensure I'm reading it accurately, "Hi,
24 Richard. I have something I think you would be the
25 person to help, and this is personal, it has nothing to

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1 do with RFTS. I have a young adult child 20 years old
2 who is transgender, she was born male but came out to me
3 almost two years ago that she is transgender. She has
4 Medicaid through expansion. Her endocrinologist
5 recommended two medications for her in her journey to
6 transition. We had no problem filling her medication
7 Spironolactone which decreases her male hormones,
8 however, the prescription for Premarin, which would give
9 her the female hormones, was denied on the basis that
10 she is listed as male. Her doctor tried to appeal this
11 and says this treatment is medically necessary for her
12 diagnosis of gender dysphoria. I have spoken to people
13 at Molina and they say this is an issue where it is
14 automatically kicked out of the system because of being
15 listed as male." Did I read that correctly?
16 A. Yes.
17 Q. Okay. And what is Molina?
18 A. So our, as I said, our current vendor for claims
19 processing is Gainwell, but we originally, they
20 originally were Molina and then they were purchased by,
21 they've gone through two purchases since then. So that
22 is our claims processing vendor.
23 Q. Got it. Okay. So it was just a name change for
24 Gainwell?
25 A. Correct, yes.

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1 Q. Okay. So then Mr. Ernest responds on
2 February 12th, "Unfortunately this is not a service that
3 we currently cover nor do I know of any cases in which
4 this has been covered in my time here at BMS." Did I
5 read that correctly?
6 A. Yes.
7 Q. And do you know how long Mr. Ernest has been
8 with BMS?
9 A. I don't. I don't think it's been a very long
10 tenure though at this point in 2015.
11 Q. Okay. And then a follow-up email in response to
12 Dr. Ernest's reply, "My pharmacist did a run-through for
13 the same medication for a female and it was covered.
14 CareLink also covers it for males, for females, but the
15 people that came into Medicaid as a part of the
16 expansion are still being held as straight Medicaid. I
17 hear they will be rolled into the MCO's around June, but
18 we don't want to wait this long as this is greatly
19 affecting her quality of life." Did I read that
20 correctly?
21 A. Yes.
22 Q. Okay. So a couple of questions. We talked
23 about this earlier, the distinction between Medicaid
24 expansion and not Medicaid expansion, I can't remember
25 if there was a term you used for that?

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1 A. There's not a good term.
2 Q. Okay. This person is calling it straight
3 Medicaid, which I guess is the old Medicaid, versus
4 Medicaid expansion. So is it an accurate description of
5 your testimony from earlier that Medicaid expansion is
6 different than not expansion Medicaid?
7 A. It is. There's different eligibility
8 requirements for expansion Medicaid and there is a
9 different benefit package for expansion Medicaid, yes.
10 Q. Okay. And what is CareLink?
11 A. So I think it was, in the context of this
12 sentence it's a little confusing, but I believe that
13 they're referring to the MCO. And that may be, I don't
14 know which one, CareLink may have been the name of their
15 processing system.
16 Q. Okay.
17 A. So if it was, say if it was Aetna, Coventry
18 Cares, it could be that CareLink is their processing
19 system. I don't recall off the top of my head, but from
20 the context of that sentence it looks like it is
21 referring to managed care versus we'll say regular fee
22 for service Medicaid.
23 Q. You said this earlier, so Medicaid expansion was
24 an expansion of the program to include previously
25 uncovered childless adults, is that an accurate

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1 description of what you said?
2 A. Yes.
3 Q. Okay. Were those recipients ever rolled into
4 managed care organizations?
5 A. Yes. So initially when we expanded Medicaid,
6 they were part of the fee for service population, but
7 once we had some claim history and were able to develop
8 rates, they were then rolled into managed care.
9 Q. So it looks like on Page 1 of this email chain,
10 it looks like on February 24th Mr. Ernest forwarded this
11 to you and Cynthia Beane. And then up above on
12 March 3rd Dr. Becker says to you, "I'll be happy to
13 review the files. I'm planning to be in the office on
14 Thursday and Friday afternoon this week." Did I read
15 that correctly?
16 A. Yes.
17 Q. Okay. Do you remember what conclusion Dr.
18 Becker came to about this request on behalf of a
19 transgender Medicaid recipient?
20 A. No, I don't.
21 Q. Okay. Do you remember any subsequent
22 conversations in email about this situation?
23 A. No, I don't.
24 Q. Or any conversations outside of email about it?
25 A. Not about this specific email.

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1 Q. Okay. Let's go back to the other half of this
2 topic. So the other part of this topic says, let me
3 just read the topic again to you, "Your policies,
4 practices and procedures related to the exclusion
5 including, but not limited to, how the exclusion is
6 developed, approved and maintained." I asked you
7 earlier what, if anything, you had done to prepare for
8 this topic. Did you do anything specifically to prepare
9 to testify about how the exclusion is developed,
10 approved or maintained?
11 A. Like I said, I looked at the policy based on the
12 date of the policy, I wasn't privy to or able to find
13 anything regarding why it was created, I wasn't able to
14 find anything about when that was added or what the
15 basis of it was.
16 Q. Okay. Do you know how the exclusion itself was
17 developed within the Medicaid manual that we looked at
18 at the beginning of the day?
19 A. Not other than how the manuals are maintained
20 probably the way that they are. I wasn't able to find
21 any notes or drafts or recorded discussions regarding
22 adding, you know, when that language was added and I
23 couldn't find any earlier versions of the policy.
24 Q. Okay. So the only policy that you're aware of
25 is as it exists in the Medicaid manual that we reviewed?

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1 A. Yes.
2 Q. Okay. And I remember we looked at the 2012
3 archived version, but you said there is an updated
4 version on the Website that is from 2013 you said?
5 A. I believe the Chapter 519 has a more recent
6 revision that's included in the list of chapters in the
7 current policy manual.
8 Q. Okay.
9 A. The Chapter 100 that we reviewed is the exact
10 same version that's available today.
11 Q. You mean on the Website?
12 A. Yes.
13 Q. You said the archive was from 5/19, okay. So
14 you said that's the earliest iteration you can find of
15 that language in West Virginia Medicaid BMS promulgated
16 documentation?
17 A. Yes, I did. As to what I have access to, we
18 have a paper copy of all the manuals up to a certain
19 date, and so I pulled the book for that Chapter 100 and
20 all that's in that book is that exact copy that's
21 online.
22 Q. Okay.
23 A. For whatever reason any earlier versions were
24 not kept in that book, if there was an earlier version.
25 Q. Okay. But you said to your knowledge the

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1 exclusion did exist before that version, you just
2 weren't able to find the documentation that showed that?
3 A. If there was an earlier version, I can't tell
4 from the information that's listed in the change log for
5 100 that says what was specifically added in that
6 change.
7 Q. Okay.
8 A. It could have been a previous version. There's
9 nothing that indicates the level of specificity as to
10 what was added in those changes.
11 Q. I see. Okay. Thank you. So generally
12 speaking, do you know when the exclusion was originally
13 developed?
14 A. I do not. That policy is the earliest version
15 that I can find where it appears.
16 Q. Okay. And since the Chapter 519 and
17 Chapter 100, does BMS do anything actively to maintain
18 the exclusion or is it just that year-to-year it doesn't
19 change and so that's all that's done as maintenance?
20 A. Yeah, I think year-to-year it doesn't change.
21 Until now it has not been challenged legally, so it has
22 been maintained.
23 Q. Okay. And so were you able to find any
24 information about how it was developed, if it was
25 developed with anyone outside of BMS?

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1 A. No, I couldn't find anything.
2 Q. Okay. With regard to those manuals in
3 particular, does BMS have to do anything year-over-year
4 to reauthorize them, do you know what I mean, like is it
5 required that sort of Cynthia Beane or somebody
6 similarly situated sort of rubber stamps those manuals
7 each year?
8 A. So I'll say ideally each manual would be
9 reviewed by the specific program manager for that area
10 to see if anything has changed. I'll admit that, you
11 know, there's a lot going on all the time, so that
12 doesn't always happen. But any time that something, we
13 are aware that something has changed we will go to see
14 what we have written about that policy or procedure and
15 review it to see if it needs to be changed.
16 We have, as I mentioned, those waivers, they're
17 reauthorized on a regular basis. And so there's changes
18 to the programs that have to be, that are authorized
19 that have to be rewritten into those policies. Our goal
20 is to review them on a regular basis, but unfortunately
21 it doesn't always happen.
22 Q. Okay. So is it safe to say that unless there's
23 a, unless there's an affirmative change, members or
24 other parties reviewing those materials should just
25 assume they are updated because -- well, sorry, let me

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1 end my question there. Like if something needs to be
2 revised it will be, but absent that happening, that is
3 the most accurate documentation?
4 A. Yes. The effective date is the date that we
5 made the policies on that page effective, to the extent
6 that we do have the disclaimer that it's not all
7 encompassing of everything.
8 Q. Okay. Let me introduce another document here.
9 Let's actually return to Exhibit 8, the deposition
10 notice again.
11 A. Okay.
12 Q. So then looking at the notice on Page 4 at topic
13 13. Just let me know when you're there.
14 A. Okay.
15 Q. And then if you would go ahead please and just
16 read topic 13.
17 A. "Any research, consideration and/or analysis by
18 or on behalf of you regarding the legality of the
19 exclusion."
20 Q. Great. Thank you. And you've been designated
21 to testify about this topic. Are you prepared to do so?
22 A. Yes.
23 Q. And once again, can you tell me what, if
24 anything, you specifically did to testify about this
25 topic?

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1 A. Again, I considered everything that we have
2 written on the topic and I was aware that other
3 individuals on the leadership team were aware of this
4 and, you know, in the absence of anyone saying that this
5 is illegal or against regulations, I believe it to be
6 legal.
7 Q. Okay. So were you able to find any research
8 that was done by BMS about the legality of the exclusion
9 of gender confirming care in West Virginia Medicaid?
10 A. No, nothing specific to this.
11 Q. So are you aware of any research that was
12 undertaken to support the particular coverage decision?
13 A. No, it was honestly more the absence of any
14 guidance or notification from CMS that I found to speak
15 to the legality of it.
16 Q. Okay. Let me back up just a little bit. From
17 the previous topic that we were discussing, you were not
18 able to find, don't know of any reasons why the
19 exclusion was developed?
20 A. Correct.
21 Q. Okay. And you also were not able to find and
22 are not aware of any, what was considered I guess in
23 making the decision to include that exclusion in the
24 Medicaid manuals we were discussing?
25 A. Correct.

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1 Q. So then are you aware of anyone in the legal and
2 regulatory department who has done any research about
3 the legality of the exclusion?
4 A. I'm not aware that, I haven't seen any documents
5 produced about it. I would assume that our legal
6 department has reviewed it and would let us know if we
7 are, their findings and if it is contradictory to what
8 we have.
9 Q. Okay. So you would assume they would, but your
10 testimony today isn't that you've seen anything saying
11 that they have done that?
12 A. I have not seen anything.
13 Q. Okay. No research by Mr. Riley -- well, no
14 research by Riley Romeo?
15 MS. BANDY: I'll just object to the extent
16 that some of the questions are asking about
17 communications with attorneys for the Bureau, which
18 would invade the attorney-client privilege.
19 MR. CHARLES: Okay. Thanks, Kim. Let me
20 back up.
21 Q. Has research been done by anyone on behalf of
22 BMS about the legality of the exclusion? So that might
23 include a contractor or a vendor specifically retained
24 to do research about this question.
25 A. Not that I'm aware of.

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1 Q. Okay. And what consideration have you or your
2 team done specifically about the legality of the
3 exclusion of gender affirming care from West Virginia
4 Medicaid?
5 A. Can you repeat the first part of that.
6 Q. Sure. So what, if any, consideration have you
7 or your team done about the legality of the exclusion?
8 A. So any time any policy is questioned, we review
9 the policy as its written. We've looked for any
10 guidance that we may have overlooked that would speak to
11 how it's written or how it's being operationalized. So
12 we would consider all the available information that we
13 have to make sure that what we have put forth in the
14 policy is correct to our understanding.
15 Q. Okay. So in the course of doing that kind of
16 work you didn't review Section 1557 of the Affordable
17 Care Act?
18 A. No, I did not.
19 Q. Okay. Let me introduce another exhibit here.
20 (Exhibit 15 marked for identification.)
21 Q. Let me know, Ms. Young, when you can see in the
22 marked exhibit folder the document labeled PL0015.
23 A. All right.
24 Q. Okay. And have you seen this document before?
25 A. Yes, I believe so.

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1 Q. Okay. And what is this document?
2 A. I believe this is the email that was sent with
3 the PowerPoint that you displayed earlier.
4 Q. And can you just read me the subject line of
5 this document, please.
6 A. "Subject: Emailing Section 1557 PowerPoint for
7 7/19/16 SOTA call.pdf."
8 Q. Okay. Thank you. And who is this email from?
9 A. It's from Robert DeBoard.
10 Q. And who is that?
11 A. He was part of our eligibility policy unit. He
12 no longer works for the Bureau.
13 Q. Okay. And the eligibility policy unit is under
14 your purview or the one that is the sister Bureau?
15 A. The one that's under my purview.
16 Q. Okay. I don't think I asked, did you attend
17 this call?
18 A. You did ask. I don't remember if I did.
19 Q. Okay. Thank you. Can you please just read me
20 the text in the email from Mr. DeBoard?
21 A. Sure. "We have to display and add tag lines in
22 two to 15 of WV's top languages. I'm not sure if anyone
23 was able to listen to this call."
24 Q. Thank you. And just to be clear, what does WV
25 stand for, based on your understanding there?

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1 A. West Virginia.
2 Q. Thank you. And so did Robert DeBoard ever
3 convey any other changes that he thought needed to be
4 made to West Virginia Medicaid based on this call?
5 A. Not that I'm aware of. The context of this
6 email is those tag lines are the statement in other
7 languages that we would have to add to all of our
8 notices and the concern was adding that tag line in 15
9 languages, it's an added cost and it adds pages to the
10 notifications that we sent out, so we were trying to
11 figure out what was actually required.
12 Q. Great. And so this was, to your knowledge this
13 was the only instruction that came from Mr. DeBoard
14 about the change that needed to be made based on the
15 call from his view?
16 A. As far as I can tell from this email.
17 Q. Okay. And do you recall if any other
18 instructions to make adjustments to West Virginia
19 Medicaid policy came as a result of this call?
20 A. Not that I recall.
21 Q. Okay.
22 (Exhibit 16 marked for identification.)
23 Q. All right. I just dropped another exhibit in
24 the marked exhibit folder. Just let me know when you
25 see it, it's marked PL0016.

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1 A. Okay.
2 Q. Do you know what this document is?
3 A. It looks like an email in response to a meeting
4 invite.
5 Q. Okay.
6 MR. CHARLES: And just for the record, I'm
7 showing the witness what has been marked Exhibit PL0016.
8 Q. Who is this email from?
9 A. It looks like it's from Jennifer Myers. I'm
10 sorry, no, it looks like it's from me to Jennifer and
11 copy to Kim O'Brien. Sorry, I got the lines mixed up.
12 Q. No, I almost, I did the same thing. So can you
13 just read me the text of your email then to Ms. Myers
14 there.
15 A. Yeah. I said, "I won't be able to attend this
16 meeting due to another standing meeting. Let me know
17 the outcome and if you need anything. Thanks."
18 Q. And did Ms. Myers ever let you know the outcome
19 of that meeting?
20 A. I don't recall. She would have probably
21 responded more to if she needed anything escalated to
22 me.
23 Q. Okay. And who is Kim O'Brien?
24 A. She's the assistant to the commissioner.
25 Q. Okay. And is that the position you once held?

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1 A. Yes.
2 Q. Okay. Do you recall what your other standing
3 meeting was that day? I know, so many meetings on
4 Monday, it's hard to keep them all.
5 A. And this was about a year and a half ago at
6 least, or two years. I don't recall.
7 Q. Okay.
8 A. No, I don't, I'm sorry.
9 Q. And do you recall getting any notes from this
10 meeting?
11 A. I don't.
12 Q. Okay. There is some other invitees on the call
13 invite, I just want to run through who those folks are
14 if we could for a minute here, who we haven't talked
15 about already. Can you tell me who Nancy Sullivan is?
16 A. Yeah, Nancy Sullivan at this point is the, I
17 don't know of her exact title, but she is with our Kepro
18 vendor who used to be an employee of DHHR, but I believe
19 at least in 2020 she was definitely with Kepro.
20 Q. Okay. And then Carrie Mallory?
21 A. Yes, Carrie Mallory is in Jennifer Myers' unit,
22 she's an employee under my division.
23 Q. And Brian Thompson?
24 A. Brian Thompson is currently our pharmacy
25 director.

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1 Q. Oh, that's right. Okay.
2 A. BMS employee.
3 Q. And then who are the two people cc'd, it looks
4 like, let's do one at a time, Selena Johe?
5 A. I believe she's an employee of Kepro.
6 Q. Okay. And Karen Wilkinson?
7 A. She is a Kepro employee as well.
8 Q. Okay. And just, I don't think I asked this, can
9 you read me the subject line of this meeting invite.
10 A. "Gender dysphoria."
11 Q. Thank you. Okay. I think we've been going for
12 about an hour, would you like to take a break?
13 A. If you'd like, and if we have much longer to go.
14 Q. Let's see. I've got a little bit more to get
15 through. Why don't we break here in the hopes that we
16 can wrap things up in the next hour or hour and a half.
17 A. Okay, sounds good.
18 (A break was taken at 2:07 p.m.)
19 (Exhibit 17 marked for identification.)
20 BY MR. CHARLES:
21 Q. So, Ms. Young, I'm going to introduce another
22 exhibit. Just let me know when you can see it there in
23 the shared folder, it's been marked Plaintiff's
24 Exhibit 0017.
25 A. Okay.

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1 Q. Do you see it there?
2 A. Yes.
3 Q. Okay, great. Do you recognize this email chain?
4 A. It looks like I interacted with it, but
5 honestly, I don't remember.
6 Q. Sure. Why don't you just take a, I just want to
7 give you a minute to look through the thread just to
8 familiarize yourself with it, so please go ahead and do
9 that, and then I've just got a few questions about it.
10 A. Okay.
11 Q. So what does it look like to you that this email
12 thread is discussing?
13 A. So it looks like, let's see. The original was
14 from a provider to the Bureau discussing psychological
15 testing for gender dysphoria, and it appears to have
16 been a managed care member, so then it was sent to the
17 managed care organization.
18 A. Okay.
19 Q. Let me back up a little bit here. Let's start
20 with on Page 3 at the top there, I'll start reading.
21 The text says, "I just received three denials for
22 psychological testing services for folks with gender
23 dysphoria who are seeking hormonal treatments from a
24 physician, two from Aetna of West Virginia (Medicaid)
25 and one from Blue Cross/Blue Shield (commercial). I've

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1 been doing these evaluations for several years and have
2 never had any difficulty getting these authorizations.
3 Any information would be appreciated. Thank you." And
4 there's a postscript, I'm just going to skip that. It's
5 from Emily Engelland Wilson, MA, owner and licensed
6 psychologist. Did I read all that text correctly?
7 A. Yes.
8 Q. And it looks like this, do you see in the to
9 line this email was sent to Cynthia Parsons, Sheila
10 Robinett, Raymond Surber, Keith Beard, Christina
11 Lawrence. Other than Cynthia Parsons, do you recognize
12 any of those names?
13 A. I do not. By the email address it looks like
14 Raymond Surber must be with Kepro, but I do not
15 recognize any of the others.
16 Q. So can you just remind me who Cynthia Parsons
17 is?
18 A. She's the director of Behavioral Health and
19 Long-Term Care Services.
20 Q. And in her role as director of Behavioral Health
21 and Long-Term Care Services, what is a brief summation
22 of that work?
23 A. Sure. So she oversees the policy managers that
24 are responsible for anything behavioral health or mental
25 health related, obviously long-term care services as

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1 well.
2 Q. All right. So looking at the next email in that
3 chain, you see it's from Susan Hall. It's possible I've
4 already asked you, but can you tell me again, please,
5 who is Susan Hall?
6 A. You've not. Susan Hall is our director of
7 managed care, she reports to Fred Lewis.
8 Q. Okay. And as the director of managed care, is
9 the title what it suggests, does she coordinate with the
10 managed care and provide oversight of managed care
11 organizations?
12 A. Yes, she does.
13 Q. Okay. And so she, being Ms. Hall, sent this
14 email, sent an email to it looks like Alva Page, III,
15 Sarah White and Todd White and cc'd Jeff Wiseman, do you
16 see all those names?
17 A. Yes.
18 Q. Okay. Other than Todd White and Jeff Wiseman,
19 do you know those other two individuals?
20 A. Yes. I'm vaguely familiar with Sarah White, but
21 I do know Alva Page.
22 Q. And who are, just generally, who are both of
23 those people?
24 A. I believe they're both with Aetna as well.
25 Q. Okay. And so Susan Hall's email request is,

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1 "Hello. Can you look into your policy for psychological
2 testing for gender dysphoria. See below. Thanks,
3 Susan." Did I read that correctly?
4 A. Yes.
5 Q. Okay. And so then scrolling up we've got a
6 response from Todd White on April the 26th, 2019, do you
7 see that?
8 A. Yes.
9 Q. Okay. And so I'll just read it and if you'll
10 please follow along. Todd White writes, "Hi, Susan.
11 See the response from our CMO Dr. Gibbon below. It
12 appears there may have been some gaps in the information
13 submitted for the authorization." And then in red text,
14 in red lettering, "According to our behavioral health
15 medical director, the provider never identified why they
16 needed to do psychological testing. Hormonal therapy
17 was not mentioned. Milliman clinical criteria was used
18 to evaluate, psychological testing org: B-807-T." Did I
19 read all that correctly?
20 A. Yes.
21 Q. Okay. Do you know why it would matter whether
22 or not hormonal therapy was mentioned when the provider
23 submitted for reimbursement?
24 A. From the context of this email, it looks like
25 the reason for the denial was the additional, there was

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1 gaps in the information submitted. I think they're
2 saying that they didn't indicate, it wasn't denied due
3 to hormonal therapy, that that wasn't mentioned in the
4 request. I believe that they're trying to illustrate
5 that it wasn't denied for that reason because that
6 reason wasn't provided.
7 Q. I see. So let's skip down to the end of Todd's
8 email there at the bottom of the page beginning with,
9 "According to." Just let me know when you're there.
10 A. Okay.
11 Q. "According to the language in the current
12 contract, transgender services are not covered, however,
13 since these services fall into the 'gray area' before
14 the actual transition services occur, what would be the
15 state's position on these being covered in the early
16 testing stages, but then not allowing the actual
17 transition services? If we could get an example of the
18 denial, we could also check to see if there are
19 diagnosis conflicts with the denied service. Todd."
20 Did I read that correctly?
21 A. Yes.
22 Q. Okay. And is it your understanding that Todd
23 White is stating that under the current Aetna contract
24 transgender services are not covered?
25 A. From the context of the email, that's what it

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1 says.
2 Q. And so he's asking in that last, second to last
3 sentence, "What would be the state's position on these
4 being covered in the early testing stages, but then not
5 allowing the actual transition services," so he's asking
6 that to it looks like Susan Hall, Alva Page, Sarah White
7 and Jeff Wiseman?
8 A. Yeah. Without seeing the MCO contract, I don't
9 know the exact language. It's clear in the fee for
10 service policy, which is the basis for coverage, that it
11 is not transgender services in general, that it's
12 specific to surgery. So I believe this to be a
13 misunderstanding and I believe that this person's
14 response at the top clarifies their misunderstanding as
15 to what is included in services.
16 Q. Okay. And then Susan forwarded this to you it
17 looks like on April, that same day, April 26th, like
18 four minutes later asking, "Can you give me your opinion
19 on this matter. Scroll down. LOL." Do you see that
20 there?
21 A. I do, yes.
22 Q. Did I read that correctly?
23 A. Yes.
24 Q. And then you forwarded it along to Cynthia
25 Parsons and Dr. Becker and asked for their thoughts by

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1 saying, "Thoughts?" Did I read that correctly?
2 A. Yes.
3 Q. Okay. And then as you were mentioning above,
4 Cynthia Parsons writes, "We have never denied for the
5 psychological testing part, especially since the DSM-5
6 recognizes gender dysphoria. So I think they should
7 allow for testing and evaluation to ensure proper
8 diagnosis. Just because a diagnosis is given doesn't
9 mean they need to pay for surgical intervention,
10 transition services or other medical services related to
11 it. Hope that helps." Did I read that correctly too?
12 A. Yes.
13 Q. And so that's what you were referring to in your
14 remarks just a few minutes ago that Cynthia Parsons is
15 clarifying that psychological services or counseling has
16 never been denied, or as she says, we have never denied
17 it?
18 A. Correct, yes.
19 Q. Okay. And so is this, is this an example of
20 when the exclusion of coverage for gender confirming
21 care would make its way to your, sort of your level of
22 the organization as we were discussing earlier?
23 A. Yeah, I mean, this isn't related to surgery,
24 this is related to a covered service, but this is a good
25 example.

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1 Q. Okay. And do you recall generally whether Susan
2 Hall has forwarded other messages like this to you for
3 review or input?
4 A. Related to this topic or in general?
5 Q. Yes, thank you. Related to this topic?
6 A. Again, I don't recall. I get thousands of
7 emails a day and on any number of topics that we cover,
8 but this does follow our process. So Susan Hall as we
9 said has oversight of managed care, I have oversight of
10 the policy, so rather than duplicate staff, we work
11 together on the issues.
12 Q. Okay. So it would be sort of common to your
13 process for this to be the way that it would come to
14 you?
15 A. Yes.
16 Q. Okay.
17 A. And I'll add too that a lot of times it's easier
18 to email me than to figure out who has the specific
19 policy, so a lot of them come to me like this and then I
20 send them to the experts and have them respond, it just
21 saves time.
22 Q. I see. So you're sort of the helpful
23 clearinghouse essentially where people know Ms. Young
24 will know where to send this if I don't know the proper
25 person to answer this question?

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1 A. Either I'll know or I'll help figure it out,
2 yes.
3 Q. Great. All right. Let's go back to the
4 Exhibit 8 again, that would be, as I'm sure you're quite
5 familiar now, the deposition notice.
6 A. Okay.
7 Q. And we're on Page 4 again of that notice.
8 A. Okay.
9 Q. And No. 18, I will read this one, "All
10 interrogatory requests, requests for admissions, and
11 requests for production of documents directed to
12 Defendants William Crouch, Cynthia Beane and West
13 Virginia Department of Health and Human Resources,
14 Bureau for Medical Services, and any discovery
15 responses, responsive documents, filings or productions
16 by or on behalf of Defendants William Crouch, Cynthia
17 Beane and West Virginia Department of Health and Human
18 Resources, Bureau for Medical Services." Did I read
19 that topic correctly?
20 A. Yes.
21 Q. Okay. And you have been designated to testify
22 in response to parts of what this topic calls for, and
23 we're just going to talk about a few of them. So let me
24 just confirm, get verbal confirmation from you that
25 you're aware that you've been designated to testify

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1 about some of these requests?
2 A. Yes, I'm aware.
3 Q. Okay. So let's start with you have been, as a
4 part of addressing topic 18, one of the responses from
5 BMS that you've been designated to testify about is
6 interrogatory No. 2. And I'm going to introduce that so
7 that you know what I'm talking about, so give me just a
8 moment.
9 (Exhibit 18 marked for identification.)
10 Q. So in your marked exhibits folder you should be
11 seeing what has been marked as Plaintiff's Exhibit 0018.
12 A. Yes.
13 Q. Okay. And I'll read that title, "Defendants'
14 response to plaintiffs' first set of interrogatories to
15 Defendants William Crouch, Cynthia Beane and West
16 Virginia Department of Health and Human Resources,
17 Bureau for Medical Services." Did I read that
18 correctly?
19 A. Yes.
20 Q. And then if you would please scroll down to
21 Page 2 and No. 2. So this is one of the interrogatories
22 you've been designated to testify about today. So would
23 you please just read No. 2 in its entirety, it's just
24 there in the middle of the page, both the request and
25 the response, please.

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1 A. "Describe in detail the factual basis for each
2 governmental interest that defendants contend supports
3 the exclusion. Response: These defendants state that
4 they provide coverage that is mandated for coverage by
5 the Centers for Medicare/Medicaid Services (CMS). These
6 defendants are constrained by budgetary/cost
7 considerations."
8 Q. All right. Thank you. And before I introduce
9 this, had you seen this document before?
10 A. Yes.
11 Q. Okay, great. And did you do anything
12 specifically to prepare to testify about interrogatory
13 No. 2 today?
14 A. Not more than read it.
15 Q. Okay. But you are prepared to provide testimony
16 about this interrogatory?
17 A. Yes.
18 Q. Okay, great. So based on this response, what do
19 you understand to be the governmental interest that BMS
20 maintains supports the exclusion?
21 A. The Centers for Medicare and Medicaid Services.
22 Q. Okay. And what are the factual basis for that
23 assertion?
24 A. As I've discussed earlier, the program is
25 mandated and is overseen by the CMS in that they

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1 maintain the Code of Federal Regulations and approve our
2 state plan and state plan amendments.
3 Q. Okay. Does CMS mandate the exclusion of gender
4 affirming care, as far as you know?
5 A. They list mandatory services and optional
6 services. To my knowledge it is not specifically
7 addressed.
8 Q. Okay. But to your knowledge it's not listed as
9 a service that must be excluded?
10 A. Correct, it is not listed as a, what you said,
11 I'm sorry.
12 Q. That's okay. A must be excluded or a mandatory
13 exclusion I guess would be an easier way to say that?
14 A. Correct, yes.
15 Q. So beyond that is there, is there another
16 factual basis or any other factual basis in response to
17 that government interest?
18 A. I think the fact that CMS does not mandate that
19 we cover the service is our basis for excluding it as
20 well.
21 Q. Okay. Sorry, I just want to make sure, that's
22 it for the factual basis for that interest?
23 A. I believe so, yes.
24 Q. Okay. And then for the second governmental
25 interest that BMS contends supports maintaining the

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1 exclusion, can you just tell me what that is?
2 A. You're referring to the budgetary and cost
3 considerations?
4 Q. Yeah, that's the other governmental interest BMS
5 identifies?
6 A. It appears so, yes.
7 Q. Okay. And so what then is the factual basis for
8 that governmental interest?
9 A. So we receive a match on our state funds, so the
10 program is only allocated so many funds from different
11 sources by the legislature, so we only have so many
12 state dollars that can then be matched with the federal
13 dollars. So obviously there is a limit to what we can
14 cover, we have to be able to pay for it, so that would
15 be the, the constraints and considerations.
16 Q. Okay. Can you point to facts about the BMS
17 budget that require maintenance of the exclusions
18 specifically, other than just what you stated generally
19 about the general obligations?
20 A. I'm sorry, can you ask it one more time.
21 Q. Sure. So are there any facts, are there any
22 more specific facts than just sort of the general
23 overview you provided about the budget, about BMS's
24 budget that require the maintenance of the exclusion?
25 A. Generally speaking, our current membership is

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1 over 600,000 individuals, and so as I spoke, the limited
2 budget that we have, we have to ensure that it will
3 cover the benefits that we have promised and outlined in
4 our policies that we do cover. So the addition of
5 anything extra or anything on top of that is what limits
6 us, you know, we have to be able to do what we said we
7 were going to do.
8 Q. Sure. And has BMS done research about the cost
9 of providing gender affirming service in West Virginia
10 Medicaid?
11 A. Not that I'm aware of.
12 Q. Sorry, can we go back. You said there was a
13 match that happened. Can you just, as you've been doing
14 such a generous job of today, explain generally to me
15 what that refers to?
16 A. Sure. So each state is allocated a federal
17 match based on a bunch of factors, but basically the
18 economics of the state. So states that are the poorer
19 states get a greater match. I believe the bottom is
20 50/50, so prosperous states get a 50 percent match on
21 the state dollars. So our budget, the amount of claims
22 that we have to reimburse or capitation that we have to
23 pay on a monthly basis we are required, generally
24 speaking let's say our match is 75 percent, so we would
25 be required to pay 25 percent of that and we can draw

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1 down on the 75 percent to match that amount. Does that
2 make sense?
3 Q. I think so. So you can spend, let's say you
4 have $25 from the state of West Virginia and 75 from the
5 federal government, is that sort of it, like you can use
6 25 West Virginia dollars and 75 federal dollars to pay
7 for that $100 Medicaid bill?
8 A. Right, if something cost $100, our obligation
9 would be $25 of that.
10 Q. Okay. So it takes into consideration the, you
11 know, sort of not being an economist here, it takes into
12 consideration the relative wealth or GDP of a state and
13 what dollars are able to be allocated by that state's
14 Medicaid program in its match determination?
15 A. Basically speaking, yes.
16 Q. Okay. All right. I got the basics. So we
17 talked about the budget and meeting the obligations of
18 the 600,000 West Virginia Medicaid members and the
19 obligation to be able to pay for what you said of those
20 claims you will pay for. Are there any additional facts
21 related to costs that you know of that require the
22 agency to maintain the exclusion?
23 A. Not that I can think of.
24 Q. Okay. So then are there any other government
25 interests that BMS contends support its maintenance of

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1 the exclusion?
2 A. None that are listed in the response. Is that
3 what you're asking?
4 Q. Yeah. And I think, yes, in the response or are
5 you aware of any other governmental interest?
6 A. None that I'm aware of.
7 Q. All right. So let's return to that exhibit we
8 were just on, Exhibit 18, and look at No. 3 there on
9 Page 2.
10 A. Okay.
11 Q. All right. And I'll go ahead and read that,
12 "Identify and describe in detail every instance in which
13 a health plan offered through West Virginia's Medicaid
14 program provides partial or full coverage for gender
15 confirming care of any kind including, but not limited
16 to, counseling and/or therapy, hormone therapy or
17 surgery. Include in your answer the coverage criteria
18 for such care and the date such coverage began." First
19 of all, did I read that correctly?
20 A. Yes.
21 Q. Okay. And are you aware that BMS has designated
22 you as the organizational representative to testify
23 about their response to this request?
24 A. Yes.
25 Q. And you are designated to respond to this

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1 request as to medical claims including counseling and/or
2 therapy and surgery, but there's a different witness
3 designated for pharmaceutical care, is that your
4 understanding?
5 A. Yes.
6 Q. Okay. So then I'll just read a little bit of
7 the response here because much of it is relevant to that
8 other witness' testimony. So, "Response: Objection.
9 This question seeking every instance is overly broad and
10 burdensome. Without waiving the objection with respect
11 to any gender confirming care that it has requested
12 through the managed care organizations, these defendants
13 are not in possession of this information. This
14 question would be best directed to the individual MCO's
15 regarding any care requested through them. Upon
16 information and belief, counseling is a covered service.
17 These defendants would not necessarily know the reason
18 for counseling and whether it was related to gender
19 confirming care or some other reason." Did I read that
20 correctly?
21 A. Yes.
22 Q. All right. So in administering West Virginia
23 Medicaid, does BMS cover medically necessary healthcare?
24 A. Yes, within the constraints of our policies.
25 Q. So is it correct to say then that if West

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1 Virginia Medicaid, I'm sorry, if in its administration
2 of West Virginia Medicaid BMS provides coverage for
3 healthcare, then that healthcare has been deemed
4 medically necessary?
5 A. If I understand correctly, our criteria for
6 covering, our criteria for approving request for covered
7 services is based on whether or not it meets medical
8 necessity.
9 Q. Yeah, I think I asked that question in a double
10 negative, so let me try to ask it again. BMS would not
11 reimburse for a service that while covered has not been
12 determined to be medically necessary?
13 A. Correct, that did not meet their requirements.
14 Q. Yes. So I guess in a plainer way of what I'm
15 asking is, if a given procedure could be determined to
16 be included in the coverage, but if the patient or the
17 provider, if it has not been assessed to be medically
18 necessary, then that doesn't fall within what BMS would
19 cover?
20 A. Correct.
21 Q. Okay. Sorry, I was sure there was some easier
22 way to ask that, but I couldn't figure it out, so thank
23 you for your patience. Okay. So as we just reviewed in
24 the response to that interrogatory request, counseling
25 is a covered service. So if that therapy was undertaken

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1 for the treatment of gender dysphoria, that claim would
2 not be denied by BMS solely on the basis that it was for
3 the treatment of gender confirming care?
4 A. Correct.
5 Q. Okay. So for those, for that particular coding,
6 the gender dysphoria coding of those visits is accepted,
7 not rejected by BMS West Virginia Medicaid?
8 A. Correct.
9 Q. Okay. And as far as you know, does BMS cover
10 office visits related to gender confirming care?
11 A. Can you be specific as to the type of office.
12 Q. Sure. So, for example, I know this is tricky,
13 but I'm asking about the office visits to an
14 endocrinologist, not for the purpose of prescribing
15 hormones, but for the purpose of monitoring, blood work,
16 kidney, kidney and liver testing, thyroid. Would those
17 kind of medical visits, again, I'm trying not to get
18 into what the other witness is going to talk about,
19 would those visits be covered under the existing policy?
20 A. Yes.
21 Q. Okay. And as far as you're aware, Ms. Young,
22 has BMS in its administration of West Virginia Medicaid
23 provided any partial or total coverage for any surgical
24 procedure for the treatment of gender dysphoria?
25 A. Not that I'm aware of.

1 Q. Okay. But as you said earlier today, if the
2 diagnostic code was something different, given other
3 variables we've discussed, it has the potential to be
4 covered?
5 A. Correct, yes.
6 Q. Okay.
7 (Exhibit 19 marked for identification.)
8 Q. I'm going to introduce a couple of documents.
9 There should be another exhibit there in the shared
10 folder.
11 MR. CHARLES: And this will be marked,
12 Kelley, as Plaintiff's Exhibit 0019.
13 Q. So as a part of your testimony in topic 18, you
14 have been designated to testify in regard to BMS's
15 response to request for production No. 2, and that is
16 included on this document that I'm showing you right
17 now. Do you have it in front of you?
18 A. I do, yes.
19 Q. Okay. And do you have that same
20 understanding -- sorry, I should be asking you. Do you
21 understand that you've been designated to testify about
22 request for production No. 2?
23 A. Yes.
24 Q. Okay. So I'll just read this, "Defendants'
25 seventh supplemental response to plaintiffs' first set

1 of request for production to Defendants William Crouch,
2 Cynthia Beane and West Virginia Department of Health and
3 Human Resources, Bureau for Medical Services document
4 requests." Did I read that correctly?
5 A. Yes.
6 Q. Okay. And No. 2 begins, "All documents relating
7 to plaintiffs' communications, injuries, requests for
8 coverage, requests for prior authorization, requests for
9 reimbursement and/or complaints regarding coverage for
10 gender confirming care through the West Virginia
11 Medicaid program. This request includes, but is not
12 limited to, all communications to and from plaintiff
13 relating to coverage for gender confirming care. Sub
14 point B, all documents and communications regarding
15 plaintiffs' requests for gender confirming care
16 including, but not limited to, communications among
17 defendants and/or the employees, entities, agents,
18 representatives, contractors, vendors and/or consultants
19 of defendants and/or West Virginia Department of Health
20 and Human Resources, Bureau of Medical Services.
21 Subpart C, all documents and communications relating to
22 consideration or processing by third-party
23 administrators, contractors and/or vendors of requests
24 for gender confirming care by plaintiff." Did I read
25 all of that correctly?

1 A. Yes.
2 Q. Thank you. Okay. And the supplemental
3 response, would you cover that for me, would you read
4 that for me, please.
5 A. "Supplemental response. See documents received
6 from Aetna marked as Exhibit 125 regarding Plaintiff
7 Anderson. The undersigned Bates numbered the pdf
8 documents using the number assigned by Aetna as
9 FAI0000000578 to FAI0000000603. All materials are
10 confidential."
11 Q. Thank you for that. So did you do anything in
12 particular to prepare to testify about this response
13 today, Ms. Young?
14 A. I reviewed a number of the documents that were
15 provided, I believe this was included.
16 Q. Okay. All right. So that was going to be my
17 next question was, have you reviewed these documents
18 that were provided to plaintiffs, they were provided on
19 Wednesday afternoon I believe, so you might have seen
20 them around that time. Does that sound familiar?
21 A. It does, yes.
22 Q. Okay. So then let me go ahead, I'm just going
23 to mark a couple of those documents.
24 (Exhibit 20 marked for identification.)
25 Q. So this first document in this batch should be

1 in your marked exhibit folder, Ms. Young, it's been
2 labeled Exhibit PL0020. Just let me know when you see
3 that.
4 A. Okay.
5 MR. CHARLES: And, Kim, this is Bates
6 FAI0000000595.
7 MS. BANDY: Thank you.
8 Q. Just before we get started with questions about
9 this document, Ms. Young, do you see the box at the top
10 of this first page where member ID and member name are
11 listed?
12 A. Yes.
13 Q. Okay. And so do you understand that our
14 plaintiff Ms. Anderson currently has a different legal
15 name, which is what her claims are listed under?
16 A. Yes.
17 Q. Okay. So if you see that different legal name
18 you'll know that that is the AKA of Ms. Shauntae
19 Anderson?
20 A. Yes.
21 Q. Okay. Thank you. I just wanted to get that out
22 of the way. Okay. So do you need any time to review
23 this or have you reviewed it very recently that you're
24 familiar with what it is?
25 A. I'm relatively familiar.

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1 Q. Okay. So let's just review that. The title,
2 "Claims for the period from 6/13/76 through 2/15/22."
3 And then this is claims submitted for care provided to
4 Ms. Anderson. Is that what you understand this document
5 to be?
6 A. To clarify, it's the ones that were provided as
7 a member of Aetna, these Aetna claims?
8 Q. Yes.
9 A. Yes.
10
11
12
13
14
15
16
17 Q. Okay. So let's go to Page 4. Just let me know
18 when you're there, that's 4 of 12 it should be.
19 A. Okay.
20 MR. CHARLES: And, Kim, that's Bates
21 stamped same number, but D, D as in dog.
22 MS. BANDY: Yeah, I got it.
23 Q. And so, Ms. Young, looking at the first claim on
24 that page, that's going to be claim No. 21174E as in
25 elephant 120344. Do you see that claim ID number?

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1 A. I do, yes.
2
3
4
5
6
7 Q. Okay. Thank you. And can you just read for me
8 the primary serv -- well, first of all, do you
9 understand primary serv code to mean primary service
10 code?
11 A. I would believe so, yes.
12 Q. Thank you. And can you just read for me that
13 code number, please.
14 A. 99213.
15 Q. And do you know what that code number stands
16 for?
17 A. Not off the top of my head, but it looks like
18 the description is under the provider name in that same
19 column.
20 Q. And could you just read that description for me.
21 A. "Office O/P est low 20 to 29 minutes." I can
22 fill in the blanks. It looks like it's an outpatient
23 office visit that was, you know, less than 30 minutes.
24 Q. I'm glad you translated that because I was not
25 going to get there, so thank you. And then looking over

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1 at the first column, I see DOS from and DOS to, do you
2 see those columns?
3 A. Yes.
4 Q. And the same date is listed. Can you just read
5 that date for me.
6 A. Sure. 6/16/21.
7 Q. Okay. And is it your understanding that DOS
8 means date of service?
9 A. Yes, I believe so.
10 Q. Okay. And then in the status column, can you
11 tell me what word is listed there too, please.
12 A. Denied.
13 Q. In preparing to testify about BMS's response to
14 this request for documents, did you have any other
15 information, did you review any other information about
16 this claim?
17 A. Nothing that wasn't provided as part of the
18 case.
19 Q. Okay. Sorry, can you say more about what you
20 mean by that?
21 A. I haven't reviewed any other documents other
22 than the ones that have been produced.
23 Q. Okay. And there were no other documents
24 produced to you about this claim that you know of?
25 A. No, none that I know of.

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1 Q. Okay. And just real quickly, what is the total
2 claimed amount in the column next to status?
3 A. $246.
4 Q. Okay. So then do you have any information about
5 what this office visit was about?
6 A. I don't. There's not a diagnosis code listed, I
7 only have the information listed here.
8 Q. Okay. And also do you have any information
9 about why it might have been denied?
10 A. No, not without any more information.
11 Q. Okay. So let's look at I think just one more
12 document here.
13 A. I apologize, the document that I mentioned that
14 Jennifer Myers provided me with the list of diagnosis
15 codes and some of the procedure codes, it does include
16 the full explanation of this 99213. That's the only
17 other information that I would have that would pertain
18 to what's obviously an abbreviated explanation for the
19 procedure code.
20 Q. Sure. Why don't you go ahead with that
21 information, please.
22 A. Sure. What she has listed for 99213, it says,
23 "Office or other outpatient visit for the evaluation and
24 management of an established patient which requires a
25 medically appropriate history and/or examination and low

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1 level of medical decision-making when using time for
2 code selection 20 to 29 minutes of total time is spent
3 on the date of the encounter."
4 Q. Thank you.
5 A. You're welcome.
6 Q. Will you repeat, Ms. Young, there was a sentence
7 in there about established medical condition and then
8 something about medical record, can you just read, can
9 you just, does that sound familiar and can you just
10 reread that for me, please.
11 A. I can reread it, "Office or other outpatient
12 visit for the evaluation and management of an
13 established patient which requires a medically
14 appropriate history and/or examination and low level of
15 medical decision-making."
16 Q. Perfect. Thank you again. Okay. Let me get
17 this document for you.
18 (Exhibit 21 marked for identification.)
19 Q. Okay. So you should see in the shared folder
20 what I have marked as Exhibit PL0021.
21 MR. CHARLES: Kim, that's Bates stamped
22 FAI0000000591.
23 Q. Okay. I think, Ms. Young, you're going to need
24 to zoom, use the toggle there.
25 A. Yeah, I'm zoomed way in.

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1 Q. Okay. So have you, are you familiar with this
2 document, have you seen it before?
3 A. Yes, I believe so.
4 Q. Okay. As a part of the documents that you
5 reviewed in relation to the response to this discovery
6 request?
7 A. Correct.
8 Q. Request for production, excuse me.
9 A. Correct, yes.
10 Q. Okay. So can you tell me generally what you
11 understand this document to be?
12 A. It looks like a list of all claims and their
13 status on the first page and possibly more detail about
14 those claims or certain claims on the other pages.
15 Q. So let me just establish again who this claim
16 information belongs to. So in the upper left you'll see
17 member and then Ms. Anderson's AKA is listed, do you see
18 that there?
19 A. I do, yes.
20
21
22
23
24
25 Q. Okay. So looking at this first page here, it

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1 again appears to be a list of claims. I'm not going to
2 ask you to affirm that it is all of the exact same
3 claims, but if you would look at the fifth claim down,
4 and I think it will likely stand out to you because in
5 the status column it's listed as denied?
6 A. Yes, I see.
7 Q. And the claim ID number there 21174E as in
8 elephant 0120344?
9 A. Yes.
10 Q. That's the claim number identified with that
11 denied status?
12 A. Yes.
13 Q. Okay. And then you'll see the date of service
14 there is 06/16/21?
15 A. Yes.
16
17
18 Q. And then the billed amount, do you see that in
19 the third column from the right, 246 again?
20 A. Yes.
21 Q. Okay, great. So let's scroll down if you would
22 please onto Page 2, again probably zooming in. So
23 Page 2, do you see the same claim ID I just read to you
24 on the first page in the upper left-hand corner?
25 A. Yes, I believe so.

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1 Q. Okay. And if you go down, let's see, I'm
2 looking at the white box that's sort of I'll call it the
3 second box from the top of this frame, it lists the
4 claim ID number, and if you go across it lists provider
5 Vickie Hudnall, and then finally member secondary ID and
6 Ms. Anderson's AKA?
7 A. Yes.
8 Q. Do you see that? Okay, perfect. So then if you
9 would just looking at this sheet here, what does this
10 sheet here appear to be?
11 A. It looks like the claim detail from the Aetna
12 claims processing system.
13 Q. Okay. And do you see on the left most side,
14 again the status is listed as denied again as well?
15 A. Yes.
16 Q. Okay. And then if you would take a look on
17 the -- I'm trying to figure out how to direct you
18 properly here. But if you go to horizontally the lower
19 half of this page you'll see on the right-hand side a
20 series of boxes, the top of the middle box there says,
21 "Sent encounter to Aetna Better Health West Virginia"?
22 A. Yes.
23 Q. Okay. And does it look to you like that box is
24 checked very lightly?
25 A. Yes.

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1 Q. Okay. And the third box down in that same
2 column says, "Accept assignment," do you see that?
3 A. Yes.
4 Q. And that box also appears to be checked in a
5 gray scale?
6 A. Correct.
7 Q. Okay. Do you know what, "Sent encounter to
8 Aetna Better Health West Virginia" means?
9 A. I don't. I don't believe they have another line
10 of business, but it could be possible if they had
11 another line of business that that would be relevant
12 with this context. I can't really tell what that would
13 mean.
14 Q. And then similarly does, "Accept assignment"
15 have any meaning to you?
16 A. Not necessarily. I can say on a fee for service
17 side it may be assignment to further review, something
18 like that.
19 Q. Okay. Let's scroll down to the third page
20 there, which is just the next page. So just
21 establishing, this is the same claim number in the upper
22 left corner?
23 A. Yes.
24 Q. Okay. And in the line No. 1, do you see that
25 box that goes all the way across the screen there?

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1 A. I do.
2 Q. And then under status do you see, "Deny"?
3 A. Yes.
4 Q. Okay. And then listed under the CPT, so there's
5 a column labeled CPT/HCPCS. Do you know what HCPCS
6 stands for?
7 A. Of course we just pronounce it HCPCS. So CPT is
8 procedure codes and then HCPCS are additional codes, I'm
9 mangling that, but they're different sets of codes for
10 different services.
11 Q. Okay.
12 A. And they fall under one or the other, HCPCS or
13 the CPT codes.
14 Q. Okay. So it wouldn't be the case that you have
15 codes that fall under both of those?
16 A. I don't believe so, no.
17 Q. Okay. Then let's look at the bottom of this
18 page. Do you see the remits, it's in blue on the
19 left-hand side?
20 A. Yes, I do.
21 Q. Can you read out loud what you see in the remit
22 comment box, as much of that as you can read, please.
23 A. "Line 1, M127, missing patient medical record
24 for this service. Line 1, 252, an attachment/other
25 documentation is required to adjudicate this

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1 claim/service. M127, missing patient medical record for
2 this service."
3 Q. Nice. Okay. Have you seen code M127, missing
4 patient medical record for this service before?
5 A. I haven't seen this particular code.
6 Q. Is that, is that concept a familiar one to you
7 though?
8 A. I think the reason for the denial, it appears to
9 be an administrative type. There's additional
10 documentation required that they denied it without that,
11 whatever the additional or other documentation.
12 Q. Okay. And then if you would just scroll down to
13 the next page, please. And do you see the box sort of
14 in the top half of the page entitled, "Outstanding
15 edits"?
16 A. Yes.
17 Q. Okay. And then under the column Line 1, do you
18 see edit No. 205?
19 A. Yes.
20 Q. Okay. And then just going across there, can you
21 read that line to me, I'm sorry, just read the line
22 under description.
23 A. "M62, missing/incomplete/invalid treatment
24 authorization code."
25 Q. Okay. And then under status, that's listed as

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1 "Okay," do you see that?
2 A. Yes.
3 Q. And then there's an override by, does PHX/EDI
4 user, are either of those terms or acronyms familiar to
5 you?
6 A. No. This may be internal to Aetna.
7 Q. Okay. And then looking down at the steps box on
8 the lower left-hand side. And then could you just read
9 the words that you see in that box for me, please.
10 A. "Program edit rules used in adjudication.
11 Validating medical policy criteria. Line No. 1 found
12 one criteria. Validating external diagnosis - primary."
13 Q. Okay. And just starting with the first line,
14 "Program edit rules used in adjudication," does that
15 mean anything to you?
16 A. It does, and it looks like this may just be
17 explaining literally the steps that the claim went
18 through.
19 Q. Okay. Do you know what they might mean by,
20 "Validating medical policy criteria"?
21 A. Possibly that it, a step might be to go through
22 any edits related to this type of claim that would be
23 part of the medical policy. I can't say without more
24 context.
25 Q. Fair enough. And then does, "Validating

1 external diagnosis - primary," does that ring a bell for
2 you, is that terminology familiar to you at all?
3 A. No.
4 Q. Okay.
5 MR. CHARLES: Kim, I am finished.
6 MS. BANDY: All right. I don't know, is
7 Eric on?
8 MR. SALYERS: Yeah, I'm here, and I don't
9 have any questions.
10 MS. BANDY: I have no questions. And just
11 advise that Ms. Young will read.
12 (Proceedings concluded for the day at
13 3:33 p.m., 03-11-2022)
14
15
16
17
18
19
20
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22
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25

1 REPORTER'S CERTIFICATE
2
3
STATE OF MINNESOTA)
4) ss.
COUNTY OF WASHINGTON)
5
6 I hereby certify that I reported the Zoom deposition
of Sarah Young on the 11th day of March 2022, and that
7 the witness was by me first duly sworn to tell the whole
truth;
8
That the testimony was transcribed by me and is a
9 true record of the testimony of the witness;
10 That the cost of the original has been charged to
the party who noticed the deposition, and that all
11 parties who ordered copies have been charged at the same
rate for such copies;
12
That I am not a relative or employee or attorney or
13 counsel of any of the parties, or a relative or employee
of such attorney or counsel;
14
That I am not financially interested in the action
15 and have no contract with the parties, attorneys, or
persons with an interest in the action that affects or
16 has a substantial tendency to affect my impartiality;
17 That the right to read and sign the deposition by
the witness was reserved.
18
WITNESS MY HAND AND SEAL THIS 11th day of March
19 2022.
20
21
22
23 Kelley E. Zilles
24 Kelley E. Zilles, RPR
Notary Public, Washington County, Minnesota
25 My commission expires 1-31-2025

1 Veritext Legal Solutions
1100 Superior Ave
2 Suite 1820
Cleveland, Ohio 44114
3 Phone: 216-523-1313
4
March 24, 2022
5
To: Ms. Bandy
6
Case Name: Fain, Christopher Et Al. v. Crouch, William Et Al.
7
Veritext Reference Number: 5096099
8
Witness: Sarah Young Deposition Date: 3/11/2022
9
10 Dear Sir/Madam:
11
Enclosed please find a deposition transcript. Please have the witness
12
review the transcript and note any changes or corrections on the
13
included errata sheet, indicating the page, line number, change, and
14
the reason for the change. Have the witness' signature notarized and
15
forward the completed page(s) back to us at the Production address
16 shown
17 above, or email to production-midwest@veritext.com.
18
If the errata is not returned within thirty days of your receipt of
19
this letter, the reading and signing will be deemed waived.
20
21 Sincerely,
22 Production Department
23
24
25 NO NOTARY REQUIRED IN CA

1 DEPOSITION REVIEW
CERTIFICATION OF WITNESS
2
ASSIGNMENT REFERENCE NO: 5096099
3 CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/11/2022
4 WITNESS' NAME: Sarah Young
5 In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
6 my testimony or it has been read to me.
7 I have made no changes to the testimony
as transcribed by the court reporter.
8
_______________ ________________________
9 Date Sarah Young
10 Sworn to and subscribed before me, a
Notary Public in and for the State and County,
11 the referenced witness did personally appear
and acknowledge that:
12
They have read the transcript;
13 They signed the foregoing Sworn
Statement; and
14 Their execution of this Statement is of
their free act and deed.
15
I have affixed my name and official seal
16
this ______ day of____________________, 20____.
17
____
18 Notary Public
19 ___________________________________
Commission Expiration Date
20
21
22
23
24
25

1 DEPOSITION REVIEW
CERTIFICATION OF WITNESS
2
ASSIGNMENT REFERENCE NO: 5096099
3 CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/11/2022
4 WITNESS' NAME: Sarah Young
5 In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
6 my testimony or it has been read to me.
7 I have listed my changes on the attached
Errata Sheet, listing page and line numbers as
8 well as the reason(s) for the change(s).
9 I request that these changes be entered
as part of the record of my testimony.
10
I have executed the Errata Sheet, as well
11 as this Certificate, and request and authorize
that both be appended to the transcript of my
12 testimony and be incorporated therein.
13 ______________ ______________________
Date Sarah Young
14
Sworn to and subscribed before me, a
15 Notary Public in and for the State and County,
the referenced witness did personally appear
16 and acknowledge that:
17 They have read the transcript;
They have listed all of their corrections
18 in the appended Errata Sheet;
They signed the foregoing Sworn
19 Statement; and
Their execution of this Statement is of
20 their free act and deed.
21 I have affixed my name and official seal
22 this ______ day of____________________, 20____.
23 ________________________________
Notary Public
24
____
25 Commission Expiration Date

1 ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
2 ASSIGNMENT NO: 5096099
3 PAGE/LINE(S) / CHANGE /REASON
4 ____
5 ____
6 ____
7 ____
8 ____
9 ____
10 ____
11 ____
12 ____
13 ____
14 ____
15 ____
16 ____
17 ____
18 ____
19
_______________ ________________________
20 Date Sarah Young
21 SUBSCRIBED AND SWORN TO BEFORE ME THIS ________
22 DAY OF ________________________, 20______ .
23 ___________________________________
Notary Public
24
____
25 Commission Expiration Date

1 DEPOSITION REVIEW
CERTIFICATION OF WITNESS
2
ASSIGNMENT REFERENCE NO: 5096099
3 CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/11/2022
4 WITNESS' NAME: Sarah Young
5 In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
6 my testimony or it has been read to me.
7 I have listed my changes on the attached
Errata Sheet, listing page and line numbers as
8 well as the reason(s) for the change(s).
9 I request that these changes be entered
as part of the record of my testimony.
10
I have executed the Errata Sheet, as well
11 as this Certificate, and request and authorize
that both be appended to the transcript of my
12 testimony and be incorporated therein.
13 04-07-2022 Sarah K. Young
Date Sarah Young
14
Sworn to and subscribed before me, a
15 Notary Public in and for the State and County,
the referenced witness did personally appear
16 and acknowledge that:
17 They have read the transcript;
They have listed all of their corrections
18 in the appended Errata Sheet;
They signed the foregoing Sworn
19 Statement; and
Their execution of this Statement is of
20 their free act and deed.
21 I have affixed my name and official seal
22 this 7th day of April, 2022.
23 Kimberly M. O'Brien
Notary Public
24
July 28, 2026
25 Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

1 ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

2 ASSIGNMENT NO: 5096099

3 PAGE/LINE(S) / CHANGE /REASON

4 pg 36/line 2 / who "was" changed to who "is" / correction, staff is still in this role

5 pg 38/line 38 / attended a different college for the fall semester of '92 then tranferred to WVU for

6 spring semester beginning January '93 / clarification

7 pg 56/line 20 / change "OARM" to "OAMR" / correction

8 pg 102/lines 2-4 / clarify that answer is specific to gender confirming medical procedures, like surgery.

9 This does not apply to counseling, as there is not an edit on the diagnosis code. / clarification

10 pg 105/lines 9-10 / clarify that the report did not ask for claims for gender confirming care. It only

11 asked for the "number of health plan participants who have submitted one or more claims with

12 a diagnosis code for gender dysphoria or gender incongruence." The report is based on diagnosis

13 codes and not procedure codes. / clarification

14 pg 108/line 12 / change "incoming assets" to "income or assets" / correction

15 pg 130/line 13 / change we had covered it "with our" to we had covered it "without" / correction

16 pg 158/line 6 / change "thousands" to "hundreds"

17

18

19

04-07-2022 Sarah K. Young

20 Date Sarah Young

21 SUBSCRIBED AND SWORN TO BEFORE ME THIS 7th

22 DAY OF April, 20 22.

23 Kimberly M O'Brien

Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

24

July 28, 2026

25 Commission Expiration Date

&

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

1 DEPOSITION REVIEW
CERTIFICATION OF WITNESS
2
ASSIGNMENT REFERENCE NO: 5096099
3 CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/11/2022
4 WITNESS' NAME: Sarah Young
5 In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
6 my testimony or it has been read to me.
7 I have listed my changes on the attached
Errata Sheet, listing page and line numbers as
8 well as the reason(s) for the change(s).
9 I request that these changes be entered
as part of the record of my testimony.
10
I have executed the Errata Sheet, as well
11 as this Certificate, and request and authorize
that both be appended to the transcript of my
12 testimony and be incorporated therein.
13 04-07-2022 Sarah K. Young
Date Sarah Young
14
Sworn to and subscribed before me, a
15 Notary Public in and for the State and County,
the referenced witness did personally appear
16 and acknowledge that:
17 They have read the transcript;
They have listed all of their corrections
18 in the appended Errata Sheet;
They signed the foregoing Sworn
19 Statement; and
Their execution of this Statement is of
20 their free act and deed.
21 I have affixed my name and official seal
22 this 7th day of April, 2022.
23 Kimberly M. O'Brien
Notary Public
24
July 28, 2026
25 Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

1 ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

2 ASSIGNMENT NO: 5096099

3 PAGE/LINE(S) / CHANGE /REASON

4 pg 36/line 2 / who "was" changed to who "is" / correction, staff is still in this role

5 pg 38/line 38 / attended a different college for the fall semester of '92 then tranferred to WVU for

6 spring semester beginning January '93 / clarification

7 pg 56/line 20 / change "OARM" to "OAMR" / correction

8 pg 102/lines 2-4 / clarify that answer is specific to gender confirming medical procedures, like surgery.

9 This does not apply to counseling, as there is not an edit on the diagnosis code. / clarification

10 pg 105/lines 9-10 / clarify that the report did not ask for claims for gender confirming care. It only

11 asked for the "number of health plan participants who have submitted one or more claims with

12 a diagnosis code for gender dysphoria or gender incongruence." The report is based on diagnosis

13 codes and not procedure codes. / clarification

14 pg 108/line 12 / change "incoming assets" to "income or assets" / correction

15 pg 130/line 13 / change we had covered it "with our" to we had covered it "without" / correction

16 pg 158/line 6 / change "thousands" to "hundreds"

17

18

19

04-07-2022 Sarah K. Young

20 Date Sarah Young

21 SUBSCRIBED AND SWORN TO BEFORE ME THIS 7th

22 DAY OF April, 20 22 .

23 Kimberly M O'Brien

Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

24

July 28, 2026

25 Commission Expiration Date

Exhibit
0001

CHAPTER 100– GENERAL INFORMATION

CHANGE LOG

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

CHAPTER 100– GENERAL INFORMATION

12/2/2004

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

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

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 140

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

Directions: Replace the page containing this section.

Change: Replace old phone numbers with the new ones.

Section 153

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

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.

Directions: Replace the page containing this section.

Change: Replace old phone numbers with the new ones.

Introduction: Added wording related to PCCM Program.

Directions: Replace the page containing this section.

Change: Add PCCM Program.

Section 161

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

Directions: Replace the page containing this section.

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

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.

CHAPTER 100—GENERAL INFORMATION

TABLE OF CONTENTS

TOPIC **PAGE NO.**

100 Introduction 2
110 Medicaid Program Overview 2
120 Purpose of the Manual 3
121 Organization of the Manual 3
130 Other Resource Information 3
140 Manual Updates 4
150 Written or Phone Inquiries 4
151 Voice Response System 4
152 Contacting Provider Services 5
153 Other Contacts 6
160 Covered Services 9
161 General Non-Covered Services 10
170 Relationship to Medicare 11
180 Out-of-State Services 11
190 Fraud and Abuse 12
191 Confidentiality 13

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.

CHAPTER 100–GENERAL INFORMATION

100 INTRODUCTION

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

110 MEDICAID PROGRAM OVERVIEW

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

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

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

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

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

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.

120 PURPOSE OF THE MANUAL

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

The following information is included:

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

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

121 ORGANIZATION OF THE MANUAL

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

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

The Chapter Titles are:

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

130 OTHER RESOURCE INFORMATION

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

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.

140 MANUAL UPDATES

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

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

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

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

150 WRITTEN OR PHONE INQUIRIES

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

151 VOICE RESPONSE SYSTEM

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

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

- **Obtain recent accounts payable information**

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

- **Verify member eligibility**

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

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

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

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

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

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

152 CONTACTING PROVIDER SERVICES

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

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

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

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

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

153 OTHER CONTACTS

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

- **Provider Enrollment**

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

- **Inpatient Admission Approval And Prior Authorization**

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

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

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

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

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

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

- **Behavioral Health Services**

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

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

- **Audits and Settlements**

  To obtain information regarding audits and cost settlements, call:

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

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

- **Pharmacy Help Desk**

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

- **Rational Drug Therapy Program**

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

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

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

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

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

- **Medicaid Managed Care**

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

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

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

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

- **Medicaid Related Programs**

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

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

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

- **Medicaid Waivers**

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

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

160 COVERED SERVICES

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

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

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

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

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

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

161 GENERAL NON-COVERED SERVICES

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

Some examples are identified below:

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

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

* Enrolled providers cannot bill Medicaid members for missed appointments.

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

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

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

170 RELATIONSHIP TO MEDICARE

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

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

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

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

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

180 OUT-OF-STATE SERVICES

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

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The following are exceptions to this policy:

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

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

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

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

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

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

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

190 FRAUD AND ABUSE

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

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

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

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

191 CONFIDENTIALITY

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

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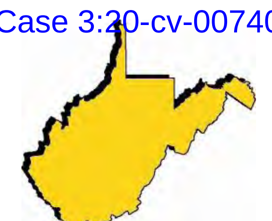

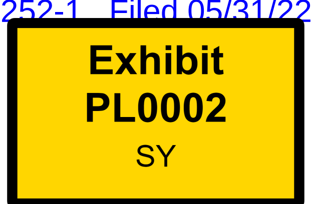

CHAPTER–519 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRACTITIONER SERVICES – INCLUDING PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED REGISTERED NURSE PRACTITIONERS

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

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Section 519.12.4.1	Colorectal Cancer Screening	5/17/05	6/1/05
Attachment 15	Approved HCPCS J Codes	5/17/05	7/1/05
Attachment 16	Drugs Approved to be Billed with HCPCS Code J3490	5/17/05	7/1/05

January 16, 2012

Attachment 16

Introduction: This is an additional attachment

Change: Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners

Directions: Add attachment to manual.

February 15, 2006

Section 519.20.1

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of service 22 (Outpatient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment 17.

Change: First paragraph to read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listing in Attachment 17, along with the PA form that may be utilized.

Directions: Replace all affected pages of the current manual.

November 21, 2005

Section 519.13.2.1

Introduction: Coverage changes related to Vaccines for Children Program.

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***Old Policy:** CPT 90645, 90646, 90656, and 90698 are provided by Vaccines for Children Program.

Change: Removing CPT 90645, 90646, 90656, and 90698 from the Vaccines for Children Program.

Directions: Replace all affected pages of the current manual.

OCTOBER 24, 2005

Section 519.19.1

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

OCTOBER 4, 2005

SECTION 519.12.5

Introduction: Clarification of Diabetes Disease Management Program. To enable providers easier access to the web based modules.

Change From: **(**Under System Process-second sentence)**.** Begin by accessing the course at www.healthywv.org. Under the column listed ―Prevention", locate and click on ―Diabetes Education for Primary Care Providers". This will take you to the actually program.

Change To: Begin by accessing the course at ―www.camcinstitute.org/professional/diabetes/camc.htm."

Change From: (Second to the last paragraph) The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate.

Change To: The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate.

Providers will receive a written notice from Unisys stating the provider file has been

updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

Change From: (Last Paragraph) In the near future, CD's of this program will be available for those who do not have broadband Internet access.

Change To: CD's of this program are available to those who do not have broadband Internet access.

Change From: (Under section Requirements for Becoming a Diabetes Management Provider: 5th paragraph –last sentence). Recertification is required annually.

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Change To: Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification

SECTION 519.13.2.2

Introduction: Tetanus Toxoid, reduced Diptheria Toxoid & Acellular Pertussis vaccine (Adacel) becomes part of the VFC Program effective 10/24/05

Old Policy: CPT 90715 Tetanus Toxoid, reduced Diptheria Toxoid & Acellular Pertussis Vaccine (Adacel) has never been covered by the Vaccines for Children Program

Change: Adding CPT code 90715 for Adolescents ages 11 through 18 years to the Vaccines for Children Program. This will appear as a bullet in Section 519.13.2.1 children's vaccine.

Directions: Replace all affected pages of the current manual.

September 28, 2005

Section 519.13.2.1

Introduction: Meningococcal Conjugate Vaccine (Menactra) CPT 90734 becomes part of the VFC Program effective 7/18/2005

***Old Policy:** CPT 90734 has never been covered by the Vaccines for Children Program

Change: Adding CPT code 90734 Meningococcal Conjugate Vaccine (Menactra) for Adolescents to the Vaccines for Children Program. This will appear as a bullet in Section 519.13.2.1 children's vaccine.

Directions: Replace all affected pages of the current manual.

Section 519.19.1

Introduction: Added Prior Authorization for Outpatient Surgeries.

Change: All surgeries performed in place of service 22 (Out patient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

Directions: Replace pages.

September 1, 2005

Section 519.14.3

Introduction: Deleted all information in Section 519.14.3.

Change: Changed to **PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES**

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic

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Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

Directions: Replace pages.

MAY 17, 2005

Section 519.7.6

Introduction: Changed 2nd paragraph to provide more clarity.

Change: Deleted 2nd sentence in the 2nd paragraph, ―Treatment of an acute condition within the 30-day cycle is paid, based on an unlisted E&M code (CPT 99499) with a report attached outlining the reasons for the services." Replaced with the following, ―Emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit".

Directions: Replace all affected pages of current manual.

Section 519.11.3

Introduction: Revision being made to include statement that Masters Level Social Worker and Counselors must be in the employ of the psychiatrist.

Change: Changed 1st paragraph from, ―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, Master's Level Social Worker, or Master's Level counselor must also be registered and assigned an authorization number by the contracted agent. Telephone numbers for this agent are located in the Behavioral Health Services section of Appendix M" to ―Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Social Worker, or Master's Level counselor in their employ must also be registered and assigned an authorization

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number by the contracted agent.

Directions: Replace all affected pages of current manual.

Section 519.12.1

Introduction: There was a typographical error in this section.

Change: In the 4th sentence in this section, changed code 92546-TC to 92543-TC.

Directions: Replace all affected pages of current manual.

Section 519.12.4.1

Introduction: Procedure code G0120 was omitted.

Change: Added procedure code G0120 as bullet 10 in this section.

Directions: Replace all affected pages of current manual.

Attachment 15

Introduction: This is an additional attachment

Change: Approved HCPCS J Codes.

Directions: Add attachment to manual.

Attachment 16

Introduction: This is an additional attachment

Change: Drugs approved to be billed with HCPCS Code J3490.

Directions: Add attachment to manual.

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CHAPTER 519—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PRACTITIONERS SERVICES

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

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers acting within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the Bureau for Medical Services (BMS).

WV Medicaid covers a broad scope of Practitioner Services subject to medical necessity, appropriateness, and prior authorization requirements. Covered Practitioner Services must be provided in settings appropriate for each specific type of practitioner. Medical records must substantiate that any Practitioner Service billed to WV Medicaid was actually provided to an eligible WV Medicaid member by an appropriately credentialed practitioner.

The policies and procedures herein are issued as regulations governing the provision of Practitioner Services in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the WV State Code. BMS is the single State agency responsible for administering the WV Medicaid Program.

519.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200.

519.2 MEDICAL NECESSITY

All services must be medically necessary and appropriate to the member‘s needs in order to be eligible for payment. The medical records of all members receiving Practitioner Services must contain documentation that establishes the medical necessity of the service.

Important: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider‘s responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are rendered.

519.3 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the WV Medicaid Program and receive payment from BMS, practitioners must meet all enrollment criteria as described in Chapter 300, as well as the specific requirements outlined below.

To participate as a practitioner, providers must submit a completed and signed application form to the

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Provider Enrollment Unit of the BMS' fiscal agent. This application form can be obtained by calling provider services at the following telephone numbers:

- (888) 483-0793 - In-state and border providers
- (304) 348-3360 - Out-of-state and Charleston, WV providers

The address for Provider Enrollment is:

Unisys
Post Office Box 625
Charleston, WV 25322-0625

The address for Provider Services and Member Services is:

Unisys
Post Office Box 2002
Charleston, WV 25322-2002

Providers must meet all of the provider requirements of the WV Medicaid Program and their practices must be fully operational before they may enroll as Medicaid providers.

519.3.1 ENROLLMENT: PHYSICIAN

All physicians whether in a private practice, a member of a group practice, or an employee of a medical services entity, must enroll with WV Medicaid in order to receive reimbursement for services rendered to Medicaid members. BMS evaluates the following credentials and circumstances when reviewing applications submitted by physicians who wish to participate in the Program:

- Current license issued by the WV Board of Medicine, Board of Osteopathy, or by the regulatory entity in the state of the practice location
- In a medical specialty:
  - Current board or board eligible certification by a Member Board of the American Board of Medical Specialties
  - Certification of satisfactory completion of a residency program accredited either by the Liaison Committee of Graduate Medical Education or by the appropriate Residency Review Committee of the American Medical Association (AMA)
  - Current board certification or board eligibility by a Specialty Board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association
  - Documented qualifications and training to take examinations of the appropriate Member Board of the American Board of Medical Specialties, if the residency program was completed in a foreign country.

519.3.2 ENROLLMENT: PHYSICIAN ASSISTANT

Physician assistants cannot be enrolled as direct Medicaid providers. However, WV Medicaid allows enrolled physicians to bill for covered services rendered to Medicaid members by physician assistants in their employ and/or under their supervision. Supervising physicians must follow the regulations established in WV Code 30-3-1 et seq. Physicians are not required to be physically present on the premises in order to bill for physician assistant services performed under their supervision.

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519.3.3 ENROLLMENT: ADVANCED REGISTERED NURSE PRACTITIONER

For purposes of this manual, an Advanced RN practitioner is an individual licensed and certified as an Advanced nurse practitioner by the WV Board of Registered Nurses, or the appropriate regulatory body in the state of the practice location, with certification in one of the following specialties: (See Chapter 30, Title 19, Series 7-8 of WV Code.)

- Certified nurse midwife
- Certified registered nurse anesthetist
- Family nurse practitioner
- Pediatric nurse practitioner
- Geriatric nurse practitioner
- Adult nurse practitioner
- Women's health nurse practitioner
- Psychiatric nurse practitioner

The Advanced RN practitioner must be enrolled as a provider in order to bill for the provision of WV Medicaid services. Prescriptive authority is not required to be enrolled as a provider.

An Advanced Nurse Practitioner must have a signed collaborative agreement for prescriptive authority with a physician who is enrolled with BMS. This collaborative agreement (which must be on file at the BMS) must document the professional relationship between the Advanced RN practitioner and the physician. The Advanced RN practitioner must notify BMS immediately, and if necessary submit a replacement document, if the collaborative agreement is cancelled, changed, or not renewed.

519.3.4 ENROLLMENT: GROUP/PAY-TO PRACTICES

Providers whose practice is incorporated under the same tax identification number or have an employer-employee relationship must enroll as a Medicaid group/pay-to provider. To receive Medicaid payments, each provider employed by or directing payment to the group/pay-to must be enrolled as an individual provider and designate that payment for rendered services is to be made to the group/pay-to entity. Individuals can participate in multiple groups and all such relationships must be documented with provider enrollment in order that payments may be appropriately made to the correct entity and reported to the correct tax identification number.

Termination of the corporation or the employer- employee relationship must be reported in writing, on office letterhead stationery, to the Provider Enrollment Unit. The notice must include the effective date of the termination. Failure to report these changes will result in incorrect routing of payments and invalid filings with the Internal Revenue Service.

519.3.5 ENROLLMENT: OTHER PRACTITIONERS

Enrollment requirements of other practitioners, e.g. chiropractors, podiatrists, and therapists, are discussed in the Chapters which corresponds to those specific providers.

519.3.6 ENROLLMENT: DOCUMENTATION

Documentation including required license, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, and any other materials substantiating an individual's eligibility to perform as a practitioner with the application for enrollment.

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Renewals of license or certification must be maintained in a current status and the documentation must be submitted to Provider Enrollment for inclusion in the provider record.

In order to be paid for services related to skills attained after the initial enrollment, an individual must submit documentation of the new capabilities and request an addition of the specialty or service group to his/her provider profile.

519.4 PRACTITONER SERVICES: OVERVIEW

Practitioner Services are medical services rendered by one of the following:

- A doctor of medicine or osteopathy within the scope of a professional license issued under State law,
- A qualified non-physician practitioner who may provide care under the direction or supervision of a licensed doctor, e.g. a physician assistant or a nurse first assistant,
- An Advanced RN practitioner enrolled and practicing independently.
- Or a Masters Level Social Worker and Masters Level Counselor employed by a participating psychiatrist.

Practitioner Services furnished in federally qualified health centers or rural health centers are included in the facility‘s reimbursement and are therefore not separately billable.

519.4.1 PHYSICIAN SUPERVISION OF EMPLOYED NON-PHYSICIAN PRACTITIONERS

With certain specific exceptions, physicians must be onsite when WV Medicaid covered services are provided in order to bill for services furnished by physician assistants, clinical nurse specialists, employed nurse practitioners (other than those specialties listed in Section 519.3.3), or other qualified non-physician practitioners. The physician may not bill for services furnished by any employee who is enrolled, or eligible to be enrolled, as a Medicaid provider.

Exception to physician supervision of employees:

- Physician Assistants - The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
- Advanced Nurse Practitioners – The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
- Masters Level Social Worker or Masters Level Licensed Professional Counselors – The supervising physician must be available for consultation, but does not need to be on the premises.

Following are some of the provisions governing the activities of physician assistants in WV. They apply to all practice settings in which physician assistants are employed:

- Physician assistants must be supervised by a designated licensed, qualified physician. No physician may supervise more than three physician assistants.
- Physician assistants must have job descriptions approved by the WV Board of Medicine.
- Physician assistants are prohibited from billing directly for their professional services.
- Physician assistant‘s authority is limited by the following:
  - The supervisory physician‘s authority

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- The physician assistant‘s license, national certification, and job description
- The employing facility‘s policies and procedures
- And all applicable statutes and regulations (See WV Code 30-3-1 et seq.)

The employing physician may also bill WV Medicaid for covered services furnished by a registered nurse first assistant acting as an assistant surgeon. See Section 519.4.5 for the requirements of this service.

519.4.2 PHYSICIAN SUPERVISION IN A TEACHING SETTING

Teaching physicians may bill for services provided by residents under their supervision. The teaching physician must be present when the service is rendered unless the individual is licensed to practice medicine and the service is within the scope of his/her license. The level of the service billed must reflect the complexity of the evaluation or treatment need; not the work effort required by the resident.

Residents in an approved graduate medical education program, who have received their license to practice, may be enrolled as Medicaid providers, but they may not bill Medicaid for physician services provided within the scope of the education program. Services related to that program are billed by the supervising physician with the following criteria:

- The teaching physician must be present for a key portion of the time during the performance of the service.
- The teaching physician must be present during the critical portion of a surgical, complex, or dangerous procedure, and be immediately available to furnish care during the entire service or procedure.

EXCEPTION: With regard to the requirement of the teaching physician‘s presence, there is a special exception to the physician presence requirement for mid-level evaluation and management services furnished through a family practice type of residency program that functions outside an inpatient hospital setting. The exception applies when Current Procedural Terminology (CPT) codes 99201-99203 or 99211-99213 are rendered within a specific residency program in an ambulatory care center. **<u>This does not apply to preventive medicine codes.</u>**

For this exception to apply, all of the following requirements must be met:

- Residents who provide services without a teaching physician present must have completed more than six months of an approved residency program.
- The teaching physician may not supervise more than four residents concurrently and must be immediately available to render care or answer questions.
- The members must be an identifiable group of individuals who use the outpatient setting for their usual and continuing source of care.
- Residents may, within the scope of their training, furnish acute care, chronic care, comprehensive care not limited by organ system or diagnosis, or coordination of care furnished by multiple providers
- The outpatient center must be located in a setting that includes the resident's time in the full-time equivalency count used for direct graduate medical education costs.

WV Medicaid does not apply this exception to preventive medicine. In other words, the teaching physician must be present to supervise the resident in order for Medicaid to pay the teaching physician for supervising the resident while the latter provided a covered preventive service.

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519.4.3 RESIDENTS AND FELLOWS

Residents in an approved graduate medical education program may not bill Medicaid for physician services provided within the scope of the education program. Medicaid reimburses these services as hospital services rather than physician services. The reimbursement is in the direct graduate medical contracted education payments WV Medicaid makes to the hospital. (This is true for both teaching and non-teaching hospitals.)

Licensed/enrolled residents may bill WV Medicaid directly for physician services provided to members under the following circumstances:

- In non-approved teaching programs may bill Medicaid for covered services they provide in hospital settings and within the scope of their license
- They may also bill for physician services provided in freestanding skilled nursing facilities or home health agencies.
- They may bill for physician services provided in non-institutional settings, such as freestanding clinics not part of the hospital if the non-institutional setting is not part of the teaching program. **This does not apply to Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC). Services provided at a FQHC/RHC are not separately billable.**

Fellows may not bill separately for services when care is provided through a teaching program, even if a fellow supervises interns and residents. In other words, physician services furnished by fellows within an approved graduate medical education program are hospital services and are not therefore separately billable as physician services.

"Moonlighting" residents may receive separate Medicaid payments for physician services provided in the outpatient or emergency department of a teaching hospital. These are residents who are providing physician services separately identifiable from services required in their graduate medical education program. Separate payment may be made if a contractual arrangement between the resident and the hospital exists and all of the following conditions are met:

- The resident is fully licensed to practice medicine in the State where the services are provided.
- The services are identifiable physician services.
- -Moonlighting" services can be differentiated from services provided as part of the approved graduate medical education program.

In these instances, a resident can be paid for covered physician services provided to the Medicaid member.

519.4.4 ADVANCED REGISTERED NURSE PRACTITIONER

WV Medicaid pays specified Advanced RN practitioners (See Section 519.3.3) separately for medically necessary and appropriate services rendered to Medicaid eligible individuals. The services must be rendered in accordance with the provisions of WV State Code, his/her State license, and within the scope of practice defined by that license. Advanced RN practitioners must meet all requirements of the WV Board of Nursing in order to obtain prescriptive authority.

Services provided by an Advanced RN practitioner may include incidental services and supplies that are included as part of another service or procedure. The cost of incidental services is not separately reimbursable.

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Advanced RN practitioners cannot bill for nursing home visits, inpatient visits, or observation services.

519.4.5 REGISTERED NURSE FIRST ASSISTANT

WV Medicaid covers services provided by a registered nurse first assistant acting as the assistant surgeon for an employing physician. The employing physician may bill assistant at surgery provided by an employed RN if the following criteria are met:

- The RN first assistant has a current, active RN license
- The RN is certified in peri-operative nursing
- The RN has successfully completed and holds a degree or certificate from a program which consists of the following criteria:
  - The Association of Operating Room Nurses, Inc., Care Curriculum for the Registered Nurse First Assistant and
  - One year of post basic nursing study, which shall include at least 45 hours of didactic instruction and 120 hours of clinical internship or its equivalent of two college semesters, or
  - Was certified by the Certification Board of Perioperative Nursing prior to 1997

Procedures for which Medicaid will reimburse an RN first assistant at surgery are indicated in Appendix 1 of the Resource Based Relative Value Scale (RBRVS) Policy and Procedures Manual. Specific information is given in the discussion of Modifiers 80, 81, 82, and AS.

In billing for the RN first assistant services, the employing physician must repeat the appropriate surgical procedure used for billing his/her service with addition of the modifier ―AS.” WV Medicaid covers only one assistant at surgery per surgical encounter. Also, an Assistant at Surgery is not reimbursable when co-surgeons or team surgery is billed.

519.4.6 OUT-OF-STATE PHYSICIAN SERVICES

WV Medicaid will reimburse **emergency** out-of-state physician services. The submitted claim must clearly indicate an emergency situation existed and the emergency room record must be submitted with the claim. Out-of-state physicians are subject to the same fee and payment regulations as in-state physicians and must enroll with WV Medicaid in order to receive reimbursement for services rendered.

Non-emergency outpatient services provided to WV Medicaid members by out-of-state physicians must be prior authorized by the BMS. (For information concerning provision of inpatient services, see Chapter 510 Hospital Services.) The exceptions to this rule are approved border providers and Medicaid-eligible children who have been placed in an out-of-state foster care home or out-of-state residential treatment center.

A physician who practices in WV and wishes to refer a member to an out-of-state physician must submit a request to the Out-of-State Unit in the BMS. The request must include the reason for the out-of-state referral, member‘s diagnosis, the expected treatment (including duration and plan for follow-up treatment by that provider), why the treatment cannot be provided in-state, and any other information deemed pertinent for the circumstances.

All claims submitted by out-of-state physicians for non-emergency medical services will be denied unless the physician is a border provider or the service is approved in advance.

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519.4.7 WV MEDICAID MUST PAY PROVIDER OF SERVICE

The provider of a service to WV Medicaid-eligible members must bill directly to the WV Medicaid Program for the service. If certain criteria are met, payment may be made to the employer of the provider. (e.g., Payment may be made to the employer of the practitioner if the practitioner is required, as a condition of employment, to turn over his fees to the employer or to the facility in which the service is provided if the practitioner has a contract under which the facility submits the claim.) Information regarding group enrollment may be obtained from the Provider Enrollment Unit.

519.5 SERVICE DESCRIPTIONS IN OTHER MANUALS

Various medical services that may complement or augment the Practitioner Services described in this chapter may be rendered to WV Medicaid members by enrolled WV Medicaid providers. The policies and procedures covering the provision of those services may be found in the appropriate Chapters as listed below:

- Chapter 504: Chiropractic Services
- Chapter 505: Dental Services
- Chapter 506: Durable Medical Equipment
- Chapter 508: Home Health
- Chapter 510: Hospital Services
- Chapter 512: Laboratory & Radiology
- Chapter 515: Occupational/Physical Therapy
- Chapter 518: Pharmacy Services
- Chapter 520: Podiatry Services
- Chapter 524: Transportation
- Chapter 525: Vision Services

Policies and procedures regarding Organ Transplant Services are found in Chapter 510 of the Hospital Services Manual.

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- **Therapy: Respiratory Vest System** **519.12.3**
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- **UNLISTED SERVICES, DRUGS, PROCEDURES, OR ITEMS** **519.15**

519.7 EVALUATION AND MANAGEMENT SERVICES

Evaluation and Management (E&M) Services involve face-to-face contacts between members and practitioners. Contacts may occur in a hospital setting, the member's home, the practitioner's office or other ambulatory setting, emergency room, or long-term care facility.

WV Medicaid coverage of E&M Services is outlined below:

- Only one E&M procedure code is covered on the same date of service per member per practitioner.
- Only one E&M procedure may be billed when more than one practitioner in the same specialty and same group provides a service to the same member on the same date of service, unless the E&M services are for unrelated problems.
- When multiple E&M visits occur on the same date of service, the practitioner must bill with the E&M procedure code that best represents the combined level of services.
- The E&M code must reflect the content of the service.
- The member's medical record must support the level of care provided and document, at a minimum, all of the following information:
  - The billed procedure code's components, based on CPT guidelines
  - The time the practitioner spent with the member for medical decision making
  - The coordination of care or counseling provided, including direct fact-to-face contact time when time is the key component for code selection.

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WV Medicaid does not cover:

- Hospital visits related to a procedure that WV Medicaid does not cover
- Visits covered by a global surgical fee
- Visits by an RN practitioner in a hospital or nursing home.

In addition, WV Medicaid does not pay separately for manual or automated urine, hemoglobin, and hematocrit tests performed as part of the visit.

519.7.1 OFFICE VISITS AND OTHER OUTPATIENT SERVICES

WV Medicaid covers medical services rendered to the member for the prevention or diagnosis and treatment of illness, accident, and injury. Except for CPT 99211, face-to-face contact must occur. (e.g., the practitioner must examine the member and provide medical services in order to bill a visit.) CPT 99211 indicates an office or other outpatient visit for an established member that does not require the presence of a practitioner. The presenting problem is usually minimal and the practitioner typically spends five minutes performing or supervising this E&M service.

An office visit associated with a covered procedure or minor surgery performed in a practitioner's office is considered part of the procedure and is not payable by Medicaid. The visit may be billed separately, with the appropriate modifier, provided the visit is for a distinctly different reason.

A visit to a practitioner's office or outpatient department of a hospital solely for a diagnostic service does not qualify for coverage or payment as an E&M procedure. Medicaid payment will be made for the diagnostic service but not for the visit as it is bundled with the payment for the diagnostic service.

A preoperative office visit and uncomplicated follow-up care are bundled with the payment for the surgery and are not separately reimbursed.

Telephone contacts are not considered to be practitioner visits. Therefore, WV Medicaid does not reimburse for telephone contacts with the member or on the member's behalf.

519.7.2 PREVENTIVE CARE FOR MEMBERS

WV Medicaid covers well child, preventive medicine examinations for children based on the recommended frequency established by the American Pediatric Association and adopted by the WV Early and Periodic Screening, Diagnostic, and Treatment Program. For adult members, WV Medicaid covers one annual physical examination in a 12 month period. The annual examination must be reported with a preventive medicine code reflective of the member's age (CPT 99381-99387 or CPT 99391-99397).

- The annual physical examination is separate and distinct from treatment or diagnosis for a specific illness, symptom, complaint, or injury. If during the examination an abnormality is found or a preexisting condition requires significant additional work to perform the key components of a problem-oriented E&M service, that service may be billed with Modifier 25. Documentation in the medical record must support the provision of this service. Clinical laboratory services, radiology procedures, and other diagnostic services must be reported and billed separately.

WV Medicaid does not cover the following types of physical examinations:

- Sport physicals
- Camp physicals

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- Physicals for inpatients in nursing facilities, hospitals, residential treatment facilities, and other such facilities
- Physicals required by third parties, such as insurance companies, Government agencies, and businesses as a condition of employment
- Daycare

Eligibility examinations requested by the county DHHR office are not annual physicals. See Section 519.7.10 for coverage information.

519.7.2.1 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

WV Medicaid‘s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. (WV Medicaid EPSDT coverage is through the month in which the member turns 21 years of age.) These services target early detection of disease and illness and provide referral of members for necessary diagnostic and treatment services.

If the Medicaid member is a member of the Physician Assured Access System (PAAS) Program, a referral from the primary care physician (PCP) must be obtained prior to performing an EPSDT exam for reimbursement if the provider administering the exam is not the member‘s PAAS PCP. If the Medicaid member is a member of a Health Maintenance Organization (HMO), the HMO is responsible for reimbursement for the services when the HMO‘s requirements have been met.

Providers must make reasonable efforts for every member under 21 years of age to determine whether a visit to the provider‘s office stems from an EPSDT referral by asking the referring provider, clinic, or member. If the visit is the result of an EPSDT screening, the appropriate space on the claim must be marked "yes" to indicate a referral was the source of the visit. Likewise, the appropriate space on the claim must be marked ―no” if the information cannot be obtained or is not the result of a screening.

519.7.3 HOSPITAL VISITS

All hospital admissions must be prior authorized based on the determination of medical necessity and appropriateness by BMS‘ contracted utilization management agent in order for WV Medicaid to reimburse for services rendered. Visits by physicians in conjunction with denied or non-covered inpatient services are non-reimbursable. Hospital admissions for diagnostic procedures may be reimbursed only when there is adequate documentation the procedure cannot be performed on an outpatient basis.

As with other E&M services, only one hospital visit per date of service is covered regardless of how many times the physician sees the member on that date. Payment for the hospital visit is included in the global fee paid for surgical/diagnostic procedures, depending on the global period for the procedure. Global periods for procedures are listed in the RBRVS table.

519.7.3.1 EMERGENCY DEPARTMENT SERVICES

WV Medicaid covers emergency department visits rendered by the onsite practitioner using CPT codes 99281-99285. If a practitioner is called in to the emergency department to treat a member, the services must be billed over the appropriate level office/outpatient procedure code. Additional billing of codes for after-hour visits or non-scheduled visits is not covered.

Surgical procedures performed in an emergency room are billable. However, the physician will not be

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reimbursed for an emergency room visit in addition to the surgical procedure performed in the emergency room.

519.7.3.2 OBSERVATION SERVICES

Observation services are defined as the use of a bed and periodic monitoring by hospital nursing or other indicated staff at the level and frequency necessary to evaluate the member's condition to determine the need for inpatient admission. Medicaid limits the coverage of observation services to a maximum of 48 hours. Even if the 48 hours extends over three calendar days, only two observation visits are covered: the initial observation care and the observation care discharge services.

In addition to documentation in order to support the medical necessity of the service, the observation record must contain dated and timed physician's admitting orders specifying the care the member is to receive while in observation, admitting history and physical, nursing notes, dated and timed progress notes written by the physician, laboratory and other diagnostic test results, active treatment protocol, and documentation to justify the level of the observation code billed. **This record must be maintained in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.**

When a member is admitted to the hospital for observation, the admitting physician must be physically present on the hospital premises.

If a member is examined by a practitioner other than the admitting physician while in observation, that practitioner must bill the outpatient E&M code appropriate for the service provided.

519.7.4 REFERRALS

A referral involves the transfer of the total or a specific part of the care and treatment of a member from one physician to another physician. A referral does not qualify as a consultation. The care provided during the course of treatment subsequent to such a referral is therefore not considered a consultation for payment purposes and therefore should not bill the consultation E&M procedure codes.

519.7.5 CONSULTATIONS

A consultation is a service provided by a physician whose opinion or advice regarding the evaluation or management of a member's condition is requested by the attending physician or another appropriate provider. A consultant may initiate diagnostic or therapeutic services at the time of the consultation. The consultant must document in the member's record that the member was seen at the request of the referring provider and that the findings, recommendations, and treatment (if initiated) were communicated to the referring practitioner. If the consultant assumes responsibility for the member's continuing care, any subsequent service provided does not qualify as a consultation and should be billed with the appropriate CPT code. The physician must not bill a consultation if the member was self-referred for services, except in the case of a confirmatory consultation which may be requested by the member and/or family.

WV Medicaid applies a service limitation of one consultation per procedure code per consultant per six months to office or other outpatient consultations, initial inpatient consultations, and confirmatory consultations. This limitation applies to the following consultations performed by an individual physician: CPT 99241-99245, 99251-99255, and 99271-99275. In other words, a member may receive only one Medicaid–covered consultation of each specific level from the same physician over a

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six month period. The member may receive consultations from different physicians within the same six month period, regardless of whether the physicians provide the same or different levels of service, unless the consultants are in the same group practice or partnership. WV Medicaid covers follow-up consultations (CPT 99261-99263) with no service limitation other than billing with other consultation codes or hospital/office visits.

Consultations are disallowed if and of the following criteria are met:

- They are provided in conjunction with other services furnished by the same physician on the same date to the same member, such as office visits, home visits, or hospital visits,
- They are provided by a surgeon immediately prior to the procedure and resulted in the initial decision to perform surgery with the use of modifier 57,
- When billed by a member of the same group and specialty as the physician performing the surgery.

Gathering of the member‘s medical history and/or performance of a physical examination prior to a member‘s admission for surgery is the responsibility of the admitting/operating surgeon under the global surgical package. This may not be billed as a consultation.

Pre-operative evaluations for anesthesia are not considered to be consultations and may not be billed as consultations. Payment for these evaluations is included in the fee for the administration of the anesthesia.

When the consultant assumes responsibility for the management of a portion or all of the member‘s care subsequent to the consultation, then consultation codes are no longer appropriate. There is a difference between consultations and referrals. See Section 519.7.4 for information on referrals.

519.7.5.1 SECOND OPINIONS FOR ELECTIVE SURGERY

Second opinions (Confirmatory consultations) are covered for elective/non-emergency surgery. The second opinion concept is to be a member oriented service that allows an individual member to make better informed decisions about a physician‘s recommendation on the need for surgery. However, a physician may also request a second opinion.

The consulting physician must document the type of surgery, the name of the member or physician requesting the second opinion, and must bill an appropriate confirmatory consultation procedure code.

519.7.5.2 TELEHEALTH SERVICES

A teleconsultation is an interactive member encounter that meets specific criteria. This service requires the use of ―interactive telecommunications systems” defined as multimedia communication equipment that involves at least audio and video equipment that permits two-way consultation among the member, consultant and referring provider. Telephones, facsimile machines, and electronic mail systems do not qualify as interactive telecommunication systems. WV Medicaid covers teleconsultations subject to the following criteria:

- The consultation must involve real time consultation as appropriate for the member‘s medical needs and as needed to provide information to and at the direction of the consulting physician.
- Medicaid coverage of teleconsultations is limited to members in non-metropolitan statistical professional shortage areas as defined by CMS. The referring provider must be located in the non-metropolitan area.

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- The referring provider may bill for an office, outpatient, or inpatient E&M service that precedes the consultation and for other Medicaid-covered services the consultant orders, or for services unrelated to the medical problem for which the consultation was requested. However, the referring provider may not bill for a second visit for activities provided during the teleconsultation.
- The consultant must be in control of the member's medical examination, with the referring provider participating, as needed, to complete the examination. The member must be present in real time, and telecommunication technology must allow the consultant to conduct a medical examination of the member.
- The consultant's findings must be documented in a written report given to the referring physician.
- Payment for a teleconsultation does not include any separate reimbursement for telephone line charges or facility fees, and a member may not be billed any amount for these charges/fees.
- Separate payment is not made for the review and interpretation of medical records.
- Medicaid coverage is limited to professional consultations that meet the criteria specified for consultation service in the CPT Manual. Covered services include initial follow-up or confirming consultations in hospitals, outpatient facilities, or medical offices, that is: CPT 99241-99245, 99251-99255, 99261-99263, and 99271-99275. These are subject to the same service limits discussed in the consultation section of this chapter, Section 519.7.5.

Modifier GT must be used with the proper consultation code in order for a physician to bill for a teleconsultation.

519.7.6 NURSING FACILITY VISITS

WV Medicaid covers one nursing facility visit per 30 days when made by the member's primary care physician. The appropriate E&M code (CPT 99301-99313) must be used to bill for the visit. WV Medicaid does not reimburse a nursing facility visit if the same physician provides another E&M visit to the same member on the same date of service.

WV Medicaid does not cover daily, weekly, or routine nursing facility visits. Emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit.

Specialists called by an attending physician must bill the code appropriate for their services, such as a procedure code for a consultation or minor surgery. The service must be provided based on a specific request of the primary care physician. **Standing orders are not acceptable.**

Nursing discharge orders, CPT 99315 – 99316, are not covered by WV Medicaid.

There is no coverage for nurse practitioner visits.

519.7.7 CARE PLAN OVERSIGHT SERVICES

Care plan oversight (CPO) consists of physician supervision of members under either home health or hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement. WV Medicaid provides payment for only one CPO service per calendar month, per member, per provider. CPT 99375 and 99378 are the only procedure codes that may be used to bill CPO services. CPO coverage is subject to the following rules:

- The member must be receiving medically necessary home health services or hospice care.
- The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.

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- A face-to-face encounter between the physician and member must occur at some time during the six months prior to the first month for which CPO services are billed, and every six months afterwards.
- Payment for CPO services may not be made to physicians having a significant ownership interest in or financial relationship with a home health agency or hospice.
- Only the attending physician may bill or receive payment for CPO services. **Exception:** The attending physician may not bill or receive payment for CPO services if he/she is the medical director or a physician employed by, or having a contractual relationship with, the home health agency or hospice.
- Physicians may not bill for CPO during the postoperative period of a global surgery period unless the service is unrelated to the procedure.
- CPT 99375 and 99378 are the only procedure codes that may be used to bill for CPO services.
- The physician must furnish at least 30 minutes of CPO services within the calendar month that is being billed. Medicaid allows multiple CPO encounters during the month on multiple days, but the total time must add up to 30 or more minutes, and can be billed only once.

CPO services for Medicaid members in nursing facilities are not covered. CPO services are not payable to physicians having a significant ownership interest in or financial relationship with a home health agency or hospice.

519.7.8 CRITICAL CARE VISITS

As circumstances warrant, physicians should bill for critical care, regardless of whether the associated visit was an initial or subsequent one, and regardless of the site if the level of care fulfills the criteria for critical care. However, physicians may not bill for procedures and services the CPT Manual defines as ―attendant to critical care management". These services are listed in the CPT Manual.

519.7.9 PROLONGED PHYSICIAN ATTENDANCE

WV Medicaid covers prolonged services only if the physician provides a prolonged direct, face-to-face service to the member that equals or exceeds the threshold time for the E&M service provided (typical time of the service plus 30 minutes). Time spent by office staff with the member or time the member was unaccompanied in the office is not counted toward the total time and may not be counted nor billed. For hospital-prolonged services, time spent waiting for certain events to occur, such as test results, changes in the member‘s condition, therapy to end, or use of facilities, may not be billed.

The member‘s medical record must document the duration and content of the billed E&M code and document that the physician personally furnished at least 30 minutes of direct service after the typical time of the E&M service had been exceeded by at least 30 minutes. (This time does not need to be continuous; however, it must be provided on the same date of service.)

Physicians may bill for prolonged services using CPT 99354-99357. These codes require billing of companion E&M codes when the same physician provides both types of services on the same date of service to the same member. CPT 99354 and 99356 are used for the first 30-60 minutes and 99355 and 99357 for each additional 30 minutes. The prolonged service codes are billed in addition to the appropriate visit code.

- The companion E&M codes for CPT 99354 are 99201-99205, 99212-99215, or 99241-99245.
- The companion E&M codes for CPT 99355 are 99354 and its related E&M code.
- The companion E&M codes for CPT 99356 are 99221-99223, 99231-99233, 99251-99255,

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99261-99263, 99301-99303, or 99311-99313.

- The companion E&M codes for CPT 99357 are 99356 and its related E&M code.

All these procedure codes are subject to Medicaid coverage rules and CPT definitions.

519.7.10 ELIGIBILITY EXAMINATIONS

The local DHHR office requests physical examinations, consultations, and reports on pending applications for the purpose of determining Medicaid eligibility. These requests are made by letter, defining the service to be provided and the member identification number to be used in billing. These services must be billed on paper with a copy of the authorizing letter. (These services are not reimbursable by Managed Care Organizations.)

Based on Social Security disability regulations, eligibility examinations may only be performed by an MD or DO.

The specific codes that must be used when billing eligibility examinations are:

- 99450 General physical examinations,
- 99456 Specialist exams (including eye exams), and
- S9981 Medical records.

Only one of these procedure codes can be billed per provider and no other E&M code may be billed.

In addition to the procedure codes listed above, diagnostic services may also be ordered by the examining physician if medically necessary to complete the examination and/or consultation. Diagnostic procedures that may be covered for eligibility determination are:

- Diagnostic Eligibility
  - Diagnostic Colonoscopy 45378
  - Diagnostic Radiology 70010-76499
  - Diagnostic Ultrasound 76506-76886, 76977
  - Nuclear Medicine Diagnostic 78000-78999
  - Laboratory 80000-86804, 87001-87999, 88104-88299, 88342-88349, 88400-89060, 89160-89240
- Medicine Codes
  - Therapeutic or Diagnostic Infusions 90780-90781
  - Therapeutic, Prophylactic, or Diagnostic Injections 90782-90799
  - Gastroenterology 91000-91100, 91110, 91122, 91132-91133, 91299
  - Ophthalmology 92015-92060, 92081-92287
  - Otorhinolaryngology 92502-92506, 92511-92520
  - Vestibular Function 92541-92548, 92551-92589, 92610-92617
- Cardiovascular
  - Cardiography 93000-93278
  - Echocardiography 93303-93350
  - Electrophysiological 93660,93701-93722, 93875-93990

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– Pulmonary	94010, 94060, 94200, 94375, 94720, 94760, 94761, 94772, 94799
– Neurology and Neuromuscular	95805-95811, 95812-95822, 95827, 95830, 95831-95904, 95920-95967
– Physical Medicine	97001,97003,97750
– A Codes	A9500-A9503, A9505, A9700
– G Codes	G0001, G0030-G0047, G0102-G0107, G0120, G0125, G0210-G0230, G0236, G0253-G0254
– P Codes	P7001,P9612

Documentation for medical necessity is required for all services. The documentation of the authorization, examination, medical necessity for diagnostic procedures, and diagnostic findings must be maintained in the member‘s record.

519.8 ANESTHESIA SERVICES

Anesthesia services covered by WV Medicaid include general, regional, and labor epidural. These services are primarily reimbursed using the American Society of Anesthesiologist‘s (ASA) ―0" CPT codes. Supportive services rendered in order to afford the member the necessary anesthesia care are also covered.

Anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) are the only providers that may be reimbursed for general and monitored anesthesia services.

519.8.1 BASE AND TIME UNITS

Two distinct unit values apply to anesthesia services. Base units are defined by the ASA Uniform Relative Value Guide. These units are part of the procedure and may not be billed separately.

The other value is the time unit. WV Medicaid defines a time unit as 15 minutes which must be rounded to the nearest whole unit. (Eight minutes or more, round up. Seven minutes or less, round down.) Only time units may be billed.

Payment is determined by the sum of the ASA base units plus time units multiplied by the anesthesia conversion factor. There is a limit of 40 units (10 hours) on each anesthesia Zero ―0" code, except for maternity-related anesthesia services. (See Section 519.8.3.) If anesthesia is provided longer than 10 hours, the claim must be billed on paper and submitted with documentation that would justify the additional anesthesia used.

519.8.2 COVERAGE POLICIES

WV Medicaid applies the following policies for coverage and reimbursement of anesthesia services:

- Payment for multiple anesthesia procedures is based on the procedure with the highest base unit value and the actual anesthesia time of the multiple procedures. Only one zero code may be billed (the highest value). Exception: Procedures performed at the same time as a delivery are included in the maternity service and must be billed with the maternity anesthesia CPT codes listed in Section 519.8.3.
- Anesthesia time begins when the CRNA or anesthesiologist begins to prepare the member for anesthesia care in the operating room or an equivalent area, and ends when the CRNA or the anesthesiologist is no longer in personal attendance.

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- Preoperative evaluations for anesthesia are included in the fee for the administration of anesthesia and may not be billed as an E&M service.
- Regional IV anesthesia (e.g., 01995) is not based on time units; the base unit is covered. Therefore, only one unit of service may be billed. CPT 01995 is used only in situations involving the application of a tourniquet to a limb and injection of an agent for regional anesthesia.
- CPT surgical procedure codes (e.g., 62311 and 62319) are used for regional anesthesia. No base units or time units of anesthesia may be billed. Instead, one unit of service (an injection) is billed.
- Epidural for pain management other than the three stages of delivery (labor, delivery, and postpartum) must be billed with CPT 62311 and 62319. Time units may not be billed.
- CPT 01996 (Daily Management of Epidural or Subarachnoid Drug Administration) is not payable on the same day as the insertion of an epidural catheter or a general anesthesia service. The service unit for this procedure is one base unit.
- Epidural anesthesia for surgical procedures must be billed with the appropriate ―0" anesthesia code with time units.
- Medications for pain relief given during the time of the epidural anesthesia are inclusive and must not be billed as a separate procedure.
- Local anesthesia and IV (conscious) sedation are bundled into the procedure being provided and must not be billed as separate services.
- Anesthesia services rendered during a hysterectomy or sterilization require completion, submission, and acceptance of the appropriate acknowledge/consent forms.
- Occasionally a procedure which is usually requires no anesthesia or local anesthesia, because of unusual circumstances, must be rendered under general anesthesia. A written description of the reason for using modifier 23 is required, and the claim will be sent for review.
- Modifiers defining the CRNA or anesthesiologist participation are used in processing to allocate payments. (e.g., AD,QK,QX,QY, and QZ) The supervising/medical directing anesthesiologist/ CRNA must bill the same procedure code.
- Physical status modifiers are not used for processing by WV Medicaid. The billing of additional base units for physical status is prohibited.

519.8.3 MATERNITY-RELATED ANESTHESIA

The CPT codes listed below are for reporting maternity-related anesthesia services. WV Medicaid limits payment for maternity anesthesia to eight ―Time Units". (A maximum of two hours) Base units may not be billed separately.

- 01960 - Anesthesia for vaginal delivery only
- 01961 - Anesthesia for cesarean delivery only
- 01967 - Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or necessary replacement of an epidural catheter during labor)
- 01968 - Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Must be used with 01967.)
- 01969 - Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Must be used with 01967.)

If the Medicaid member is a recipient of a documented emergency cesarean section, the anesthesia

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provider may receive reimbursement for up to two additional units of anesthesia. (See Section 519.8.4 for further details on billing emergency anesthesia.)

WV Medicaid‘s payment policy for labor epidural is as follows:

- Labor epidural provided by the surgeon must be billed with the appropriate delivery anesthesia code and modifier 97. Labor epidural provided by the anesthesiologist and/or CRNA must be billed with the appropriate ―0” anesthesia code
- CPT surgical codes 62311 and 62319 are not to be used to bill pain management for the three stages of delivery.
- Medications for pain relief given during the time of the epidural anesthesia are not covered as a separate procedure.
- Only one provider or team will be paid for epidural services.
- Emergency anesthesia is not allowed with the provision of epidural anesthesia or vaginal deliveries.
- The labor epidural procedures covered by WV Medicaid are inclusive of labor, delivery, and postpartum care. Additional procedure codes used for pain management are not covered.

519.8.4 EMERGENCY ANESTHESIA

Additional payment is allowed to anesthesiologists and non-medically directed certified registered nurse anesthetists for providing anesthesia for surgery on an emergency basis. The ASA recommended payment policy of two additional base units is followed. CPT code 99140 must be billed one unit in order to receive payment for this service.

519.8.5 MONITORED ANESTHESIA CARE

Monitored anesthesia care involves the intra-operative monitoring of the member‘s physiological signs in anticipation of the need for administration of general anesthesia or the development of adverse reactions to the procedure.

It must be performed at the request of the attending physician, made known to the member, and performed according to the facility‘s policies and procedures. If medically necessary, monitored anesthesia care is paid on the same basis as other anesthesia services.

WV Medicaid reimburses an anesthesiologist or CRNA for monitored anesthesia care only if they meet all of the following requirements:

- Performs a pre-anesthetic examination and evaluation of the member
- Prescribes the required anesthesia
- Participates personally in the entire plan of care
- Is continuously physically present when participating in the case
- Observes all facility regulations pertaining to anesthesia services
- Furnishes all the usual services an anesthetist usually performs.

The modifiers which are to be used for monitored anesthesia care are G8, G9, and QS.

519.8.6 OTHER ANESTHESIA SERVICES

Anesthesiologists and non-medically directed CRNAs (within the scope of their license) may bill for the following additional services: Swan-Ganz placement or any other central venous pressure line, critical care visits, emergency intubations, spinal puncture, and blood patch. Payment for these

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specific services is based on the RBRVS payment system. Time units are not billable for these services.

They may also bill for cardiopulmonary resuscitation performed in conjunction with the anesthesia procedure or outside the operating suite.

519.8.7 ANESTHESIOLOGIST DIRECTED ANESTHESIA

Medical direction may apply to a single anesthesia service furnished by a CRNA or up to four concurrent anesthesia services. A physician who is directing the administration of anesthesia to four surgical members is not expected to be involved routinely in furnishing any additional services to other members. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic rather than continual monitoring of an obstetrical member would not substantially diminish the physician's capacity to direct the CRNA services.

The medical directing anesthesiologist must document in the member's medical record that all medical direction requirements have been met, including:

- Perform the pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Participate personally in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence
- Ensure a qualified individual performs any procedure in the anesthesia plan he/she does not perform personally
- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergency that may develop
- Provide indicated post-anesthesia care.

A physician may appropriately receive members entering the operating suite for the next surgery while directing concurrent anesthesia procedures. However, checking or discharging members in the recovery room and handling scheduling matters are not compatible with reimbursement to the physician for directing concurrent anesthesia procedures.

519.8.8 ANESTHESIA TEAMS

An anesthesia team is defined as one directing anesthesiologist and one CRNA providing services to a member. The payment split between the anesthesiologist and medically directed CRNA equals 100 percent of the payment level for an individually performing anesthesiologist with the anesthesiologist receiving 60 percent and the medically directed CRNA 40 percent.

Only one provider or anesthesia team will be paid for epidural anesthesia.

519.9 SURGICAL SERVICES

WV Medicaid covers medically necessary surgical procedures. No surgical procedure will be covered on an inpatient basis if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting, unless the procedure is performed secondarily to another necessary inpatient procedure.

If the Medicaid member is a participant in the PAAS Program, surgical services will require a referral

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from the PCP prior to rendering the service.

Under Medicaid RBRVS payment rules, physicians are paid a single global fee for all necessary services. Payments are not made for individual components of a complete or bundled procedure.

In global billing, all expenses for surgical care must be dated the day the surgery occurred.

The following services are typically bundled into the global surgery period and are; therefore, covered by the global surgery fee and are not paid separately:

- Visits to/by the surgeon the day before or the day of the surgery (Neither hospital nor office visits)
- Visits to a member in intensive care or critical care unit
- Services normally a part of the surgery itself (e.g., use of an operating microscope)
- Services for any complications not requiring an additional trip to the operative room
- Preoperative and postoperative medical care. Only the surgical procedure code is necessary for billing purposes, using the date of the surgery as the date of service.
- Ninety days of postoperative care for major surgery and zero to 10 days for minor surgery.
- Biopsy procedures performed concurrently with a major surgical procedure

When multiple surgeries are performed during the same operative session, payment is based on the full amount for the primary procedure and 50 percent of the fee for all other necessary and appropriate procedures performed during the session. RBRVS coverage guidelines for bilateral surgery, assistant surgeon, co-surgeon, team surgery, and site of service differential also apply to all procedures.

519.9.1 RECONSTRUCTIVE SURGERY

The following types of reconstructive surgery must be medically necessary and require prior authorization prior to rendering the service:

- Eyelid surgery **(Attachment 1)**
- Breast reconstruction following cancer surgery **(Attachment 2)**
- Reduction mammoplasty **(Attachment 3)**
- Panniculectomy (request for panniculectomies must include written documentation demonstrating medical necessity) **(Attachment 4)**

The attachments listed above are copies of the forms that must be completed and submitted to request prior authorization for reconstructive surgery. Each form must be completed in full.

Photographs may be necessary when submitting documentation for medical necessity. However, HIPAA guidelines must be followed to ensure the privacy of Medicaid members.

Questions regarding reconstructive surgery and prior authorization requests must be addressed to BMS' Case Management Unit at (304) 558-1700 or fax number (304) 558-1776. Services must not be provided before any necessary prior authorization is received. The member must be informed he/she may be financially liable for services provided without the requisite authorization.

519.9.2 INTEGUMENTARY SERVICES

WV Medicaid applies multiple surgery rules to most dermatological procedures (e.g., CPT 11400, 11600, and 17260). Multiple surgery payment rules do not apply to selected dermatological services that are, by definition, multiple procedures.

WV Medicaid defines simple and intermediate repairs as follows:

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- Simple repair procedure code must be used if the wound involves the skin and subcutaneous tissue.
- Intermediate repair must be used to close one or more of the deeper fascial layers in addition to the skin and subcutaneous tissue.

Services provided to PAAS Program members require a referral from the PCP for reimbursement prior to rendering services.

Procedures must be medically necessary and not for cosmetic purposes. (i.e., Scar revisions/excisions will only be covered for documented medically necessary reasons.)

519.9.3 BARIATRIC SURGICAL PROCEDURES

The West Virginia Medicaid Program covers bariatric surgery procedures subject to the following conditions.

519.9.3.1 MEDICAL NECESSITY REVIEW AND PRIOR AUTHORIZATION

The patient's primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request, along with all the required information, to the West Virginia Medical Institute (WVMI), 3001 Chesterfield Place, Charleston, West Virginia 25304. The West Virginia Medical Institute (WVMI) will perform medical necessity review and prior authorization based upon the following criteria:

- A Body Mass Index (BMI) greater than 40 must be present and documented for at least the past 5 years. Submitted documentation must include height and weight.

- The obesity has incapacitated the patient from normal activity, or rendered the individual disabled. Physician submitted documentation must substantiate inability to perform activities of daily living without considerable taxing effort, as evidenced by needing to use a walker or wheelchair to leave residence.

- Must be between the ages of 18 and 65. (Special considerations apply if the individual is not in this age group. If the individual is below the age of 18, submitted documentation must substantiate completion of bone growth.)

- The patient must have a documented diagnosis of diabetes that is being actively treated with oral agents, insulin, or diet modification. The rationale for this criteria is taken from the Swedish Obese Subjects (SOS) study, *International Journal of Obesity and Related Metabolic Disorders*, May, 2001

- Patient must have documented failure at two attempts of physician supervised weight loss, attempts each lasting six months or longer. These attempts at weight loss must be within the past two years, as documented in the patient medical record, including a description of why the attempts failed.

- Patient must have had a preoperative psychological and/or psychiatric evaluation within the six months prior to the surgery. This evaluation must be performed by a psychiatrist or psychologist, independent of any association with the bariatric surgery facility, and must be

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specifically targeted to address issues relative to the proposed surgery. A diagnosis of active psychosis; hypochondriasis; obvious inability to comply with a post operative regimen; bulimia; and active alcoholism or chemical abuse will preclude approval.

- The patient must demonstrate ability to comply with dietary, behavioral and lifestyle changes necessary to facilitate successful weight loss and maintenance of weight loss. Evidence of adequate family participation to support the patient with the necessary lifelong lifestyle changes is required.
- Patient must be tobacco free for a minimum of six months prior to the request.
- Documentation of a current evaluation for medical clearance of this surgery performed by a cardiologist or pulmonologist, must be submitted to ensure the patient can withstand the stress of the surgery from a medical standpoint.

519.9.3.2 PHYSICIAN CREDENTIALING REQUIREMENTS

In order to be eligible for reimbursement for bariatric surgery procedures, physicians must: submit the following to the provider enrollment unit:

- Evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.
- Documentation that the physician is working within an integrated program for the care of the morbidly obese that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training and psychological/psychiatric assistance as needed.
- Assurances that surgeons performing these procedures will follow the guidelines established by the American Society for Bariatric Surgery including:
    - Credentials to perform open and laporoscopic bariatic surgery
    - Document at least 25 open and/or laporoscopic bariatic surgeries within the last three years

519.9.3.3 PHYSICIAN PROFESSIONAL SERVICES

Professional services which will be required of the physician performing bariatric surgery include the surgical procedure, the 90-day global post-operative follow-up, and a 12 month assessment period which includes the following: medical management of the patient‘s bariatric care, nutritional and personal lifestyle counseling, and a written report at the end of the 12 month period consisting of: an assessment of the patient‘s weight loss to date, current health status and prognosis, and recommendations for continuing treatment. That 12 month assessment report must be submitted to the patient‘s attending or primary care physician, as well as to the Bureau for Medical Services.

While the bariatric surgeon‘s association with the patient may end following the required 12 month

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follow-up, the patient's continuing care should be managed by the primary care or attending physician throughout the patient's lifetime.

519.9.3.4 REIMBURSEMENT

The physician performing the bariatric surgery procedure will be reimbursed through the existing RBRVS payment methodology for the surgical procedure. Reimbursement includes a post-operative follow-up for the global period of 90 days. For the remainder of the required 12 month follow-up period and assessment, the bariatric surgeon may submit claims using the appropriate evaluation and management procedure code. After completion of the required 12 month evaluation period, the patient may be followed-up and medically managed either by the surgeon or primary care physician utilizing appropriate E & M procedure codes.

519.9.3.5 COVERED BARIATRIC PROCEDURES

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty.

43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty.

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy.

43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption.

43848 Revision of gastric restrictive procedure for morbid obesity (separate procedure). (This is only for correction of serious complications caused by the procedure within the first 6 months postoperatively, and is not meant to indicate that a patient can have a second procedure due to failure to lose weight from a prior procedure.)

Note: Only one procedure will be covered per lifetime. Those failing to lose weight from a prior procedure will not be approved for a second one.

519.3.6 NON-COVERED BARIATRIC PROCEDURES

The following procedures will not be covered by West Virginia Medicaid Program:

- Mini-gastric bypass surgery
- Gastric balloon for treatment of obesity
- Laparoscopic adjustable gastric banding

519.9.4 EXCLUDED SURGICAL PROCEDURES

Following the guidelines of the Correct Coding Initiative, procedures that would be billable when they are the only billed services become non-covered when billed in conjunction with other surgical procedures. Examples of these situations are:

- Surgical procedures incidental to the primary procedure. Examples of incidental surgeries are appendectomies, lyses of adhesions, and scar revisions. If incidental surgeries are billed and subsequently paid, the physician must return the payment to the BMS.
- Exploratory laparotomies performed at the same time as another surgical procedure in the same anatomical region. The exploratory laparotomy is included in the fee paid for the surgical procedure.
- Surgical destruction during a procedure. Payment for surgical destruction is included in the global fee for the surgery. Under special circumstances, where methods of destruction substantially alter

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the standard management of the member's condition, consideration will be given for separate coverage. These special circumstances would require prior authorization.

WV Medicaid does not cover elective cosmetic surgery (surgery that has as its primary purpose the improvement of the member's appearance and is not medically necessary). Many of these procedures may be covered when provided for treatment of congenital anomalies, traumatic injury, or a disease process. Documentation supporting the medical necessity for the procedure must be maintained in the member's record. Examples of cosmetic surgery are otoplasty, rhinoplasty (except to correct internal nasal deformity and must be approved in advance), nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathia, malar augmentation, dermabrasion, certain skin grafts, lipectomy, mastopathy, liposuction, breast augmentation, replacement of breast implants used for purposes other than reconstruction due to cancer, and removal of tattoos.

WV Medicaid does not cover Stretta procedure, lung volume reduction surgery, pancreatic islet cell transplant, and living donor hepatic transplant.

WV Medicaid does not cover experimental, research, or investigational medical and surgical procedures, including those identified by the United States Department of Health and Human Services, nor transportation for any of these services. Minimally, the following criteria are considered in determining whether a procedure is experimental, research, or investigational:

- The current and historical judgment of the medical community as evidenced by medical research, studies, journals, or treaties
- The extent to which Medicare and private insurers recognize and cover the procedure
- The current judgment of experts and specialists in the medical specialty in which the procedure is applicable or performed
- The effectiveness of the procedure as predicated by the number of times the procedure has been performed, the mortality rate, the long-term prognosis, the reputation of the physicians and hospitals performing the procedure, among other factors.

519.10 OBSTETRICAL AND GYNECOLOGICAL SERVICES

A wide range of Obstetrical and gynecological services are covered under WV Medicaid including preventive, pregnancy related, and disease related services.

519.10.1 MATERNITY SERVICES

The practitioner may provide all or a portion of antepartum care, delivery, and/or postpartum care.

Antepartum care includes the initial and subsequent history, physical examinations, monitoring of weight, blood pressure, fetal growth and development, heart tones, and routine chemical urinalysis. During a normal pregnancy, prenatal visits are monthly up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Procedure code 99213TH must be billed for each individual pre-natal visit. Adjustments to the frequency may be made based on documentation of maternal and fetal risk factors.

Delivery services include admission to the hospital, admission history and physical examination, management of labor, vaginal delivery with or without episiotomy and with or without forceps, or cesarean delivery and postpartum care provided in the hospital. Postpartum care during the confinement for delivery is not separately billable.

Postpartum care is normally included in the payment for the delivery unless performed by a

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practitioner other than the delivering practitioner. Postpartum care cannot be billed using 99213TH.

Visits or services for medical conditions unrelated to prenatal care may be billed using the appropriate procedure code along with the appropriate modifier: -25, -59, or -79. The diagnosis code reflecting the unrelated condition must appear on the claim and the description of the services must be related in the member's medical record.

WV Medicaid covers the following CPT codes for maternity services:

- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59410 - Vaginal delivery only, including postpartum care
- 59412 - External cephalic version, with or without tocolysis
- 59414 – Delivery of placenta (separate procedure)
- 59430 - Postpartum care only (separate procedure for six to eight weeks post-delivery)
- 59514 - Caesarean delivery only
- 59515 - Cesarean delivery only, including postpartum care
- 59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps) including postpartum care
- 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

WV Medicaid will not reimburse for the following global maternity-related procedure codes or the following bundled services codes:

- 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59425 - Antepartum care only; 4-6 visits
- 59426 - Antepartum care only; seven or more visits
- 59510 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

  The preceding bundled maternity codes are not reimbursed because Medicaid members often change physicians or managed care entities during maternity care, which greatly complicates or precludes the use of global codes to pay for maternity care.

59414 will only be reimbursed when an infant is delivered by someone other than the provider (i.e., nurse or paramedic) and the provider delivers the placenta and reviews the case. This code cannot be billed along with a vaginal or cesarean section delivery code.

The following multiple surgical rules govern the coding of, and reimbursement for, deliveries involving multiple babies:

- Both babies delivered vaginally: CPT 59409 (Twin A) and 59409-51 (Twin B)
- One twin delivered vaginally and one twin delivered by C-section: CPT 59409-51 (Twin A) and

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59514 (Twin B)

- Multiple babies delivered by C-section (CPT 59514). This code must be used only once because only one caesarian procedure was performed.

CPT 99440 is used for newborns requiring life support following delivery; specifically, when providing positive pressure ventilation and/or chest compressions in the presence of inadequate ventilation and/or cardiac output.

Attendance at ―delivery" (when requested by the delivery physician) and initial stabilization of newborn (CPT 99436) is covered by WV Medicaid. The delivering physician must document the request in the member's medical record and explain the reasons for the request. The statement ―high risk delivery" is **not** sufficient to document the procedure's necessity.

Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output (CPT 99440) cannot be billed with 99436.

519.10.1.1 OBSTETRICAL ULTRASOUNDS/FETAL NON-STRESS TESTS

WV Medicaid covers obstetrical ultrasounds and fetal non-stress tests when medically necessary and in accordance with the criteria for high risk pregnancies established by the American College of Obstetrics and Gynecology (ACOG). Obstetrical ultrasounds on a routine basis or for determining the gender of the fetus are not covered.

Documentation of medical necessity for all ultrasounds and fetal non-stress tests is required. An office visit on the same date of service as an ultrasound or fetal non-stress test performed in the physician's office is billable only if a distinct, separately identifiable reason for the visit is documented in the member's medical record. The E&M procedure code must be billed with modifier 25.

If an ultrasound or fetal non-stress test in the physician's office, a separate interpretation of the results must be documented in the member's medical record in order to obtain reimbursement.

Any ultrasound performed before the 17th week of pregnancy must have documentation of medical necessity since there is a high false negative rate (Guidelines for Ultrasound as Part of Routine Prenatal Care, Journal of the Society of Obstetricians and Gynecologists of Canada, No. 28, 1999).

Medicaid follows ACOG Guidelines for fetal non-stress testing. Since testing prior to 28 weeks is not accurate, such testing will require documentation of medical necessity. Documentation of medical necessity must be retained in the member's medical record. ***These tests will be monitored for over utilization or inappropriate use.***

A referral from the PAAS PCP is not required for maternity services provided to PAAS members.

519.10.2 PREGNANCY TERMINATION

WV Medicaid covers pregnancy termination when the attending physician determines, in consultation with the member, that termination is medically advisable. Before making the determination, the physician must discuss the possible pregnancy termination with the member in light of her age, physical, emotional, psychological, and familial circumstances.

Certification by the physician is required for payment. A copy of the certification form to terminate a pregnancy can be accessed through the Unisys webpage which is located at www.wvmmis.com. The completed and signed form must accompany all claim forms for pregnancy terminations.

Attachment 5 lists the CPT codes physicians must use to report pregnancy termination procedures

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and summarizes the services represented by these codes.

519.10.2.1 DRUG RU-486 (MIFEPREX)

WV Medicaid covers pregnancy termination using the drug RU-486 subject to the physician's compliance with all of the federal and manufacturer's requirements listed below. An appropriately executed physician certification for pregnancy termination form must be submitted for this service. The physician is required to maintain, on file at their practice location and available for review upon request, a copy of the order form/prescriber's agreement, certifying compliance with all manufacturer's prescribing requirements, including guidelines for use of this product, and an agreement, signed by the Medicaid member prior to the treatment, acquiescing to the procedure.

Reimbursement for pregnancy termination utilizing RU-486 includes:

- A visit for administration of three Mifepristone pills
- A second visit two days later for administration of Misprostol, if termination of the pregnancy cannot be confirmed
- A follow-up visit within two weeks to ensure and document that the abortion is complete.

Under federal law, Mifeprex must be provided by or under the supervision of a physician who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately
- Ability to diagnosis ectopic pregnancies
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and are able to assure member access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.

Following completion of the pregnancy termination service, the physician may bill using CPT codes S0190, S0191, and/or S0199.

Payment for S0199 includes laboratory services and ultrasounds. If these services are referred by a physician, the physician must pay the provider of the service and Medicaid cannot be billed.

If it is decided during the first visit that the member is not a candidate for this type of pregnancy termination, the physician may bill the appropriate E&M code.

519.10.3 STERILIZATION

Based on Federal Social Security Act requirements, WV Medicaid covers the sterilization of a male or female member if the following conditions are met:

- The member is at least 21 years of age at the time consent is given; i.e., when he/she signs and dates the consent form.
- At least 30 days, but not more than 180 days, have elapsed since the date of informed consent and the date of sterilization.
- The two exceptions to these conditions are:
  - Premature Delivery - A member may be sterilized at the time of premature delivery if informed consent was obtained at least 30 days before the expected date of delivery AND at least 72 hours have passed from the time the consent form was signed to the time of sterilization.
  - Emergency Abdominal Surgery - A member may be sterilized at the time of emergency abdominal surgery if at least 72 hours have passed since the informed consent was given (Cesarean sections are not emergency abdominal surgery for purposes of this exception).

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In order to establish the 72-hour period, the specific time of the signing of the consent form is necessary. If premature delivery is indicated on the consent form, the member's expected delivery date must be indicated. If emergency abdominal surgery is indicated, the circumstances of the emergency must be explained. If both cases, the space for the condition that does not occur must be crossed out.

Informed consent is the voluntary assent from an individual that he/she has been informed orally of, and given the opportunity to, question and receive satisfactory answers concerning sterilization. Informed consent may not be obtained while the member is in any one of the following conditions:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substance that affects the individual's awareness
- Under anesthesia.

The consent form previously prescribed and distributed by the United States Department of Human Services (DHHS) should be used. The "State Agency Copy" of the consent form must be submitted to P.O. Box 2254, Charleston, WV 25328-2254. WV Medicaid uses the sterilization consent form deve1oped/approved by the Federal DHHS. A copy of the sterilization consent form can be accessed through the Unisys webpage which is located at www.wvmmis.com. It must be signed and dated by the:

- Member who wants to be sterilized
- Interpreter, if applicable
- Person who obtained the consent
- Physician who performed the sterilization procedure.

On the sterilization consent form:

- The interpreter's statement must be completed only if the member does not understand the language on the consent form or the language used by the person obtaining consent and needs an interpreter. If this section is used, the interpreter must sign and date the consent form, using the date informed consent was given.
- The physician must fully complete the ―Physician's Statement" section.
- The ―Date of Surgery" must list the specific date; "to be scheduled" and "after delivery" is not acceptable.
- The ―Date of Physician's Signature" must occur within one day of the date of surgery.

The person who obtains the informed consent must answer any questions the member may have concerning the procedure and provide orally the following information to the member who is considering sterilization:

- Advise the member he/she may withhold or withdraw consent at any time prior to the procedure without affecting his/her right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which he/she may otherwise be entitled,
- Explain alternate methods of family planning with emphasis that sterilization is considered to be irreversible,
- Explain thoroughly all forms of sterilization procedures with special emphasis on the specific procedure being planned for this individual,
- Explain thoroughly the specific sterilization procedure to be performed and describe fully its advantages and disadvantages, including a thorough discussion of the discomforts and risks that

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may accompany or follow the procedure. The explanation must include a description of the effects of the anesthetic to be used,

- Advise that the sterilization will not be performed for at least 30 days unless an exception (i.e., premature delivery or emergency abdominal surgery) applies,
- Make a copy of the consent form available to the individual,
- Make suitable arrangements to ensure the above information is effectively communicated to any individual not understanding the language on the consent form and to any individual who is handicapped in any way that would prevent a full understanding of the procedure (i.e., deaf or blind). If necessary, make arrangements for an interpreter prior to the consent form being signed. The individual must also be permitted to have a witness of his/ her choice present when consent is given,
- Follow any additional State or Local laws.

The sterilization consent may be sent with the claim or separately. Photocopies or faxes of the Sterilization Consent Form are acceptable. The photocopy or fax must be an exact copy of the actual form in the member's record. If the consent form is not attached or on file, all claims with a sterilization diagnosis and/or a sterilization procedure will ―pend" for review. If a consent form is not received within 60 days, the claim will deny.

Procedures may have been done unilaterally, but did not render the member sterile because the other tube/ovary had not been previously removed. These must be billed on paper with the patient history, physical exam, pathology report and operative report attached to the claim and sent to P.O. Box 2254, Charleston, WV 25328-2254.

No Medicaid payments will be made unless the member has voluntarily given informed consent. WV Medicaid does not cover sterilizations under any of the following situations:

- Member is under 21 years of age at the time the consent form is signed
- Member is mentally incompetent
- Member is institutionalized
- Sterilization by court order
- Hysterectomy solely to achieve sterilization.

Attachment 6 lists the CPT codes physicians must use to report sterilization procedures and summarizes the services represented by these codes.

The requirements in this section also apply to Managed Care entities which provide services to Medicaid members.

519.10.4 HYSTERECTOMY

WV Medicaid covers hysterectomies performed for medical reasons regardless of the member's age. Federal regulations ensure that women can make informed and voluntary choices and emphasize a hysterectomy is not an appropriate or acceptable means of sterilization. A medically necessary hysterectomy is covered when:

- The person who performs the hysterectomy has informed the member and her representative, if any, orally and in writing the hysterectomy will render the member permanently incapable of reproduction
- The member or her representative has signed and dated the hysterectomy acknowledgment form.

The hysterectomy acknowledgment form will be accepted by WV Medicaid regardless of whether it

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was signed by the member before or after the procedure. However, when the member signs the acknowledgment form after the surgery, the member's records must contain language which clearly states she was informed before surgery of the consequences of the surgery (i.e., it would render her sterile) and that the member was competent to sign.

WV Medicaid does not cover a hysterectomy that was performed solely to render a member incapable of reproduction; even when there are other indicators for a hysterectomy.

The physician who performs a medically necessary hysterectomy must complete and sign an acknowledgment form except under the two following conditions:

- The member was already sterile when the hysterectomy was to be performed
- The member requires a hysterectomy because of a life-threatening emergency (e.g., the member is in imminent danger of loss of life) for which the physician determines prior acknowledgment is not possible.

The physician who performs the hysterectomy must certify in writing on the Physician's Certification Form that the exception conditions are met. If the member was already sterile at the time of the hysterectomy the physician must indicate the cause of the sterility. If the hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgment was not possible, the nature of the emergency must be documented. An example of a life-threatening emergency that does not require an acknowledgment statement is a hysterectomy necessitated by a perforated uterus or an uteroplacental apoplexy.

WV Medicaid accepts photocopies or faxes of the Hysterectomy Acknowledgement Form as acceptable documentation. A photocopy or fax must be an exact copy of the actual signed form and contain all the required signatures. The provider must retain the original copy of the Hysterectomy Acknowledgement Form. This form, as well as the Physician's Certification Form to perform a hysterectomy, can be accessed through the Unisys webpage which is located at www.wvmmis.com.

The acknowledgment form or physician certification may be submitted with the claim or separately. If the appropriate form is not on file or submitted with the claim, it will suspend for review. No service related to the hysterectomy will be reimbursed unless appropriate documentation is received. If the documentation is not received within 60 days, the claim will deny.

If a physician performs a hysterectomy on an individual who later becomes eligible for Medicaid and Medicaid eligibility is retroactive to the date on or before the date which the hysterectomy was performed, the physician may bill Medicaid for the surgery if he/she certifies in writing:

- The member was informed before the operation the hysterectomy would make her permanently incapable of reproduction
- The member was already sterile and the cause of the sterility
- The hysterectomy was performed under a life-threatening emergency for which he/she determined prior acknowledgment was not possible. The physician must describe the nature of the emergency.

Attachment 7 lists the CPT codes physicians must use to report a hysterectomy and summarizes the services represented by these codes.

519.10.5 FAMILY PLANNING SERVICES

Family Planning services may be provided as part of the practitioner's routine care. If the practitioner does not wish to provide these services, the member must be informed they may go to any participating practitioner offering these services.

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WV Medicaid does not make separate payment for obtaining a Pap smear. This is included in the E&M service. Laboratory services for Pap smears and other medically necessary tests are covered with payment to the performing pathologist and laboratory respectively.

Attachment 8 contains charts listing diagnostic and procedure codes covered for family planning services.

519.11 SPECIALTY SERVICES

Specialty Services refers to services provided to Medicaid members by specialists in a specific field of medicine.

519.11.1 PAIN MANAGEMENT

WV BMS covers a variety of pain management treatment modalities. Prior authorization is required if more than three months of treatment is necessary. Regardless of the treatment for pain management, the following information must be submitted with the physician's order and request for prior authorization:

- Number of additional visits and weeks of treatment requested, such as three visits a week for four weeks
- Progress the member has already made toward short-term and long-term goals since therapy began
- Reasons for short-term and long-term goals requiring extended services
- Treatment plan to reach goals
- Estimated number of visits to reach goals

WV Medicaid does not cover hypnosis, acupuncture, prolotherapy, any treatment not approved by the FDA or therapy not accepted as effective by the medical community for chronic pain managment.

DOCUMENTATION REQUIREMENTS

Documentation in the hospital's records and/or the therapist's records must contain the following information about the pain management a member received:

- Diagnosis – The diagnosis must document the member's need for pain management. A brief description of the member's medical condition may be necessary.
- Date of injury or onset of illness, if applicable.
- Name and Medicaid provider number of the physician prescribing the pain management and the physician's order itself.

Documentation of the service provided on the date billed must substantiate fully the amounts charged to WV Medicaid. The documentation must be clear, concise, demonstrate medical necessity and be made available upon request to the BMS or its representative.

519.11.1.1 OSTEOPATHIC MANIPULATIONS

WV Medicaid covers the following osteopathic manipulative services:

- 98925 Osteopathic manipulative treatment, one to two body regions involved
- 98926 Osteopathic manipulative treatment, three to four body regions involved
- 98927 Osteopathic manipulative treatment, five to six body regions involved
- 98928 Osteopathic manipulative treatment, seven to eight body regions involved
- 98929 Osteopathic manipulative treatment, nine to ten body regions involved.

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Body regions include head, cervical, thoracic, lumbar, sacral, pelvic, lower and upper extremities, rib cage, abdomen, and viscera.

An E&M code cannot be billed with any manipulative service unless it is related to a distinctly separate service. However, if the manipulative service is distinctly a separate service, then modifier 25 must be used and the service documented in the patient's record.

Medicaid coverage is limited to a combined total of 40 manipulative treatments (not per procedure code) in a 12-month period.

519.11.1.2 PARAVERTEBRAL FACET JOINT BLOCK AND DENERVATION

Prior authorization is required if treatment is required more often than every three months. Treatment of more than three levels per side is considered excessive and will be denied. Use the LT and RT modifiers to indicate a unilateral procedure at any level. If both sides of any level are treated, use the -50 modifier. The fluoroscopy code, CPT 76005 may be used with these procedures. When more than one drug, i.e. anesthetic or steroid, is injected into the same site, only one injection codes is allowed.

The following chart lists the covered services in this pain management modality.

Procedure Code	Description	Coverage
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level	One unit per date of service
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	Two units per date of service
64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level	One unit per date of service
64476	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	Two units per date of service
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level MED:CIM 35-17	One unit per date of service

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Procedure Code	Description	Coverage
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) MED:CIM 35-17	Two units per date of service
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level MED:CIM 35-17	One unit per date of service
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) MED:CIM 35-17	Two units per date of service
All of the above listed procedure codes are subject to the bilateral modifier (50).		

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519.11.2 WOUND THERAPY

WV Medicaid covers a variety of modalities for wound care. Wound care encompasses local treatment such as topical medications, dressings, pressure relief, tissue healing therapies or debridement. This may also involve systemic treatment to improve underlying nutritional needs, infections, circulatory limitations or management of other contributory factors. Wounds are classified according to the following:

- Stage I Non-blanchable erythema or superficial redness with skin intact
- Stage II Partial thickness skin loss involving epidermis and/or dermis
- Stage III Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- Stage IV Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

Indications and Limitations of Coverage/Medical Necessity

The following criteria must be met for wound care to qualify for reimbursement by WV Medicaid:

- The services must be medically necessary in the treatment of the member‘s condition. Medical necessity is defined as:
  - The status of the dermal surface and/or wound is such that the treatment will make a significant improvement in the wound in a reasonable and generally predictable period of time.
  - There is an expectation that treatment will substantially effect tissue healing and viability, reduce or control tissue infection, remove necrotic tissue or prepare that tissue for surgical management.
  - The member‘s expected restoration potential must be significant in relation to the extent and duration of treatment required to achieve that potential. If wound closure is not a goal then the expectation is to optimize recovery and establish an appropriate non-skilled maintenance program.
- For criteria not otherwise listed, the BMS follows Medicare‘s criteria for the specified service.

Clinical Indicators

Some clinical indicators that may be used to determine medical necessity are:

- A history of slow-to –heal wounds
- Significant health factors that impair recovery
- Multiple, severe or extensive soft tissue injuries and/or wounds
- Increasing severity of tissue impairment, infection, or necrosis, undermining or an increase in size.

Documentation

Medical records should include the following information:

- Practitioner‘s order: Services may only be provided on the basis of a practitioner‘s written, signed and dated order
- Evaluation: The purpose of a wound care evaluation is to determine both the medical necessity and the appropriate type of skilled service. The evaluation should demonstrate the following:

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- The type of tissue involvement; the severity of tissue destruction; undermining or tunneling, necrosis, infection, or evidence of reduced circulation. If infection has developed, the member's response to this infection should be described.
- The size and depth of tissue involvement and its location
- The medical and mental condition and all health factors that may influence the member's ability to heal tissue
- The prior response to other therapies
- A determination of the appropriate treatment plan and therapeutic goal(s) including specific objectives, goal-specific treatment plan and the expected frequency and duration of the skilled treatment
- If the wound therapy is being performed by other than a physician, (e.g., home health agency, physical therapist), an evaluation must be performed by a licensed practitioner who must see the member at least once every thirty days during treatment.

- Treatment Plan: This plan must include specific functional goals and a reasonable estimate of when they will be reached. The modalities/procedures, frequency, and duration of treatment must be defined in the plan. This plan must be reviewed and recertified by the ordering practitioner every 30 days. If this therapy is performed by other than the attending practitioner, the plan must be reviewed and recertified by the attending provider every 30 days and should be completed by licensed professional only.
- Treatment Notes: Documentation for each treatment should specify date and time, types of treatment, status of the member's contributory factors to the wound (i.e., status of infection or level of diabetic control), member and wound/or tissue status and the response to the treatment.
- Progress Reports: Weekly and monthly summaries should systematically describe the need for skilled service. Each progress report should describe changes in risk, severity or size of the wound with a comparison to the previous week or month. If the goals for that week or month are not met, or the wound status has worsened, then describe or detail any associated factors that may account for this condition. If the wound has worsened, there should also be documentation that the physician has been informed and any needed changes in the wound care protocol have been made. A photograph or wound drawing may be useful in reporting the status of the wound. There should be documentation that the provider has been informed if the therapy is administered by other than the attending provider.
- Discharge Summary: The final report that provides the measurement(s) and description of the dermal surface/wound at the time of admission or initiation of treatment and at the time of discharge, and the reason(s) skilled services are no longer required. The summary specifies all the discharge recommendations, the member's or caregiver's capability to care for the residual wound, and prevent further dermal lesions.

The following modalities for wound treatment are not covered by BMS:

- Procuren and other platelet releasate
- Topical Hyperbaric Oxygen Therapy
- Non-contact Normothermic Wound Therapy (NNWT). NNWT promotes wound healing by warming a wound to a predetermined temperature. (A6000, E0231, E0232)
- Maggot therapy
- Alloderm, Biobrane (considered a dressing), Celaderm (not FDA approved), Epicel, EZ Derm, Integra (non-human dermal template, Q0182), Laserskin (available in Europe only), Oasis collagen dressings (A6021-A6024)
- Electrical stimulation and electromagnetic therapy (G0281, G0282, G0283, G0295, G0329) for

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wound care are not covered by BMS. (97014 and 97032 are not covered procedure codes for wound therapy.)
- Monochromatic Infrared Therapy (the Anodyne Therapy System) is not covered (E0221 and 97026).

Covered Services

- Wound repairs – local anesthesia is included in reimbursement of this service.
  - Wound closure using tissue adhesives only
  - Wound repair – The CPT procedure used to report the repair is dependent on the location of the wound, classification of the repair and length of the repair. WV Medicaid has not adopted CPT Manual definition of simple intermediate and complex repair, but follows those of CMS. WV Medicaid defines these as follows:
    - Simple repair procedure code should be used if the wound involves the skin and subcutaneous tissue
    - Intermediate repair should be used to close one or more of the deeper fascial layers in addition to the skin and subcutaneous tissue.
  - Wound closure with steri-strips or butterfly band aids is included in the E&M service and not separately billable.
  - Wound repairs of specific anatomic parts such as lips or eyelids have pertinent specific codes, as do repairs of internal structures.
- Debridement
  - Debridement performed by licensed physical therapists should be coded with 97597 and 97598 which represent non-surgical debridement, not requiring anesthesia. This service can also be provided by the attending provider.
    - CPT 97597- Removal of devitalized tissue from wound(s), selective debridement, without anesthesia, (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application (s), wound assessment, and instructions for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters.
    - CPT 97598- Removal of devitalized tissue from wound(s), selective debridement , without anesthesia,(e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application (s), wound assessment, and instructions for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters.
  - The status of the wound(s) including size should be adequately documented.
  - Debridement in this sense is covered only to promote wound therapy, and should not be reported in the same claim with the surgical debridement codes, 11040 – 11044.
  - Debridement during a repair procedure is bundled with the repair procedure.
  - Debridement of the wound is included in all repair codes. If in rare cases there is greater amounts of devitalized tissue removed, significant and extensive debridement performed in addition to the wound repair, modifier 59 could be added to the debridement code. Documentation in the member's record must substantiate the use of a debridement code with the 59 modifier in addition to the repair code.

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- Codes 11010 – 11012 are used only for debridement associated with open fractures and open dislocations. These codes are not used for treatment of ulcers or wounds that are not associated with open fractures/open dislocations. Documentation must substantiate the medical necessity for the use of debridement codes in these situations.

- Negative pressure vacuum pump for wound healing – WV Medicaid follows Medicare criteria for the medical necessity of this modality.
- Regranex:
  - This agent is prescribed to the member when:
    - There is a diagnosis of a diabetic neuropathic ulcer, extending into the subcutaneous tissue, on the lower extremity
    - There is no evidence of infection in the wound and anti-infective therapy is being employed
    - The wound is full thickness (Stage III or IV)
    - The wound is free of necrotic debris
    - The member has adequate circulation in the area of the wound
    - Off-loading of pressure to the wound has been accomplished
    - Member and/or caregiver have been instructed on the appropriate application, storage and cost of Regranex
    - Regranex is prescribed appropriately (once-daily application, with no concomitant topical medications).
  - Prior authorization for quantities of Regranex that exceed 3 tubes in a 90-day period or therapy that extends beyond 12 weeks will be granted only if:
    - The above conditions have been met, and
    - The wound size requires additional quantities of gel to provide adequate coverage, as directed by the manufacturer. (Each square centimeter of ulcer surface requires 0.25 – centimeter length of gel)

or

    - There is evidence of healing in the initial 90-day period and additional application is required for complete healing.

- Hyperbaric Oxygen Therapy (HBOT). Systemic HBOT is covered for the treatment of non-infected diabetic ulcers when the criteria are met. See Section 519.12.2 of this chapter for information on HBOT.
- Engineered skin – Apligraf and Dermigraft are covered for the treatment of diabetic ulcers. WV Medicaid follows CMS criteria for medical necessity and reimbursement of these agents. Orcel and Transcyte are analogues used for burns.
- Miscellaneous dressings are covered when listed as covered in the DME manual. Dressings and supplies for office procedures are part of the global fee for the procedure and not separately billable.

519.11.3 PSYCHIATRIC SERVICES

Outpatient psychiatric services must be registered with BMS‘ contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master‘s Level Social Worker, or Master‘s Level counselor in their employ must also be registered and assigned an authorization number by the contracted agent.

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Psychiatric services are not the responsibility of the managed care organization, nor do they require PAAS approval prior to rendering services. Claims must be billed to Medicaid for reimbursement.

See **Attachment 9** for policies and regulations related to outpatient psychiatric services.

519.11.4 LABORATORY AND PATHOLOGY SERVICES

WV Medicaid covers various pathology services and offers a comprehensive scope of basic and extended clinical laboratory services to Medicaid members, subject to medical necessity and appropriateness criteria and prior authorization requirements.

519.11.4.1 LABORATORY SERVICES

A practitioner may bill for laboratory services if the practitioner owns a CLIA certified lab, or if the practitioner has CLIA certification to perform CLIA waived testing. CLIA waived tests (a list of which are available on the CMS CLIA website) are tests that can be performed within an office laboratory setting, but for which a CLIA certification is still necessary. Provider-performed Microscopy Services (PPM) also require certification. These tests include pin worms preps, koh scrapings etc. Physicians billing waived laboratory tests or PPM tests must have CLIA certification on file with the Medicaid Program.

Separate charges made by practitioners for drawing or collecting specimens are allowable whether or not the specimens are referred to outside laboratories. Payment is made only to those extracting the specimen. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. A specimen collection fee is allowed when drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

NONCOVERED LABORATORY RELATED SERVICES:

- Routine reflex testing is not covered. Reflex testing occurs when initial test results are positive or outside normal parameters and indicate that a second related test is medically appropriate. This is covered only when specifically ordered by the physician, that a second test would be performed only under conditions clearly indicated on the requisition.
- Separate payment will not be made for obtaining a blood sample through a finger, heel or ear stick.
- Separate charge for collecting a Pap smear or throat smear are not covered, as these services are included in the E&M visit.
- A practitioner may not bill an office visit if the sole purpose of the visit was to obtain laboratory work.
- A practitioner may not bill a laboratory fee for conveying or interpreting the laboratory results to the patient. This is considered part of the E&M visit for which the patient sought medical care.

519.11.4.2 PATHOLOGY SERVICES

A pathologist will only be paid for the professional component of physician pathology services. For those procedure codes that do not have a technical and professional component, do not bill modifier 26. The CPT code for the procedure with modifier 26 is paid according to the RBRVS fee schedule. Medicaid payment for the professional component of consultative anatomical and surgical pathology

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services must be requested by an attending practitioner regarding an abnormal condition and results in a written report by the pathologist. Covered consultative services may be billed with CPT 80500 Clinical pathology consultation; limited, without review of the member's history and medical records and CPT 80502 Clinical pathology consultation; comprehensive, for a complex diagnostic problem with review of member's history and medical records.

NONCOVERED PATHOLOGY SERVICES

- Separate payment for reviews of laboratory services for quality assurance purposes.
- Autopsies - West Virginia Medicaid does not pay for autopsies and/or supervisory pathology services.
- Fertility services such as embryo/sperm collections and banking.

519.12 MEDICAL SERVICES

WV Medicaid covers the following medical services.

519.12.1 CALORIC VESTIBULAR TESTING

WV Medicaid covers up to four irrigations provided to a member on a single date of service. The procedure code for this service, 92543, is divided into technical and professional components. A physician must both perform and interpret the ear irrigation(s) in order to bill the total service. When performing only one component, the physician must bill 92543-TC for the irrigation or 92543-26 for the interpretation. **When providing both, this service must not be unbundled.**

519.12.2 HYPERBARIC OXYGEN THERAPY (HBOT)

WV Medicaid covers hyperbaric oxygen therapy provided in an inpatient or outpatient hospital setting for certain medical conditions identified below.

For WV Medicaid to reimburse hyperbaric oxygen therapy, the physician must be in constant attendance during the entire procedure and carefully monitor the member during therapy and be immediately available if a complication develops. (The physician must be on site during the entire treatment.) In general, hyperbaric oxygen does not require prior authorization, but a physician's order and documentation for the treatment's medical necessity must be kept in the member's medical record. Hyperbaric oxygen therapy must not be indefinite in duration. If HBOT is medically necessary beyond two months, prior authorization is required from BMS' contracted agent regardless of the member's condition. The physician's order and medical documentation that substantiates medical necessity must be faxed or mailed to BMS' contracted agent.

Coverage of hyperbaric oxygen therapy is limited to members with the following medical conditions and diagnosis codes:

- Acute carbon monoxide intoxication (ICD-9-CM diagnosis 986)
- Decompression illness (ICD-9-CM diagnosis 993.2, 993.3)
- Gas embolism (ICD-9-CM diagnosis 958.0, 999.1)
- Gas gangrene (ICD-9-CM diagnosis 040.0)
- Acute traumatic peripheral ischemia. Hyperbaric oxygen therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb or life is threatened. (ICD-9-CM diagnosis 902.53, 903.01, 903.1, 904.0, 904.41)
- Crush injuries and suturing of severed limbs. As in the previous condition, hyperbaric oxygen therapy would be an adjunctive treatment when loss of function, limb or life is threatened. (ICD-9-

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CM diagnosis 927.00-927.03, 927.09-927.11, 927.20-927.21, 927.8-927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0-929.9, 996.90-996.99).

- Progressive necrotizing infections (necrotizing fasciitis) (ICD-9CM diagnosis 728.86). Meleney ulcers (necrotizing soft tissue infections that are a result of clostridium or synergistic aerobic-anaerobic infection).
- Acute peripheral arterial insufficiency (ICD-9-CM diagnosis codes 444.21, 444.22, and 444.81).
- Preparation and preservation of compromised skin grafts (not for primary management of wounds) (ICD-9-CM diagnosis 996.52; excludes artificial skin graft). Hyperbaric oxygen therapy use is limited to the loss of viability of full thickness, free vascular, or pedicle flap grafts. Hyperbaric oxygen therapy must be used after signs and/or symptoms indicate compromise of graft. It is not covered for split thickness grafts or the initial preparation of the body site for a graft.
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management (ICD-9-CM diagnosis 730.1).
- Osteoradionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis 526.89).
- Soft tissue radionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis 990).
- Cyanide poisoning (ICD-9-CM diagnosis 987.7, 989.0).
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment, (ICD-9-CM diagnosis 039.0-039.4, 039.8, 039.9).
- Lower extremity diabetic wound if the following criteria are met:
  - The member has type 1 or 2 diabetes and has a lower extremity wound that is due to diabetes. (ICD-9 diagnoses codes 250.70-250.73, 250.80-250.83, 707.0, 707.10, 707.12-707.14, and 707.19);
  - The member has a wound classified as Wagner grade III or higher; and
  - The member has failed an adequate course of standard wound therapy. The use of HBOT will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in members with diabetic wounds includes:
    - Assessments of a member's vascular status and correction of any vascular problems in the affected limb if possible,
    - Optimization of nutritional status,
    - Optimization of glucose control,
    - Debridement by any means to remove devitalized tissue,
    - Maintenance of clean, moist bed of granulation tissue with appropriate moist dressings,
    - Appropriate off-loading,
    - Necessary treatment to resolve any infection that might be present,

    Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBOT. Continued treatment with HBOT is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

The only WV Medicaid-covered indications for HBOT are those specified above. No program payment may be made for any conditions other than those listed above.

The provider must code to the highest level specified in the ICD-9-CM, (e.g., fourth or fifth digit). However, correct use of an ICD-9 code does not assure coverage of a service.

BILLING CODES

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The following procedure codes are used to bill for hyperbaric oxygen therapy:

- Physician - 99183 Physician attendance and supervision of hyperbaric oxygen therapy, per session. (Physician billing is per session, not per minute.)
- Hospital - C1300 Hyperbaric oxygen under pressure, full body chamber, per 30-minute intervals. Separate payment for inpatient hyperbaric oxygen therapy is not made because payment is in the Diagnosis Related Group (DRG) payment rate.

The amount of time billed includes only the time the member spends in therapeutic pressure. Billed time must not include descent or ascent time or air-break time.

DOCUMENTATION REQUIREMENTS

Medical documentation to support the conditions for which hyperbaric oxygen therapy is provided must include:

- An initial assessment including a detailed medical history and physical exam
- Physician progress notes
- Any communication between physicians detailing past or proposed treatments
- Treatment records for hyperbaric oxygen therapy
- Culture reports to confirm the infection status of the member
- Definitive x-ray findings and positive culture to confirm the diagnosis of osteomyelitis
- Definitive x-ray findings to establish the diagnosis of osteoradionecrosis
- For soft tissue radionecrosis, clinical photographs of the necrotic site must be available in the medical record
- Documentation must support the continued efficacy and need for treatment.

The need for more than one service daily will be reviewed.

PHYSICIAN CREDENTIALS

A physician must be credentialed by the hospital in which the therapy is being performed, including hyperbaric medicine, management of acute cardiopulmonary emergencies, and placement of chest tubes.

Credentialing includes the following minimum requirements:

- Training, experience, and privileges within the institution to manage acute cardiopulmonary emergencies, including advanced cardiac life support and emergency myringotomy.
- Completion of a recognized hyperbaric medicine training program as established by either the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society with a minimum of 40 hours of training and documented by a certificate of completion
- Continuing medical education in hyperbaric medicine of a minimum of 16 hours every two years after initial credentialing.

The hospital must keep documentation of the physician‘s credentials on file.

Since hyperbaric therapy requires the physician be ACLS certified with adequate support staffing and equipment, reimbursement of this service will be restricted to the inpatient or outpatient hospital setting. **Exception: Free standing facilities must meet all credentialing requirements listed above.**

Team coverage for cardiopulmonary resuscitation must be immediately available during the operational hours of the hyperbaric chamber.

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EXCLUSIONS

Hyperbaric oxygen therapy is not covered to treat the conditions listed below. No exceptions or prior authorizations are available for any of the listed conditions.

- Cutaneous, decubitus, and stasis ulcers
- Congenital conditions, such as cerebral palsy, autism, mental retardation. Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell anemia
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome (Pick‘s Disease, Alzheimer‘s Disease, Korsakoff‘s Disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic disease
- Acute cerebral edema
- Mental retardation
- Traumatic brain injury

Topical application of oxygen does not meet the definition of hyperbaric oxygen therapy. No Medicaid payment will be made for the topical application of oxygen.

519.12.3 HIGH FREQUENCY CHEST WALL OSCILLATION, AIRWAY CLEARANCE THERAPY: RESPIRATORY VEST SYSTEM

WV Medicaid covers respiratory vest systems for eligible members including Medicaid-eligible children in the Children‘s Specialty Care Program. This devise must be prior authorized before its use can commence.

All of the following criteria must be met before consideration will be given to coverage of the airway clearance therapy/respiratory vest system:

- The devise must be prescribed by a physician (MD/DO) specializing in pulmonary or critical care medicine
- The letter requesting prior authorization and the physician‘s prescription for the devise must be in the physician‘s own words and on his/her letterhead/prescription pad. No request from the

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manufacturer's reimbursement specialist or patient advocate will be accepted. The original letter and prescription with the physician's original signature must be submitted to BMS' contracted agent.

- A diagnosis of cystic fibrosis, neuromuscular disease, or broncheictasis must be documented and associated with at least three of the following:
  - Peak flow <300 LPM
  - Sputum production of at least 30 ml per day
  - FEV1 <80% of predicted
  - FVC <50% of predicted
  - 25% decrease in small airway score (FEF 25-75%) over past year
  - For bronchiectasis, radiologic evidence of the diagnosis must be provided in addition to the three other measurements
- Failure with flutter valve and manual chest physiotherapy
- Pattern of at least yearly hospitalizations for respiratory illnesses.

Exclusions/contraindications – The respiratory vest system will not be covered if any of the following exist:

- Unstable head or neck injury
- Subcutaneous emphysema
- Bullous emphysema
- Recent skin grafts to chest
- Recent transvenous or subcutaneous pacemaker
- Chest wall pain
- Uncontrolled hypertension
- Intracranial pressure
- Pleural effusions or emphysema
- Active or gross hemoptysis
- Susceptibility to pneumothorax, pneumomediastinum, or cardiovascular instability
- Diagnosis of COPD
- Distended abdomen
- Suspected pulmonary tuberculosis
- Recent spinal injury or surgery (within the past year)
- Rib fractures
- Hemodynamic instability
- Pulmonary edema/congestive heart failure
- Bronchopleural fistula
- Bronchospasm
- Recent esophageal injury (within the past year)
- Recent epidural anesthesia (within the past year)
- Recent spinal infusion (within the past year)
- Surgical wounds
- Burns of chest wall
- Osteoporosis
- Lung contusion
- Osteomyelitis

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- Coagulopathy
- Uncontrolled airway at risk for aspiration

Other provisions:

- Only one generator per family can be covered.
- No other respiratory therapy services will be approved after approval of the respiratory airway clearance system.
- Approval of the respiratory airway clearance system will transpire only if other methods of therapy have failed. Documentation of therapies tried and the reason for failure must be kept.
- This devise will not be covered for individuals who are less than two years of age.

Covered diagnoses- The following ICD-9 diagnosis codes will be covered if they are accompanied by documentation of medical necessity and documentation that manual techniques do not work. (Use of this devise will not be covered merely because there is no one available to perform manual techniques.)

- 277.0 Cystic fibrosis
- 335.20 Amyotrophic lateral sclerosis
- 358.0 Myasthenia gravis
- 359 Muscular dystrophies
- 494 Bronchiectasis
- 518.81 Respiratory failure
- 748.61 Congenital bronchiectasis

The diagnoses listed above are the only diagnoses covered. All other diagnoses are not covered for this service.

If approved, this devise will be rented for three months (payment to go towards the purchase price or lease purchase). If applicable, modifier RR will be used to bill the rental period. Continued coverage will be dependant on a follow-up report which must include:

- The outcome – What expected goals were met?
- The number of times used daily and the duration of each treatment
- An assessment of compliance

The only billable procedure code for this service is:

- E0483 High frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each.

Payment for this service will be according to WV Medicaid Program guidelines for Durable Medical Equipment.

Questions regarding this service should be directed to WV Medicaid's contracted agent for Durable Medical Equipment.

519.12.4 CANCER SCREENING

WV Medicaid covers various types of cancer screening.

519.12.4.1 COLORECTAL CANCER SCREENING

WV Medicaid covers colorectal cancer screening tests for high risk members and for members aged 50 and over. Characteristics of the High Risk Individual at high risk for developing colorectal cancer:

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- Close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- Family history of familial adenomatous polyposis.
- Family history of hereditary nonpolyposis colorectal cancer.
- Personal history of adenomatous polyps.
- Personal history of colorectal cancer:
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

The following Healthcare Common Procedure Coding System (HCPCS) codes are used to report the service:

- G0104 - Colorectal cancer screening; flexible sigmoidoscopy (service limit: one in 48 months for members age 50 and over)
- G0105 - Colorectal cancer screening; colonoscopy for an individual at high risk (service limit: one in 24 months for members at high risk)
- G0106 - Colorectal cancer screening; (alternative to G0104, screening sigmoidoscopy) barium enema (service limit: one in 48 months for members age 50 and over)
- G0107 - Colorectal cancer screening; fecal-occult blood test, one to three simultaneous determinations (service limit: one in 12 months for members age 50 and over) Screening fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. Fecal occult testing can only be billed by providers who have certification to perform CLIA waived tests.
- G0120 – Colorectal cancer screening; (alternative to G0105, screening colonoscopy) barium enema (high risk). (1 in 24 months/high risk members).

G0106 and G0120 are covered as alternatives to (but not in addition to) G0104 and G0105. G0104 and G0106 cannot be billed for the same episode of care, nor can G0105 and G0120.

Additionally, the preceding ―G" codes cannot be billed with their equivalent CPT codes. For example:

- G0106 and G0120 may not be billed with CPT 74280
- G0107 may not be billed with CPT 82270
- G0104 may not be billed with CPT 45330
- G0105 may not be billed with CPT 45378.

If during the course of performing a screening procedure, a condition is discovered that warrants further service, the code for the diagnostic procedure must be billed rather than the screening code. Stool DNA analysis as a part of colorectal screening is not covered by WV Medicaid.

519.12.4.2 PROSTATE CANCER SCREENING

West Virginia Medicaid covers yearly digital rectal examination of the prostate for cancer screening, but makes no separate payment for this exam, as it is included as part of the E&M service. PSA (prostate specific antigen testing) is covered for susceptible populations when the appropriate counseling regarding the potential for over diagnosis has been discussed with the patient.

519.12.4.3 BREAST AND CERVICAL CANCER SCREENING

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The Breast and Cervical Cancer Screening Program (BCCSP), administered by the West Virginia Department for Health and Human Resources' Bureau for Public Health, provides statewide screening services free of charge or at a minimal fee to low income and uninsured or underinsured women. Women at or below 200 percent of the Federal Poverty Level qualify for services. The BCCSP offers screening mammography and diagnostic services for breast abnormalities to women age 50 and older. Diagnostic services for breast abnormalities are available for women under the age of 50. Cervical cancer screening services are available for women 25 and older. Cervical cancer screening services are also available for women under age 25 with Pap test results of HGSIL.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) effective October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer, including pre-cancerous conditions. Qualifying patients are eligible for Medicaid benefits while the cancer condition is undergoing active treatment.

The West Virginia Medicaid program covers yearly pap smears for cervical cancer screening in susceptible populations. A separate reimbursement for obtaining the Pap smear is not allowed, as this is considered part of the E&M service and examination. Billing for a pap smear with a laboratory (8000) code is only paid to the pathology facility actually reading the smear. In addition, a separate specimen handling charge is also not covered.

519.12.4.4 MAMMOGRAPHY

West Virginia Medicaid covers yearly screening mammograms for any aged female (according to the guidelines established by the American Cancer Society.) The order must come from the treating provider. If the physician who is performing the test (ordered by a patient's doctor) decides the patient needs additional testing procedures based upon the findings of screenings, the testing physician may proceed with appropriate diagnostic testing. The testing provider should receive authorization from the ordering physician (either by phone or fax) for the additional tests believed to be necessary if possible. If this cannot be obtained while the patient is present for the mammography, the testing physician may order those tests necessary as a result of abnormal findings of the screening.

Mammography services are regulated by the Food and Drug Administration. Therefore, a physician who meets the qualification requirements for an interpreting physician may order a diagnostic mammogram based upon the findings.

519.12.5 DIABETES DISEASE STATE MANAGEMENT

The concept of the Medicaid Diabetes Disease State Management Program is based upon the premise that eligible Medicaid members will benefit from a patient-centered health care approach that is responsive to the unique needs and conditions of people living with diabetes.

The program provides for a coordinated approach to the treatment of Medicaid members who have been diagnosed with Type 1, Type 2, or gestational diabetes mellitus. The essential program components of Medicaid's disease management program have been developed from the American Diabetes Association Guidelines (ADA), which aim to prevent the development of serious complications from diabetes. Not only will the member's PCP or provider (doctor, nurse practitioner) agree to manage the member's medical treatment, but will also ensure that self-management skills and diabetes educational needs are met. Practitioners will provide diabetes education or refer

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individuals with diabetes to a Certified Diabetes Educator who is enrolled in the Diabetes Disease Management Program. This policy does not change the requirement for PAAS primary care referral.

The components of Diabetes Disease State Management are:

- Evaluation and education, which includes a comprehensive assessment of the member's clinical status, including health care needs, risks, hygiene, and diet, etc.
- A drug therapy evaluation of the member's oral or injectable medication requirements and their ability to self-monitor blood glucose, to recognize emergency conditions, etc.
- Diet management/education including education on diet restrictions, eating patterns, diet and medication interactions, etc.
- Referral to other providers to meet identified health care needs, such as skin and/or wound care, eye or renal care, etc.
- Comprehensive diabetes assessment using a Diabetes Managing Provider Care Tool. (See **Attachments 10 &11**)

  Medicaid members with diabetes will benefit from a patient-centered health care approach that is responsive to their unique needs and conditions. Because the care is patient centered, the most effective treatment options can be implemented that will ultimately prove cost-effective with outcomes and results that are quantifiable and measurable. The evaluation form to be used for initial and ongoing screening for members is the Diabetes Managing Provider Care Tool, which is included with the instructions for this program, and provides for the ADA Guidelines for appropriate treatment of members with diabetes. This form, which is to be completed by the member's Managing Provider, will define the health care and health related support needs of the member.

Requirements for Becoming a Diabetes Management Provider:

Managing providers may be any of the following licensed practitioners:

- Physicians (MD, D.O.)
- Medicaid Enrolled Nurse Practitioners
- Certified Diabetic Educators

In order to be reimbursed for diabetes management extended visits and for comprehensive educational services, Medicaid providers are required to meet the following criteria:

- enroll as a Medicaid provider
- Certified Diabetes Educators may only enroll with West Virginia Medicaid for the provision of diabetes education and self-management skills. Along with the provider enrollment information found in Chapter 300, the CDE must submit a copy of credentials showing current, unrestricted certification as a Certified Diabetes Educator issued by the National Certification Board for Diabetes Educators.
- Demonstrate successful completion of the six hours of web-based training provided by the Bureau for Medical Services and the Diabetes Prevention and Control Program by submitting the provider's Medicaid number via the web upon completion of the training program. This will provide the documentation necessary for BMS to enroll the provider as a provider of diabetes disease management and will allow reimbursement for diabetes disease management service codes. Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification.

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- Document care utilizing the tools provided
- Submit documents for outcome monitoring as required by BMS
- Demonstrate a capacity to provide all core elements of disease state management services, which includes:

    - Comprehensive client assessment and service plan development
    - Assisting the client to access needed services, i.e., assuring that services are appropriate for the client's needs and that they are not duplicative or overlapping.
    - Monitoring and periodically reassessing the client's status and needs.

System Process

The following are directions for completing the on-line course for ―Diabetes Education for Primary Care Providers":

Begin by accessing the course at www.camcinstitute.org/professional/diabetes/camc.htm. On the course ―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 WV Medicaid advising them that you have successfully completed the course. Another automated email is sent to the email address you provided in your demographic information. You may print the Certificate of Completion for your personal records. The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate. Providers will receive a written notice from Unisys stating the provider file has been updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

CD's of this program will be available for those who do not have broadband Internet access. However, to use CD version of the course, the computer you use must have dial-up access to the Internet. CDs will be provided upon request, at no charge by contacting CAMC Health Education and Research Institute at 304-388-9960 or email tera.kirk@camc.org.

Reimbursement

Medical care that is covered by Medicaid and provided will be reimbursed at the Medicaid fee schedule. Diabetes disease management service codes are only reimbursable if the requirements previously noted for becoming a diabetes disease management provider have been met. In addition, reimbursement for the managing provider's extended office visit is a billable service based on the completion of the Diabetes Managing Provider Care Tool. This service is reimbursable, separate

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from, and in addition to, the evaluation and management services rendered on the same date of service. Modifier 25 must be used to indicate that a significant separately identifiable EM service was required by the same provider on the same day of a procedure or other service. Reimbursement for diabetes education and self-management training is a separate service from the extended office visit, and payable to either managing providers or Certified Diabetes Educators. Billing should be submitted on the HCFA-1500 claim form or through electronic transmission. Claims which exceed the service limits spelled out in this program instruction will not be reimbursed.

If a Diabetes Managing Provider determines that a patient may benefit from diabetes education beyond extended office visits, a referral may be made to a Certified Diabetes Educator or provided by the practitioner. Certified Diabetes Educators and Diabetes Managing Providers who choose to provide diabetes education must define the educational support needs and develop an educational plan of care. Certified Diabetes Educators must develop and implement a plan of care and supply a copy of this plan to the patient's Diabetes Managing Provider, as well as maintaining documentation for services rendered and billed to Medicaid for audit purposes. For your convenience, a Diabetes Educational Provider Care Tool is included with this manual. The provider of diabetes education and self-management training will monitor and re-assess the patient periodically. It is the responsibility of those submitting claims to inquire whether these services have been previously received from other entities, so that service limits are not exceeded. The member may not be held liable for payment of claims which are not reimbursed by Medicaid.

Disease State Management services are reimbursed on a fee-for-service basis with limitations as follows:

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HIPAA Compliant Code 7/01/04	Explanation	Previous Code
S0315	Disease management program; Managing Provider Extended Office Visit Limits - 2 visits per year	**W1875**
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes replaces Certified Diabetes Educator Contact Visit and Certified Diabetes Educator Brief Visit (1 unit = 30 minutes) Combination of G0108 and G0109 Limits - 8.5 hours per year (17 units)	**W1870** **W1874**
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes replaces Certified Diabetes Educator Group Service. (1unit = 30 minutes) Combination of G0108 and GO109 Limits - 8.5 hours per year (17 units)	**W1871**
S0316	Follow-Up/reassessment replaces Certified Diabetes Educator Follow-Up Visit Limits - 2 visits per year	**W1873**

519.12.6 PULMONARY FUNCTION TESTS

WV Medicaid covers the following pulmonary function tests:

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- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94060 Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94375 Respiratory flow volume loop
- 94642 Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
- 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- 94720 Carbon monoxide diffusing capacity (e.g., single breath, steady state)
- 94772 Carbon dioxide, expired gas determination by infrared analyzer
- 94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determination (e.g., during exercise)

Separate payment for 94760 and 94761 is made only when the services are medically necessary and there are no other covered services provided on the same date by the same physician.

No other pulmonary function tests are covered by WV Medicaid.

519.12.7 HEMOPHILIA SERVICES

Diagnostic, treatment and prophylactic blood factor therapy are covered for members with hemophilia and other hemorrhagic conditions.

Blood factor supplied to a member with a crisis episode is covered without restriction as needed to control the bleeding.

519.12.8 TOBACCO CESSATION PROGRAM

West Virginia Medicaid operates a tobacco cessation program in cooperation with the Public Employees Insurance Agency and the Bureau for Public Health. In order for members to have access to drugs and other tobacco cessation services, they are required to enroll in the program through the YNOTQUIT Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available through the quit line program. Additional information regarding the YNOTQUIT Line can be accessed through the Partners in Corporate Health website, www.ynotquit.com.

All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate. Drug products are limited to:

- Nicotine gum – 24 pieces per day
- Nicotine patches – 1 patch per day
- Nicotine lozenges – 20 lozenges per day
- Nicotine inhalers – 168 inhalers per 30 days

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- Nicotine nasal spray – 4 spray bottles per 30 days (This therapy is reserved for those who have failed other forms of nicotine replacement therapy.)
- Buproprion – 2 tablets per day

519.13 MEDICATION SERVICES

Medication Services involve drugs and their administration to Medicaid members.

519.13.1 INJECTIONS

Therapeutic, prophylactic or diagnostic injection (CPT 90782) is not covered by WV Medicaid when billed in conjunction with an E&M code. Reimbursement for the drug is covered. If the injection is the primary purpose for the visit, an E&M service is not allowed.

Appropriate HCPCS ―J Codes" are used to bill for the provision of the medication injected. If there is not a specific code for the medication, a non-specific ―J Code" (J3490 or J9999) is used. These claims must be billed on a paper claim with the name, NDC, and quantity of the medication written on the claim on the line below the billed line or in ―Field 19".

When an unlisted drug is billed using a J-code, the following information is required:

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- The name of the drug
- National Drug Code (NDC)
- Exact dosage administered
- Strength of the drug administered
- Method of administration (i.e., subcutaneous, intramuscular, etc.)
- A cost invoice for the drug

When an HMO is the member‘s provider, the HMO is responsible for the cost of the drug and injection fees when the service is provided in the practitioner‘s office during the office visit. The requirements of the HMO must be followed for reimbursement.

The following injected substances have specific coverage and reporting requirements:

- Intra-articular and intra-bursal injections must be appropriate for the diagnosis; type, NDC, and quantity of steroid or other medication must be reported on the claim with the appropriate CPT code.
- Medications available in parenteral form, only; i.e., gold salts are covered for psoriasis or rheumatoid arthritis and cancer chemotherapy.

WV Medicaid covers Vitamin B-12 injections for particular illnesses and injuries. Following are the medical conditions covered for Vitamin B-12 injections:

- Anemia
  - Pernicious
  - Megaloblastic
  - Macrocytic
  - Fish tapeworm.
- Gastro-intestinal disorder
  - Gastrectomy
  - Malabsorption syndrome
  - Surgical and mechanical disorders resulting from resection of small intestine, strictures, anastomosis, and blind loop syndrome.
- Neuropathy
  - Neuropathy associated with pernicious anemic
  - Severe or acute neuropathy due to malnutrition
  - Severe or acute neuropathy due to alcoholism.

Importantly, diagnoses such as "vitamin deficiency," "secondary anemia," "neuritis," and "menopause" are not sufficient for Medicaid coverage.

WV Medicaid does not cover injections for uses other than those approved by the United States Food and Drug Administration.

519.13.1.1 PALIVIZUMAB/SYNAGIS

Palivizumab (Synagis®) is a humanized monoclonal antibody produced by recombinant DNA technology. It is used to help prevent serious lower respiratory tract disease caused by respiratory syncytial (RSV) in pediatric members at high risk of RSV disease. This antibody is usually administered intramuscularly on a monthly basis even though the RSV season usually spans October

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through March in WV.

Prior authorization through the Rational Drug Therapy Program is required for all orders for Palivizumab (Synagis®). This program may be reached at 1-800-847-3859 or faxed at 1-800-531-7787. Its mailing address is:

Rational Drug Therapy Program
West Virginia University, School of Pharmacy
Robert C. Byrd Health Sciences Center
PO Box 9511
Morgantown, West Virginia 26506-9511

Medicaid coverage of Palivizumab (Synagis®) is limited to members who meet one of the following criteria:

- Member is under 24 months of age at the start of therapy and has chronic lung disease and needs oxygen chronically, or has been off oxygen use for less than 3 -6 months.
- Member is under one year of age at the start of therapy with a gestational age of under 28 weeks.
- Member is under 6 months at the start of therapy with a gestational age of 28-32 weeks or 32-36 week gestational age with concomitant medical problems/risk factors.
- Member is under 3 months of age at the start of therapy with gestational age of 32-36 weeks.

Requests must include the information needed to make a coverage determination, including medical documentation supporting the factors placing the child at high risk of RSV, past or present use of oxygen, current medication, or exposure to risk factors in the American Academy of Pediatric (AAP) guidelines. A diagnosis of bronchopulmonary dysplasia alone is insufficient.

Palivizumab (Synagis®) will not be approved for members currently exhibiting RSV infection or receiving immunoglobulin infusions.

Pharmacies may submit claims for Palivizumab (Synagis®) through the pharmacy point-of-sale (POS) system or appropriate manual form using the National Drug Code.

Physicians and outpatient hospitals may bill using CPT 90378 per 50mg, which equals 1 unit. No separate claim for inpatients must be submitted for Palivizumab (Synagis®) provided to hospital inpatients because payment for the drug is included in the DRG payment rate.

519.13.2 IMMUNIZATIONS

WV Medicaid covers medically necessary immunizations provided to members.

519.13.2.1 IMMUNIZATIONS FOR CHILDREN

Routine vaccines to Medicaid members less than 19 years of age are provided free-of-charge through the Vaccines for Children (VFC) Program, which the WV Department of Health administers. When these vaccines are provided, the practitioner is reimbursed only for the administration.

The following list of CPT codes and modifiers must be used for reimbursement of vaccinations using VFC supplies:

- 90647 Hemophilus influenza B vaccine (Hib)
- 90648 Hemophilus influenza B vaccine (Hib)
- 90655 Influenza virus vaccine 6-35 months
- 90657 Influenza virus vaccine 6-35 months
- 90658 Influenza virus vaccine three years and above (to age 19)

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- 90669 Pneumococcal conjugate vaccine
- 90700 Diphtheria, tetanus toxoids, acellular pertussis vaccine (DtaP)
- 90702 Diphtheria and tetanus toxoids, (seven years old or less)
- 90707 Measles, mumps, and rubella vaccine (MMR)
- 90713 Poliovirus vaccine (IPV)
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
- 90716 Varicella virus vaccine
- 90718 Tetanus and diphtheria toxoids (Td), seven years or older (to age 19)
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine (DtaP - HepB - IPV)
- 90732 Pneumococcal polysaccharide vaccine
- 90734 Meningococcal Conjugate Vaccine (Menactra)
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage

90660 is not a covered service.

In order to assist Medicaid in the accurate identification of the vaccine administered, the appropriate CPT code must be billed. In addition to the specific CPT vaccine codes, an ‗SL' (state supplied) modifier must be placed on the claim to indicate the vaccine was provided by VFC. The appropriate administration CPT codes, 90471 or 90472, must be billed with the appropriate CPT code. Administration codes will not be reimbursed if the corresponding VFC code is not billed.

To bill a single vaccine, bill the CPT vaccine code with the ‗SL' modifier and CPT code 90471 for administration reimbursement.

To bill multiple VFC or subsequent vaccines itemize each CPT vaccine code using the ‗SL' modifier and bill 90472 with the number of additional administrations in the units block.

For vaccines administered to adults >19 years of age, or for vaccines not supplied by VFC, bill the appropriate CPT code. Do not bill the ‗SL' modifier or the administration codes 90471 or 90472. Reimbursement will include the serum and the associated administration.

Coverage of Influenza Vaccine

VFC has restricted coverage due to limited stocks of influenza virus vaccine. Medicaid members must meet one of the CDC's defined criteria for at-risk populations as follows:

- All children aged 6-23 months
- Adults aged 65 years and older
- Persons aged 2-64 years with underlying chronic medical conditions
- All women who will be pregnant during influenza season
- Residents of nursing homes and long-term care facilities
- Children 6 months-18 years of age on chronic aspirin therapy
- Health-care workers with direct patient care who are Medicaid eligible
- Out-of-home caregivers and household contacts of children aged <6 months.

Medicaid will reimburse for influenza vaccine if VFC's serum is depleted if BMS has been notified by VFC that serum supply has been depleted.

According to the National Immunization Program at the CDC, states' immunization programs should

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have enough influenza vaccine to meet the demands. However, in the case that VFC's serum is depleted, WV Medicaid will reimburse providers for private stock of vaccine. WV Medicaid will review for inappropriate use and billing of vaccines. A member's high risk status and VFC depletion must be documented or reimbursement will be recouped.

If VFC depletion occurs, bill the appropriate CPT code without modifiers and without the administration code.

WV Medicaid will reimburse practitioners for the administration of vaccine through VFC using specific billing methodologies outlined in this chapter.

519.13.2.2 IMMUNIZATIONS FOR ADULTS

The provision of many immune globulins and vaccines/toxoids for adults is covered by WV Medicaid when prescribed and provided by their practitioner. When this occurs, the appropriate CPT code must be billed. Reimbursement for this service includes the serum and the associated administration. Do not bill 90471 or 90472 when providing immunizations to adults. The vaccine must be billed by the practitioner. WV Medicaid does not reimburse pharmacies for Medicaid members' vaccines.

The following CPT codes are covered for adult WV Medicaid members:

- 90281 Immune globulin (Ig), human, for intramuscular use
- 90283 Immune globulin (IgIV), human, for intravenous use
- 90288 Botulinum immune globulin, human, for intravenous use
- 90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
- 90296 Diphtheria antitoxin, equine, any route
- 90371 Hepatitis B immune globulin (HBIg), human, for intramuscular use
- 90375 Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use
- 90376 Rabies immune globulin, heat treated (RIg-HT), human, for intramuscular and/or subcutaneous use
- 90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
- 90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
- 90386 Rho(D) immune globulin (RhIg), human, for intravenous use
- 90389 Tetanus immune globulin (TIg), human, for intramuscular use
- 90393 Vaccinia immune globulin, human, for intramuscular use
- 90396 Varicella-zoster immune globulin, human, for intramuscular use
- 90399 Unlisted immune globulin
- 90581 Anthrax vaccine, for subcutaneous use
- 90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
- 90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, for intravesical use
- 90632 Hepatitis A vaccine, adult dosage, for intramuscular use
- 90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- 90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- 90665 Lyme disease vaccine, adult dosage, for intramuscular use
- 90675 Rabies vaccine, for intramuscular use
- 90676 Rabies vaccine, for intradermal use
- 90703 Tetanus toxoid absorbed, for intramuscular use
- 90704 Mumps virus vaccine, live, for subcutaneous use

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- 90705 Measles virus vaccine, live, for subcutaneous use
- 90706 Rubella virus vaccine, live, for subcutaneous use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live , for subcutaneous use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live , for subcutaneous use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
- 90717 Yellow fever vaccine, live, for subcutaneous use
- 90718 Tetanus and diphtheria toxoids (Td), absorbed for use in individuals seven years or older, for intramuscular use
- 90720 Diptheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
- 90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza B vaccine (DtaP - Hib) , for intramuscular use
- 90725 Cholera vaccine for injectable use
- 90727 Plague vaccine, for intramuscular use
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
- 90733 Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
- 90735 Japanese encephalitis virus vaccine, for subcutaneous use
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
- 90749 Unlisted vaccine/toxoid

519.13.3 ANTIGEN/ALLERGY SERVICES

WV Medicaid covers diagnostic services, antigen desensitization, and allergen immunotherapy in accordance with Medicare's policies, as described below.

- A dose is defined as the total amount of antigen to be administered to the member during one encounter/treatment session whether mixed or in separate vials.
- Members selected for covered immunotherapy must have significant life-threatening symptomatology (e.g., anaphylaxis) or a chronic allergic state (e.g., allergic rhinitis, asthma), which has not responded to conservative measures, such as environmental control or judicious use of pharmacological agents. Immunotherapy has been shown to be effective in stinging insect hypersensitivity, inhalant allergies, and allergic asthma, but has not been shown to be effective for food allergies and non-allergic rhinitis.
- Desensitization, not immunotherapy, is the procedure of choice for drug allergies.
- The length of immunotherapy depends on the demonstrated clinical efficacy. A presumption of failure can be made when the member does not experience a noticeable decrease of symptoms after 12 months of therapy, there is no evident increase in tolerance to the offending allergen, and no reduction occurs in medication usage. Long-term treatment will not be reimbursed when it has no apparent clinical benefit.
- Whole body extract of biting insect or other arthropod is indicated for use for fire ant allergy only.

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- Antigens prepared for sublingual administration are not covered as they have not been proven to be safe and effective. Antigens are covered only if they are administered by injection.
- Very low dose immunotherapy or continued submaximal dose immunotherapy has not been shown to be effective and will be denied as not medically necessary.
- Immunotherapy is not covered for food allergies as it has not been shown to be effective. Strict elimination of the offending allergen is the only proven effective treatment of food hypersensitivity.

- Oral desensitization therapy has not been shown to be effective and is not covered by Medicaid, as it is not considered reasonable and necessary.

WV Medicaid **does not** cover allergen immunotherapy for the following antigens: newsprint, tobacco smoke, dandelion, orris root, phenol formalin, alcohol, sugar, yeast, grain mill dust, goldenrod, pyrethrum, marigold, soybean dust, honeysuckle, wood, fiberglass, green tea, or chalk.

Only physicians who have training and experience in the specialty of allergy and clinical immunology are paid to perform allergy testing and for antigen extract or allergy serum. Follow-up immunotherapy can be referred to a practitioner other than an allergist.

There are no restrictions on the services for acute anaphylaxis whether related to the source of reaction (Allergen, venom, etc.) or the practitioner providing the care.

An E&M service is covered on the same day as allergy testing or immunotherapy if a significantly identifiable E&M service is performed (and billed with modifier 25); that is, the primary purpose of the visit was not the allergy service. Preparation and provision of the antigens for the therapy is separately billable. The global codes are not covered.

WV Medicaid‘s payment for antigen services is included in the corresponding RBRVS fee. No separate payment is made for antigen services. An allergist must bill two codes when preparing and administering an antigen. WV Medicaid does not allow allergists to bill for a global service (i.e., injection and extract/extract preparation). Injections must therefore be billed using the following codes:

- 95115 Professional services for allergen immunotherapy, not including provision of allergenic extracts; single injection
- 95117 Two or more injections.

The antigen extract and the physician's professional service for preparing the extract must be billed using one of the following codes:

- 95144 Professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens, single dose vials; specify number of vials
- 95145 Professional services for supervision and provision of antigens for allergen immunotherapy; (specify number of does); single stinging insect venom
    - 95146 Two single insect venoms
    - 95147 Three single stinging insect venoms
    - 95148 Four single stinging insect venoms
    - 95149 Five single stinging insect venoms
- 95165 Professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens; specify number of doses
- 95170 Whole body extract of biting insect or other arthropod; specify number of doses.

CPT codes 95120 through 95134 are not valid for payment purposes.

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HMOs are responsible for reimbursing for allergy injections and the cost of serum when the service is provided in an office setting to an HMO member. Requirements of the HMO must be followed for reimbursement. PAAS PCP referrals are required prior to rendering the service if the servicing provider is not the PCP.

MULTIPLE DOSE VIALS

Allergists must produce multiple dose vials rather than the more expensive single dose vials, unless another physician will inject the antigen. Therefore, CPT 95144 (single dose vial) is not covered when injection code 95115 or 95117 is billed.

Payment is based on a maximum of 10 doses per multiple dose vial. Medicaid can only be billed for a maximum of 10 doses per vial, even if more than 10 doses are obtained from the vial (e.g., if the physician administered 0.5 cc doses, instead of one cc dose). If fewer than 10 doses are prepared from a vial, the smaller number must be billed.

Medicaid must not be billed any additional amount for diluted doses, for example, by taking a one cc aliquot from a multi-dose vial and mixing it with nine cc of diluent in a new multi-dose vial.

If the number of doses is subsequently adjusted (perhaps because of a member's reaction) and a different number of doses are provided than was originally anticipated, the physician may not change the number of doses billed. In other words, the number of doses anticipated when the antigen was prepared is the number that must be billed because the CPT codes require the number of prospectively planned doses. The physician will not be required to refund any payments if fewer doses are provided than were originally planned.

The practice of reducing the amount of antigen provided in a -dose" in order to increase the number of doses from a multiple dose vial so that the payment would be increased for the same amount will be monitored.

When a provider bills allergen immunotherapy (CPT 95115, 95117, 95144-95180) and an E&M code on the same date of service, Modifier 25 must be used with the E&M code to indicate the member's condition required a significant, separately identifiable service above and beyond allergen immunotherapy. Supporting documentation is required in the member's medical record.

The member's medical record must confirm that allergen immunotherapy is clinically reasonable and necessary and show that indications for immunotherapy were determined by the appropriate diagnostic procedures coordinated with clinical judgment. The number of vials or doses and injection schedule must be maintained in the member's medical record. Documentation must be made available upon request to the BMS.

519.13.4 CHEMOTHERAPY ADMINISTRATION

WV Medicaid covers chemotherapy administration. This service includes refilling and maintenance of a portable or implantable pump, chemotherapy injection, and provision of the chemotherapy agent. The preparation of the chemotherapy agent is included in the payment for administration of the agent and; therefore, is not separately reimbursable. An office visit on the same date of service as the chemotherapy administration may be covered if it is for a separately identifiable service documented in the member's medical record.

Chemotherapy drugs administered in the office are reimbursed using the appropriate HCPCS code. If no code is available, CPT 96545 may be billed and the appropriate medical documentation and an invoice showing the drug's actual cost must be attached to the claim.

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Separate payment will be made when different chemotherapeutic agents are furnished or administered on the same date of service by different routes. For example, if Adriamycin is administered by "push" on the same date as cisplatin is administered by "infusion," both administrations may be billed to Medicaid. Each chemotherapeutic agent must be billed with a separate code for each method of administration.

HMOs are responsible for reimbursing for chemotherapy administration to HMO members regardless of the setting. Requirements of the member's HMO must be followed in order to be reimbursed. A PAAS PCP referral is required if an oncologist or other specialist provides the chemotherapy services.

519.14 RADIOLOGY SERVICES

WV Medicaid covers diagnostic and therapeutic radiology and nuclear medicine services. Specific policies and procedures concerning coverage of radiology services are listed below or found in Chapter 512 of the Laboratory & Radiology Manual.

A signed provider's order listing the service and the appropriate diagnosis is required for Medicaid coverage. West Virginia Medicaid has adopted CMS's policy to cover diagnostic tests only if ordered by the physician or non-physician practitioner who is actively treating and managing the patient. Diagnostic tests ordered by a physician who is not the patient's attending/treating physician, e.g., medical director of a nursing home for a nursing home patient, or a physician in a mobile center, will NOT be covered except in the following situations:

- On call physician who has been given responsibility for a patient's care when the patient's physician is unavailable.
- Specialist who is managing an aspect of the patient's care.
- Non-physician practitioners can order diagnostic test within the scope of their practice. However, supervision of diagnostic testing, such as required by CMS in IDTFs, can only be performed by physicians.

Providers should bill modifier-26 for the professional component only, if only performing radiological supervision and interpretation, and TC only if the provider owns the equipment. Practitioners performing services that require radiological supervision and interpretation may bill for these services. However, oftentimes, the facility also has a radiologist providing another reading. At this time, WV BMS pays for only one reading of a procedure. The provider whose reading results in a decision making process is typically the one that is medically necessary and that is reimbursed. Payment for a second reading interpretation of x-rays for quality assurance/confirmation is NOT covered.

Medicaid will pay for portable x-rays and for low osmolar contrast media. When billing for low osmolar contrast media, use Procedure Code 78990 and attach a manufacturer's or cost invoice. For radiation oncology management services, West Virginia Medicaid requires physicians to bill for weekly treatment management instead of daily treatment management.

Comparison x-rays are not covered routinely. If performed, documentation must substantiate the necessity of the second x-ray. This must be in the patient's record for review.

519.14.1 EMERGENCY ROOM X-RAYS AND ELECTROCARDIOGRAMS

West Virginia Medicaid will only cover one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. The professional component of service must include an interpretation and written report for inclusion in the patient's medical record. Reviewing an x-ray or EKG without providing a written report does not meet the criterion that CMS and public payers have established for separate payment.

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CMS' criterion is also used for determining which claim should pay in the event of multiple claims being submitted for the same emergency room visit:

- The interpretation and report that directly led to the diagnosis and treatment of the patient.
- Interpretation of the x-ray or EKG by a radiologist/cardiologist if the interpretation is performed at the same time as the diagnosis and treatment.

Note: When circumstances warrant and are well documented, Medicaid will cover two interpretations. However, in most instances only one interpretation will be covered. Payment for interpretation of x-rays and EKG's for quality assurance is NOT Covered.

519.14.2 BONE DENSITY TESTING

WV Medicaid covers bone density scans in order to prevent the morbidity associated with osteoporosis and osteoporotic fracture. The bone density test is not to be routinely performed for dialysis patients. Routine screening of individuals without symptoms or risk factors is not covered. Criterion for providing bone density testing is: The test must be ordered for the symptoms or disorder associated with the loss of bone density.

- The bone density test is limited to one every two years. More frequent requests will require prior authorization with documentation of the medical necessity. (An exception of the limit would occur if the member had an abnormal screen on a peripheral site and an actual test was necessary to confirm the abnormality.)
- Only axial testing is allowed for monitoring osteoporosis therapy. Photo-densitometry of a peripheral bone and ultrasound bone densitometry are not allowed as part of this monitoring.

Only one scan can be billed regardless of how many sites are tested during the session. For those providers who are also the treating physician, a separate written interpretation of the scan must be included in the ember's chart as the codes include interpretation and report.

A complete list of diagnostic codes covered for bone density scans is found in **Attachment 13.**

519.14.3 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES

Effective 10/01/05, prior authorization will be required on all outpatient Radiological/Nuclear Medicine services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic Services required during an emergency room episode will not require prior authorization.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

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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

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through post payment reviews conducted by BMS or its contracted agent.

On a case-by-case basis, WV Medicaid determines whether to cover and pay for unlisted physician services, i.e., procedure codes with the last two digits typically ending in 99. These clinical codes require the physician to submit a detailed report with the claim for payment. These codes cannot be billed electronically because they must be reviewed manually.

519.18.2 CLINICAL CODE MODIFIERS

At times, a physician may have to attach a 2-digit modifier to the end of a CPT code in order to report accurately and completely the services provided to a Medicaid member. WV Medicaid has adopted the definitions of modifiers consistent with the AMA's CPT-4.

519.18.3 PAYMENT FOR ANESTHESIA SERVICES

Medicaid fees for anesthesiology services are calculated somewhat differently from the fees paid for all other physician services. The fee equals the conversion factor for anesthesia services multiplied by the sum of the base units and time units for a service. (There are no relative value units for these services.)

The base units for a given anesthesia service are the same every time the service is provided and have been established by the American Society of Anesthesiologists (ASA). The time units depend on the length of time to provide the service. The time units are expressed in 15-minute blocks and are expressed in whole units. Thus, a service that takes 75 minutes would be assigned five time units.

An example follows:

If an anesthesia service has three base units and five time units and the anesthesia conversion factor is $15.25 per unit, the fee would be $122.00.

Fee = Conversion Factor x Total Units

$122.00 = $15.25 x 8

Base units are in the system and are not billed by the provider.

Time units do not apply to certain anesthesia services. These services are paid using the RBRVS fee schedule. The BMS establishes relative value units for these services so the fee equals the number of units multiplied by the anesthesia conversion factor.

519.18.4 CMS 1500 CLAIM FORM

A physician must submit a completed claim (CMS-1500) in order to be paid for covered services furnished to Medicaid members. **Attachment 14** lists a brief description of the spaces or fields the physician must complete to bill the WV Medicaid Program.

519.19 SOLICITATIONS

It is unlawful for a physician to knowingly solicit, offer, pay, or receive any remuneration including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for furnishing or arranging to furnish any item or service for which payment may be made under the WV Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging or recommending the provision of a service.

519.20 MEDICAL NECESSITY CERTIFICATION AND PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In

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addition, the following limitations also apply to the requirements for payment of Practitioner Services described in this chapter:

- Requests for medical necessity certification and prior authorization must be submitted to the Bureau for Medical Service's contracted agent.
- Prior authorization requests for Practitioner Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.
- Prior authorization numbers will not be issued over the telephone. Practitioners must not render services until an authorization number is received.
- Prior authorization does not guarantee payment. Services must be rendered by approved provider to eligible individual within service limitations in effect on date of service. All provider/member eligibility requirements and service limitations apply.

519.20.1 PRIOR AUTHORIZATION FOR OUTPATIENT SURGERIES

Certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listing in Attachment 17, along with the PA form that may be utilized.

519.21 MANAGED CARE

Unless noted otherwise, services detailed in this manual are the responsibility of the HMO if the Medicaid member is a member of an HMO. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met for those members.

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CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 1
PRIOR AUTHORIZATION FORM FOR
BLEPHAROPLASTY, UPPER EYELIDS
PAGE 1 OF 3

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Upper Eyelid Surgery

Member Name: ____

Member ID#: ______________________ Member Date of Birth: ______________________

Physician Name: ______________________ Medicaid Provider ID#: ______________________

Medical Necessity Criteria

West Virginia Medicaid covers eyelid surgery with documentation of medical necessity according to the following criteria.

ICD-9-CM Code(s): ______________________ CPT Code(s): ______________________

Blepharoplasty and repair of blepharoptosis are considered for payment by WV Medicaid when medically necessary.

Symptoms documented by member complaints which may justify functional surgery and are commonly found in patients with: (Check as appropriate and attach required documentation)

_____ Visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis
_____ Sensation of looking through lashes
_____ Symptomatic redundant skin weighing down on upper lashes
_____ Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin; prosthesis difficulties in an anophthalmia socket

History:

Myasthenia Gravis
Thyroid Disease
Diabetes
Partial blindness or unilateral blindness

Physical Examination: (Must include a full visual examination to rule out other potential causes of visual disturbance. The presence of any of the following should be documented.)

_____ Ptosis
_____ Dermatochalasis
_____ Pseudoptosis
_____ Chronic blepharitis
_____ Upper eyelid margin approaches to within 2.0 mm of the corneal light reflex
_____ Upper eyelid skin rests on the eyelashes
_____ Upper eyelid indicates the presence of dermatitis
_____ Upper eyelid position contributes to difficulty tolerating prosthesis in an anophthalmia socket
_____ Any significant retinopathy

Documentation: (Attach to Request)

_____ Current photographs: The photographs must be taken with the head perpendicular to the plane of the ground, pointing straight ahead, canthus to canthus. Photos should also be taken from the side to show the excess skin resting on the eyelid.
For requests for blepharoptosis repair, another set of photos with the skin lifted off the lid to show persistent drooping is necessary.

_____ Copies of current visual fields, both taped and untaped, recorded to demonstrate:

_____ Minimum twelve (12) degree or thirty percent (30%) loss of upper field of vision with upper lid skin and/or upper lid margin in natural position and elevated (by taping of the lid) to demonstrate

potential correction by the proposed procedure or procedures. Visual field examination by tangent screen testing is not acceptable.

_____ Visual field testing by either Goldman perimetry or automated perimetry will be accepted. The test object must be indicated with Goldman testing, and the fixation monitor with fixation losses must be listed with the automated testing. The test must show a superior (vertical) extent 50-60 degrees above fixation with targets present at a minimum of 4 degrees vertical separation starting at 24 degrees above fixation while using no wider than a 10 degree horizontal separation.

_____ Demonstration of an improvement of visual field examination with lid (in the case of blepharoptosis) or excess lid skin (for blepharoplasty) elevated is necessary to show that the procedure is medically necessary. The improvement must be at least 30%.

Per National Correct Coding Edits, requests for a blepharoplasty, CPT 15283 with a blepharoptosis repair 67904, will be bundled into the latter.

For the most part, lower eyelid surgery is cosmetic, and medical necessity for entroprion repair must be documented with photos and slit lamp examination.

This procedure must be performed on an outpatient basis by a Board Certified/Eligible plastic surgeon or Board Certified Ophthalmologist with experience with this procedure.

_______________________________________ _______________

Physician Signature Date

WVDHHR/BMS/PARequest01/10/05

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 2
PRIOR AUTHORIZATION FORM FOR
BREAST RECONSTRUCTION
PAGE 1 OF 3

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Open Periprosthetic Capsulectomy, Periprosthetic Capsulectomy, or Revision of Reconstructed Breast Surgery

Member Name: ____

Member ID#: _________________________ Member Date of Birth: ______________________________

Physician Name: _____________________________ Medicaid Provider ID#: ______________________

Medical Necessity Criteria

ICD-9-CM Code(s): _________________________ CPT Code(s): _______________________________

Reconstruction after cancer:

West Virginia Medicaid covers reconstructive breast surgery for those patients who have had surgical procedures for cancer. A pathology report and operative report is necessary for documentation of breast cancer surgery.

If the patient has elected to undergo reconstruction at the time of breast cancer surgery, a separate prior authorization for the reconstructive process is necessary over and above the authorization for the hospital stay. If any part of staged procedures is performed on an outpatient basis, prior authorization is also necessary.

The reconstructive surgeon must list the proposed procedure(s), and any subsequent procedures if the reconstruction is performed in stages. Reconstructive surgery on the opposite breast, if necessary for symmetry, will also be approved when documentation of medical necessity is submitted.

The following procedures are covered:

Reconstruction with tissue expanders and implants
Latissimus flap reconstruction
Nipple areola reconstruction

Nipple tattooing is not covered as this is not considered medically necessary.

Implants:

If placed for reconstruction after cancer surgery is covered. Replacement of breast implants originally placed for reconstruction after cancer is covered with documentation of medical necessity. (i.e., Baker Class III contracture or implant ruptures.)

Removal of ruptured implants and/or Baker Class III placed for any other reason is also covered. **(Removal due to patient anxiety is not covered.)**

Replacement of implants placed for reasons other than post-cancer reconstruction is not covered.

The following should be documented for revision of a reconstructed breast:

Photos are required only in cases when a revision of a reconstructed breast, or the contralateral breast is requested.

Medical condition that necessitates the surgery:

_____ Pain
_____ Asymmetry
_____ Deformity
_____ Ruptured implant
_____ Infection
_____ Malignancy/tumor

Documentation: (Attach to request)

_____ Current original photographs (Only for revision requests and for requests for surgery on contralateral breast)

_____ Preoperative studies
_____ Preoperative diagnosis
_____ Postoperative studies
_____ Postoperative diagnosis
_____ Operative report
_____ Pathology report
_____ History/physical report

Requests for reconstruction for congenital defects are reviewed on a case-by-case basis, and require photos as part of the documentation process.

These procedures must be performed by Board Eligible/Certified Plastic Surgeons. The procedures may be inpatient or outpatient depending on whether other cancer surgery is performed during the same hospitalization. Prior approval for these procedures is necessary over and above the approval for the hospital admission.

_______________________________________ _______________________

Physician Signature Date

WVDHHR/BMS/PA Request01/10/05

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 3

PRIOR AUTHORIZATION FORM FOR
BREAST REDUCTION
PAGE 1 OF 2

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Breast Reduction Mammoplasty Surgery

Member Name: ____

Member ID#: ______________________ Member Date of Birth: ______________________________

Physician Name: __________________________ Medicaid Provider ID#: _______________________

Medical Necessity Criteria

ICD-9-CM Code(s): ________________________ CPT Code(s): ______________________________

History:
Documentation showing the patient has sought medical attention for any of these conditions must be submitted in support of medical necessity for reduction mammoplasty. (Mark all that apply)

_____ Health problems and/or discomfort related to breast hypertrophy
_____ Postural problems related to breast size (Must be depicted in photo)
_____ Respiratory symptoms related to breast size (Must be documented by need for medications and/or physician/ER visits)
_____ Neurological symptoms related to breast size (e.g., ulnar nerve parasthesia) (Must be documented by EMG and/or neurologic consultation
_____ Refractory skin infections in the inframammary creases (Must be documented by need for medications and/or practitioner visits)

Physical Examination:

_____ Weight _____ Height _____ Bra Size
_____ Right low nipple position (distance of nipple from level of suprasternal notch >21cm)
_____ Left low nipple position (distance of nipple from level of suprasternal notch >21cm)
_____ Right span of distance from inframammary crease to nipple >6.5cm
_____ Left span of distance from inframammary crease to nipple >6.5cm
_____ Right areolar diameter
_____ Left areolar diameter
_____ Refractory candidal rashes beneath breasts
_____ Secondary skeletal effects
_____ Dorsal kyphosis of spine
_____ Supraclavicular bra strap grooves **(Must be shown in photographs. If shoulders are cut off in photographs, the appeal will be returned for lack of documentation of medical necessity.)**
_____ Ulnar nerve compression secondary to descent of coracoid process (Requires documentation by EMG)
_____ Additional information (please attach documentation, if applicable)

Documentation: (Attach to Request)

_____ Copy(ies) of recent mammogram
_____ Current original photographs
_____ Copy(ies) of previous breast operation and pathology reports, if applicable

Other information needed:
(These services can only be performed by Board Certified or Board Eligible Plastic Surgeons.)

_____ Right estimate excess breast tissue weight to be removed
_____ Left estimate excess breast tissue weight to be removed

Will this procedure be performed in an outpatient or inpatient setting? (Circle either inpatient or outpatient)

____ ______________________

Physician Signature Date

WVDHHR/BMS/PA Request01/12/05

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 4
PRIOR AUTHORIZATION FORM FOR PANNICULECTOMY

PAGE 1 OF 2

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Panniculectomy Surgery

Member Name: ____

Member ID#: ______________________ Member Date of Birth: ______________________________

Physician Name: ____________________________ Medicaid Provider ID#: ______________________

Medical Necessity Criteria

ICD-9-CM Code(s): ________________________ CPT Code(s): ______________________________

Documentation must show that the patient has significant dermatologic and musculoskeletal problems as a result of large pannus. Panniculectomy solely to improve appearance is not covered by West Virginia Medicaid.

History:

_____ Ulcers and/or intertrigo under surface of panniculus refractory to treatment for at least six months
_____ Antibiotics/antifungals (type used, length of use, and outcome of use)
_____ Hospitalization for infections
Treatments for back pain (List):
Medications: ____
Therapy: ____
Chiropractic: ____
Functional limitations (List): ____
Other medical conditions (List): ____
____
_____ Previous abdominal surgery (e.g., gastric by-pass/gastroplasty)

Documentation of the above conditions must be attached to this prior authorization request.

Physical Examination:

_____ Weight _____ Height
_____ Approximate weight of panniculus to be removed
_____ Back exam as affected by pannus
_____ Examination of abdomen

Documentation:

_____ Current photographs taken from the front and side which show the full extent of the pannus, hanging to, at least, the pubic bone

Liposuction is not covered.

Abdominoplasty to cover a rectus diastasis is not covered, as this does not represent a true hernia.

This procedure must be performed by a Board certified/Eligible plastic surgeon or a Board Certified general surgeon with experience performing this procedure. This procedure must be performed as an inpatient procedure; therefore, the patient's admission requires a separate authorization from the procedure's prior approval.

______________________________ ______________________

Physician Signature Date

WVDHHR/BMS/PA Request01/12/05

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ATTACHMENT 5
CPT CODES TO REPORT PREGNANCY TERMINATION PROCEDURES
PAGE 1 OF 2

ICD-9-CM Diagnosis	Description
635.10	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Unspecified
635.11	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Incomplete
635.12	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Complete
635.20	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Unspecified
635.21	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Incomplete
635.22	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Complete
635.30	Legally induced abortion - Complicated by renal failure - Unspecified
635.31	Legally induced abortion - Complicated by renal failure - Incomplete
635.32	Legally induced abortion - Complicated by renal failure - Complete
635.40	Legally induced abortion - Complicated by metabolic disorder - Unspecified
635.41	Legally induced abortion - Complicated by metabolic disorder - Incomplete
635.42	Legally induced abortion - Complicated by metabolic disorder - Complete
635.50	Legally induced abortion - Complicated by shock - Unspecified
635.51	Legally induced abortion - Complicated by shock - Incomplete
635.52	Legally induced abortion - Complicated by shock - Complete
635.60	Legally induced abortion - Complicated by embolism - Unspecified
635.61	Legally induced abortion - Complicated by embolism - Incomplete
635.62	Legally induced abortion - Complicated by embolism - Complete
635.80	Legally induced abortion - With unspecified complication - Unspecified
635.81	Legally induced abortion - With unspecified complication - Incomplete
635.82	Legally induced abortion - With unspecified complication - Complete
635.90	Legally induced abortion - Without mention of complication - Unspecified
635.91	Legally induced abortion - Without mention of complication - Incomplete
635.92	Legally induced abortion - Without mention of complication - Complete

CPT or HCPCS Code	Description
	(Anesthesia)
01964	Anesthesia for abortion procedures
	(Surgery)
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis – injections), including hospital admission and visits, delivery of fetus and secundines;
59851	with dilation and curettage and/or evacuation
59852	with hysterotomy (failed intra-amniotic injection)
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856	with dilation and curettage and/or evacuation
59857	with hysterotomy (failed medical evacuation)
S0190	Mitepristone, oral, 200 mg (Mifoprex 200 mg oral)
S0191	Misoprostol, oral, 200 mcg
S0199	Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drug

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ATTACHMENT 6
CPT CODES TO REPORT STERILIZATION PROCEDURES
PAGE 1 OF 2

ICD-9-CM Diagnosis	Description
V25.2	Sterilization – Admission for interruption of fallopian tubes or vas deferens

CPT Code	Description
	(Anesthesia)
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral/bilateral
	(Surgery)
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during the same hospitalization (separate procedure)
58611	Ligation or transaction of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

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ATTACHMENT 7
CPT CODES TO REPORT HYSTERECTOMIES
PAGE 1 OF 2

ICD-9-CM

Diagnosis

NA

CPT Code	Description
	(Anesthesia)
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy
01962	Anesthesia for urgent hysterectomy following delivery
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
	(Surgery)
51925	Closure of vesicouterine fistula; with hysterectomy
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152	with colpo-urethrocystopexy (e.g., Marshall-Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling with or without removal of tube(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260	Vaginal hysterectomy, for uterus 250 grams or less;
58262	with removal of tube(s) and/or ovary(s)
58263	with removal of tube(s) and/or ovary(s), with repair of enterocele
58267	with colpo-urethrocystoplexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58280	with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)

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ATTACHMENT 8
DIAGNOSTIC & PROCEDURE CODES FOR COVERED FAMILY PLANNING SERVICES

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FAMILY PLANNING
DIAGNOSTIC CODES

ICD 9	DESCRIPTION
V15.7	Hx of Contraception
V25.01	Prescription of Oral Contraceptives
V25.02	Initiate Contraceptive Measure NEC
V25.03	Emergency Contraceptive Counsel/Rx
V25.09	Contraceptive Management NEC
V25.1	Insertion of IUD
V25.2	Sterilization
V25.3	Menstrual Extraction
V25.4	Contraceptive Surveillance
V25.40	Contraceptive Surveillance NOS
V25.41	Contraceptive Surveillance
V25.42	IUD Surveillance
V25.43	Subderm Contraceptive Surveillance
V25.49	Contraceptive Surveillance NEC
V25.5	Subderm Contraceptive Insertion
V25.8	Contraceptive Management NEC
V25.9	Contractive Management NOS
V26.4	Procreative Management Counseling
V26.8	Procreative Management NEC
V26.9	Procreative Management NOS

Family Planning Procedure Codes

Code	Description
J1051	Medroxyprogesterone Injection
J1055	Medrxyprogester Acetate, 150 mg, Injection
J1056	MA/EC Contraceptive Injection
J7302	Levonorgestrel IU Contracept
11975	Insert Contraceptive Capsules
11976	Remove Contraceptive Capsules
11980	Subcutaneous Hormone Pellet Implant
57170	Fitting of Diaphragm/Cervical Cap
58300	Insert Intrauterine Device (IUD)
58301	Remove Intrauterine Device (IUD)
58615	Occlude Oviduct(s)

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ATTACHMENT 9

APS UTILIZATION MANAGEMENT GUIDELINES (FOR PSYCHIATRIC SERVICES)

PAGE 1 OF 33

APS UTILIZATION MANAGEMENT GUIDELINES

WEST VIRGINIA

PSYCHIATRIC SERVICES - CPT CODES

VERSION 1.0

APS HEALTHCARE, INC.- WEST VIRGINIA

Service Utilization Management Guidelines

Psychiatric Services – CPT Codes

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APS Healthcare, Inc.
West Virginia Medicaid ASO

The right consumer

receives the right service

at the right time

from the right provider

at the right intensity

for the right duration

with the right outcome

The purpose of the utilization management system is to assure that the "rights" as listed above are in place for every consumer and to assure consistency in level and duration of treatment and support among service providers and throughout regions.

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services psychiatrists and eligible staff in their practices may provide Medicaid beneficiaries and invoice the WV Bureau for Medical Services for reimbursement. Notice that each service listing provides:

- a definition,
- level of benefit,
- initial authorization limits,
- increments of re-authorization, and
- service exclusions.

In addition, the service listing provides:

- consumer-specific criteria, which discusses the conditions for
  - admission,
  - continuing stay,
  - discharge,
- clinical exclusions, and
- basic documentation requirements.

The elements of these service listings will be the basis for utilization reviews and management by APS Healthcare, Inc. (APS). Additional detail regarding service definitions and documentation requirements can be found in the American Medical Association Current Procedural Terminology (CPT) Manual.

Request for Prior Authorization

APS has developed a tiered system for initial and continuing-stay service authorizations. While most services require the provider submit only minimal information for the initial authorization; others require the provision of more clinical information to establish medical necessity. Continued-stay authorizations most frequently require the additional clinical information be submitted. Admission and continued stay criteria for these services were developed based upon the intensity of the service in question, as consumers are best served when services are tailored to individual needs and are provided in the least restrictive setting.

Status of Request for Prior Authorization

When a prior authorization for service is required, the service provider submits the required information to APS. The provider will be notified if the request is authorized, pended (additional information is needed to make the decision), closed or denied and/or what alternative services may be recommended.

Provider requests for service authorizations failing to meet the medical necessity guidelines are subject to negotiations between the provider and APS. APS strives to assist the provider in developing an appropriate plan of care for each consumer. Typically, the vast majority of discrepancies between the request for service and final status are resolved through discussion and mutual agreement. In the event that a consumer truly does not have a demonstrated behavioral health, or MR/DD diagnosis and/or need that meets the guidelines for care, the request will be denied. In this event, it is the provider's responsibility to share the denial with the consumer and their support system so that alternative arrangements may be made. Please see the APS Provider Manual for additional information regarding the denial process.

MULTIPLE SERVICE PROVIDERS

Each provider is responsible for obtaining authorization for the service(s) they provide an individual. In cases where one provider has already registered or received prior authorization to perform a service and an additional provider(s) attempts to register or request prior authorization that would exceed the client benefit, APS Care Managers will make every effort to determine which provider the consumer chooses to render the service. We are hopeful that providers will continue to coordinate services for consumers to avoid duplication and maximize the therapeutic benefit of interventions.

Note: It is the provider's responsibility to coordinate care and establish internal utilization management processes to ensure consumers meet all medical necessity/service utilization guidelines and to obtain authorization prior to the onset of service when required. In instances where another provider is performing the service requested or the consumer benefit is exhausted, requests will not be authorized.

Medical Necessity

Prior authorization does not guarantee payment for services. Prior authorization is an initial determination that medical necessity requirements are met for the requested service. In the Managed Care position paper, published in 1999, the state of West Virginia introduced the following definition of medical necessity:

"services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided."

The CPT code services rendered by psychiatrists more clearly define the services and criteria utilized to meet parts (1) and (2) of the definition above. In determining the appropriateness and necessity of services for the treatment of specific individuals the

- diagnosis,
- level of functioning,
- clinical symptoms and
- stability and available support system are evaluated.

The current role of the ASO is to devise clinical rules and review processes that evaluate these characteristics of individuals, and ensure that psychiatric services requested are medically necessary and to enforce the policies of the Bureau for Medical Services.

The Utilization Management Guidelines published by APS serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the specific services.

Part (4) of the definition, in the context of CPT code services rendered by psychiatrists, relates to services requested by the consumer that may be helpful but are not medically necessary, as well as to alternative and complementary services not provided by the psychiatrist but to which the consumer may be referred. This portion of the definition prohibits the utilization of treatment codes to provide service that meets a consumer need but does not meet the medical necessity criteria. Prior authorization review will utilize these guidelines as well as specific clinical requirements for the specific service(s) requested.

Part (5) of the definition which refers to the "most appropriate level of care that can be safely provided", in the context of CPT codes used by psychiatrists, relates to the least restrictive type and intensity of service acceptable to meet the consumer's needs while ensuring that the consumer does not represent a direct danger to himself or others in the community.

PRIOR AUTHORIZATION REQUEST TIERED SYSTEM

The information submitted at the ***"Registration"*** tier is brief and is primarily used to track utilization of various services. Significant clinical review of medical necessity and/or clinical appropriateness is not conducted at the registration level. A registration is allowed as long as the consumer has not exhausted the Medicaid benefit for the service requested.

The information submitted at the second tier (Tier 2) through the West Virginia Behavioral Health Care Connection® provides a clinically relevant summary but it alone is not always sufficient documentation of a consumer's medical necessity. For this reason, APS Care Managers may request additional information to make prior authorization decisions for consumers who do not clearly meet the UM guidelines for the service or do not clearly meet medical necessity requirements. The assessment, plan of care and proposed discharge criteria all serve to document the appropriateness and medical necessity of services provided to a consumer.

RETROSPECTIVE REVIEWS

Retrospective reviews may determine that services as planned and documented do not meet the criteria requirements in the Medicaid manual. Through internal utilization management processes, providers need to ensure that medical necessity documentation is complete and consistent throughout the clinical record.

90801 Psychiatric Diagnostic Interview Examination

Definition: Psychiatric diagnostic interview examination by a psychiatrist includes a history, mental status, and a disposition, and may include communication with family or other sources.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration required for 2 sessions/per consumer/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Registration required for additional units after one year by any provider previously utilizing the benefit for the same consumer. 2 sessions/per consumer/ per year Unit= Session/Event 2. Tier 2 data submission required to exceed limit of two (2) units per consumer/per year (consumer benefit is two (2) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Consumer has, or is suspected of having, a behavioral health condition, **-or-** 2. Consumer is entering or reentering the service system, **-or-** 3. Consumer has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Codes 90862 Pharmacologic Management, 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, and 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes, may not be billed *on the same day as* 90801 Psychiatric Diagnostic Interview Examination.
Clinical Exclusions	None
Documentation Requirement	Documentation must include a written record of findings and recommendations from the interview examination. Documentation must be signed (in practices of five (5) practitioners or less, where

	initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

H0031 AJ Mental Health assessment by a non-physician

Definition: Initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual. Specialty evaluations such as occupational therapy, nutritional, and functional skills assessments are included. The administration and scoring of functional skills assessments are included. This code is to be utilized by Master's Level Licensed Social workers or Licensed Professional Counselors working in a psychiatric practice.

Level of Service	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child & Adult (C&A)
Medicaid Option	Psychiatric Services-CPT Codes
Initial Authorization	Registration required for 1 session/per consumer/per year/per provider from start date of initial service Unit= Session/Event
Re-Authorization	1. Registration required for additional units after one year by any provider previously utilizing the benefit for the same consumer. 1 session/per consumer/ per year/per provider Unit= Session/Event 2. Tier 2 data submission required to exceed the limit of four (4) units per consumer/per year (consumer benefit is four (4) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Consumer has, or is suspected of having, a behavioral health condition, **-or-** 2. Consumer is entering or reentering the service system, **-or-** 3. Consumer has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for the consumer's treatment have been substantially met.
Service Exclusions	None

Clinical Exclusions	None
Documentation	Documentation must include a written record of findings and recommendations from the interview examination. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. The assessments are evaluative services and standardized testing instruments.
2. The assessments are administered by qualified staff and are necessary to make determinations concerning the mental, physical and functional status of the consumer.

90862 Pharmacologic Management

Definition: Pharmacologic Management by a psychiatrist including prescription, use and review of medication with no more than minimal medical psychotherapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration required for 12 sessions/per consumer/per 184 days/per provider 12 sessions for 184 days from start date of initial service Unit = Session/Event
Re-Authorization	1. Registration required for additional units after 184 days by any provider previously utilizing the benefit for the same consumer. 12 sessions for 184 days Unit = Session/Event 2. Tier 2 data submission required to exceed the limit of twelve (12) sessions per consumer/per provider/per 184 days. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units/sessions being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit/session will be granted.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. A psychiatrist has determined the need for and prescribed psychotropic medication.
Continuing Stay Criteria	Consumer continues to meet admission criteria.
Discharge Criteria	Consumer no longer needs medication or refuses this service.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, and 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes may not be billed *on the same day as* 90862 Pharmacologic Management.
Clinical Exclusions	Service excludes intensive medical psychotherapy.
Documentation Requirement	Psychiatrist must complete a note describing the service provided. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

90804 Individual Psychotherapy 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized, depending

	on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90804 AJ Individual Psychotherapy 20-30 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts

	and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90807 Individual Psychotherapy with Medical Evaluation and Management

	Services 45-50 minutes, may not be billed *on the same day as* 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes. This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90806 Individual Psychotherapy 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/ per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g. 15, 20 etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in

	the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment needs. 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: **1. *Physician Assistant may also perform this service.***
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90806 AJ Individual Psychotherapy 45-50 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes

Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis (other than a V-code) which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90805 Individual

	Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, may not be billed *on the same day as* 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes. This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90846 Family Psychotherapy (without patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed limit of ten additional units/per consumer/per year. This level of data is required to exceed authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*90846 Family Psychotherapy (without patient present) has a combined service limit with 90847 Family Psychotherapy (with patient present) of 10 units/per consumer/per year.*
Clinical Exclusions	1. There is no outlook for improvement with this level of service.

	2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. ***Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.***

90847 Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*90847 FAMILY PSYCHOTHERAPY (WITH PATIENT PRESENT) HAS A COMBINED SERVICE LIMIT WITH 90846 FAMILY PSYCHOTHERAPY (WITHOUT PATIENT PRESENT) OF 10 UNITS/PER CONSUMER/PER YEAR.*

Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90847 AJ Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*NONE.*
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.

Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 Group Psychotherapy 75-80 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual consumers. This code may not be utilized for multiple family group therapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 75-80 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/ per year Unit = 75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.

Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 AJ Group Psychotherapy 75-80 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual consumers. This code may not be utilized for multiple family group therapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = session/75-80 minutes
Re-Authorization	2. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/ per year Unit = session/75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. Additionally, the need for additional units must be described in the free-text field.

ADMISSION CRITERIA	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90875 Individual Psychotherapy Biofeedback 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes

	NOTE: Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Psychiatrist, Physician Assistant or other qualified professional billing this code must have specific training in biofeedback techniques.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90876 Individual Psychotherapy Biofeedback 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must

	be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Psychiatrist, Physician Assistant or other qualified professional billing this code must have specific training in biofeedback techniques.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90899 Special Evaluation Services

Definition: Provision of special evaluation services especially those ordered by the court. Services must relate to a consumer's known or suspected behavioral health condition, symptoms or functional impairments and must be either court ordered or specifically requested by Child Protective Services, Adult Protective Services, or Youth Services for purposes related to treatment planning, permanency planning, possible court action and/or removal from the current living situation **and** to make recommendations related to interventions or services that will ameliorate the client's symptoms and/or improve current functioning. Special Evaluation Services include substance abuse evaluation, forensic and/or competency evaluation, sexual victim or perpetrator evaluation or domestic violence/child abuse evaluation (other than sexual abuse). The evaluator must have specific training and expertise in the area of specialty evaluation and evaluation activities must include two (2) or more of the following activities to be considered a special evaluation service: specialized testing or screening relevant to the specialty area (including interpretation of findings), ancillary or collateral interviews, extensive record review or review of court testimony/police reports, special interviewing techniques or videotape review. Documentation must include interpretation and scoring of any testing and a written report of findings and recommendations.

Service Tier	Tier 2 Prior Authorization
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Tier 2 Prior Authorization required 1 evaluation/per consumer/per year Unit = 1 hour The number of units requested should be included in the free text field. Units will be approved based on reasonable and customary times and rates for comparable evaluations. Unique circumstances that justify units above reasonable and customary should be noted in the free text field.
Re-Authorization	Tier 2 data submission is required for additional units within one-year of the start date of the authorized Special Evaluation by any provider for the same consumer. 1 evaluation/per consumer/per year Unit = 1 hour The number of units requested should be included in the free text field. Units will be approved based on reasonable and customary times and rates for comparable evaluations. Unique circumstances that justify units above reasonable and customary should be noted in the free text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services or a suspected behavioral health condition that requires special evaluation, **-and-**

	2. Consumer requires evaluation for a specific purpose (which is identified and documented), **-and/or-** 3. Evaluation is required to make specific recommendations regarding specialized treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the consumer's progress to the court.
Discharge Criteria	Consumer has withdrawn or been discharged from service.
Service Exclusions	90801 Psychiatric Diagnostic Interview by a Psychologist may not be billed on the same day as 90899. 96100 Comprehensive Evaluation by a Psychologist; 96110 Developmental Testing: Limited; 96111 Developmental Testing: Extended; 96115 Neurobehavioral Status Exam; and 96117 Neuropsychological Testing Battery may not be billed by the psychiatrist during the period 90899 is authorized but referrals may be made to psychologists to provide testing. Requests for authorizations by psychologists for these services will pend if a psychiatrist has authorization for 90899 and will be authorized on a case-by-case basis.
Clinical Exclusions	None.
Documentation Requirement	Documentation must include scoring and/or interpretation of testing, assessments and screenings administered and a written report of findings and recommendations. Documentation must be signed (including the credentials of the individual performing the service) and dated (date of service).

Additional Service Criteria:

1. Service must be provided by a Psychiatrist with specific training and expertise in the type of special evaluation requested;

2. The number of units requested should be based on reasonable and customary evaluations of a similar type **and** the activities required to complete the special evaluation for the specific client.

3. The designated start date will be the service start date and the end date of the request will be negotiated between the provider and the APS Care Manager but will be no more than 45 days from the designated start date.

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ATTACHMENT 10

DIABETES EDUCATION PROVIDER TOOL

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Diabetes Education Provider Tool

This tool is based on the "National Standards for Diabetes Self-Management Education" and indicates minimum services to be provided in the continuing care of people with diabetes. It is not intended to replace or preclude clinical judgment or more intensive management where medically indicated. Use it as a reminder to simplify record keeping and as a way to continually improve care to all patients with diabetes.

DEMOGRAPHIC INFORMATION		
Patient Name:		
DOB:	Type of Diabetes: 1 2 GDM (circle one)	Year of Diagnosis:

DIABETES EDUCATION NEEDS	DATE OF VISIT					
Diabetes Disease Process						
Medical Nutrition Therapy						
Physical Activity						
Medication Therapy						
Monitoring						
Acute Complications						
Risk Reduction						
Goal Setting/Problem Solving						
Psychosocial Issues						
Preconception/Pregnancy						
Other Education Needs						

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ATTACHMENT 11
DIABETES MANAGING PROVIDER CARE TOOL
PAGE 1 OF 2

Diabetes Managing Provider Care Tool
(MDs, DOs, FMPs, PNPs)

This tool is based on the 2004 American Diabetes Associations "Clinical Practice Recommendations 2004" and indicates minimum services to be provided in the continuing (initial visits have additional components) care of adults with diabetes. It is not intended to replace or preclude clinical judgment or more intensive management where medically indicated. Use it as a reminder for exams or important tests to simplify record keeping and as a way to continually improve care to all patients with diabetes.

DEMOGRAPHIC INFORMATION		
Patient Name:		
DOB:	Type of Diabetes: 1 2 GDM (circle one)	Year of Diagnosis:
Height	Smoker: YES NO (circle one)	Pneumococcal Vaccine Date (s):

CLINICAL INFORMATION	DATE OF VISIT					
Every Visit						
Weight						
B/P **Goal <130/80**						
A1c (every 3-6 mo.) **Goal: <7%**						
Foot Exam (Visual)						
Annually						
Foot Exam: Sensation, foot structure/biomechanics, vascular, and skin integrity						
Fasting Lipid Profile: • Total Cholesterol **Goal <200**						
• LDL **Goal <100**						
• HDL **Goal: Men >40 Women >50**						
• Triglycerides **Goal <150**						
Microalbumin **Goal: <30**						
Dilated Eye Exam **Referral Date**						
Flu Vaccine						
Counseling						
Self-Management Education **Referral Date**						
Exercise/Physical Activity						
Medical Nutrition Therapy **Referral Date**						
Nephrology **Referral Date**						
Behavioral Health **Referral Date**						
Tobacco Cessation						
Preconception Counseling (women of childbearing age)						
Other						
Review Self-Monitoring Glucose Log						
Assess Need for Aspirin Therapy						
Assess Need for Statin Therapy						

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PRACTITIONER SERVICES

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ATTACHMENT 12
RESPONSIBILITIES FOR LICENSED PRACTITIONER TO GET EXTENDED OFFICE VISIT MEDICAID REIMBURSEMENT

PAGE 1 OF 2

Responsibilities for Licensed Practitioner to get Extended Office Visit Medicaid Reimbursement

A. The provider or a member of the staff (RN, NP, PA, or LPN) must attend a Medicaid/Public Health Session **or receive equivalent training.**

B. Document that a diabetes instructional session of the provider's staff has taken place in the provider's office. (i.e. held a meeting in the practice and reviewed the DSM/Preventive Service manual with the staff, or used the CD ROM [Quick Tips] in the packet to educate the staff to the new diabetes information.)

C. Institute and complete the Flow sheet for each Medicaid patient with diabetes. The sheet includes:

1. Blood Pressure
2. HbA1c
3. Lipid Profile
4. Fasting/random blood glucose
5. EKG
6. Urinalysis
7. 24 hour urine or Microalbuminuria
8. Lytes, H&H, WBC, BUN, Creatinine
9. Aspirin as prevention
10. Immunizations (flu/pneumococcal)
11. Weight
12. Foot Exam
13. Eye referral
14. Nutrition Counseling

D. Complete a Diabetes Assessment (including exercise) and Plan for each **patient (A copy of this assessment is sent with a written referral to the Certified Diabetes Educator)**.

E. Provide written referral for nutrition counseling to **a certified diabetes educator (CDE)**.

F. **A written referral is sent by the provider to a diabetes educator indicating the material to be taught. The provider is responsible for survival skill information for diabetes:**

1. Medication administration with signs and symptoms of adverse effects
2. Monitoring: Glucose & Urine testing for ketones. Ketone testing for type 1 and illness in type
3. What to do in the event of Hypo/Hyperglycemia & sick day management
4. Foot care
5. Exercise Plan
6. Advanced level education: **Acute and chronic complications include** impotence, cardiovascular, nephropathy, neuropathy, pre-pregnancy counseling, pregnancy counseling , gestational diabetes

G. A written individualized diabetes plan of care is given to each patient by the provider. The plan includes meal plan, exercise, medication, monitoring and goal for blood glucose.

H. The Certified Diabetes Educator will send a written report of the items taught and recommendations back to the Provider for review.

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Attachment 13
Diagnostic Codes Covered For Bone Density Scans
Page 1 of 2

Diagnostic Code	Description
242.90-91	Thyrotoxicosis
252.0	Hyperparathyroidism
255.0	Cushing's Syndrome
256.2, 627.2, 627.8	Estrogen deficient states
256.31-256.39	Other ovarian failure
259.3	Ectopic hyperparathyroidism
259.9	Other endocrine disorder, estrogen/testosterone deficiency
268.0-268.9	Osteomalacia, rickets, vitamin D deficiency
275.41	Hypocalcemia
626.0	Absence of menstruation
627.0-627.9	Menopausal disorders
733.00-733.09	Osteoporosis
733.11-733.16	Pathologic fractures
733.90	Disorder of bone and cartilage, unspecified
733.13	Pathologic fracture of vertebrae
756.51	Osteogenesis imperfecta
756.83	Ehlers-Danlos Syndrome
758.6	Gonadal dysgenesis, Turner's Syndrome
759.82	Marfan's Syndrome
805.00-805.9	Fracture of vertebral column, without spinal cord injury
806.00-806.9	Fracture of vertebral column with spinal cord injury
962.0, 995.2	Long-term use of glucocorticoid drugs
E932.0	Drugs causing adverse effects in therapeutic use
V49.81	Post menopausal status
V58.69	Long-term use (current) of other medications
V67.51	Following treatment with high-risk meds, monitoring for response to osteoporosis therapy
V67.59	Following other treatment, for monitoring ongoing therapy for osteoporosis

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PRACTITIONER SERVICES

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ATTACHMENT 14

INSTRUCTIONS FOR COMPLETING THE CMS 1500 CLAIM FORM

Item 1a. **Insured's ID Number**

Enter the member's 11 digit identification number (no letters) assigned by the WV DHHR for Medicaid members. The Medical Card may indicate an "M" for Medicare or "P" for private insurance. This is NOT part of the Member I.D. Number.

Item 2. **Member's Name**

Enter the patent's last name, first name and middle initial.

Item 3. **Member's Birth Date and Gender**

Indicate the member's date of birth and whether male or female.

Item 4. **Insured's Name**

Enter the insured's name as listed on the Medicaid (Medical) Card.

Item 5. **Member's Address**

Enter the member's address in full.

Item 6. **Member's Relationship to the Insured**

Check "self."

Item 7. **Insured's Address**

Enter the current address of the member.

Item 8. **Member's Status**

Not required for Medicaid.

Item 9. **Other Insured's Name**

Enter policyholder's name if insurance other than Medicaid is covering this member. If no insurance, go to Block 10.

Medicaid is the payer of last resort program. Medicare and all other payers must be billed before Medicaid is billed.

Item 9a. **Other Insured's Policy or Group Number**

Enter policy or group number of the insurance policy.

Item 9b. **Other Insured's Date of Birth**

Enter the policyholder's date of birth and gender.

Item 9c. **Employer's Name or School Name**

Enter the name of the employer through which the policy is held.

Item 9d. **Insurance Plan Name or Program Name**

Enter the name of the insurance plan or program other than Medicaid.

Item 10. **Member's Condition Related to Employment, Auto Accident or Other Accident**

If treatment was due to accidental injury, auto accident or was employment-related, enter an "X" in the proper block.

Item 11. **Insured's Group Number or FECA Number**

Item 11a-11d. Enter insurance information other than listed in Block 9a - 9d.

Item 12. **Member's Signature**

Not required for Medicaid.

Item 13. **Insured's Signature**

Not required for Medicaid.

Item 14. Date of Current Illness, Injury and/or Pregnancy

Indicate the date of onset of current illness, injury, or pregnancy.

Item 15. Previous Date of Same or Similar Illness

Indicate the date of initial treatment for the same or similar condition, if known.

Item 16. Dates Member Unable to Work

Desired, but not required.

Item 17. Name of Referring Physician or Other Source

Enter the referring physician's name.

Item 17a. I.D. Number of Referring Physician

Enter the referring physician's UPIN, NPI or Medicaid Provider Number. Leave blank if the member was not referred for treatment.

Item 18. Hospitalization Dates

Admission and discharge dates, if known.

Item 19. Reserved for Local Use

Enter the 10 digit PAAS approval number, if applicable.

Item 20. Outside Lab

Not required for Medicaid.

Item 21. Diagnosis Code

Enter up to four ICD-9-CM diagnosis codes in priority order (primary, secondary, etc.).

The claim will be denied if there is no diagnosis code.

Diagnosis and procedure codes must be consistent.

Item 22. Medicaid Resubmission Code/Original Reference Number

If this is an adjustment for a previous claim, enter the TCN of the original claim.

Item 23. Prior Authorization Number

Enter the 10 digit prior authorization number if applicable for the claim. The claim must be split if more than one prior authorization applies.

Item 24A. Service Period

Enter the date(s) of service in the block (MM, DD, YY).

Item 24B. Place of Service

Enter the appropriate place of service code from the codes listed below.

CODE	Place of Service
11	Office
12	Member's Home
21	Hospital - Inpatient
22	Hospital - Outpatient
23	Hospital - Emergency Department
24	Ambulatory Surgical Center (ASC)
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility

33 Custodial Care Facility
34 Hospice
41 Ambulance (Land)
42 Ambulance (Air-Water)
51 Psychiatric Facility - Inpatient
52 Psychiatric Facility - Outpatient
53 Community Mental Health Center (CMHC)
54 Intermediate Care Facility
55 Residential Substance Abuse Facility
56 Psychiatric Residential Treatment Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic (RHC)
81 Independent Lab
99 Other Unlisted Facility

Item 24C. Type of Service - Defaults to 1 for CMS Services

Item 24D. Procedure Codes

Enter the five-digit code that describes the procedure performed on the date of service. The code will be a CPT-4 (Level I), HCPCS (Level II) or State-Specific (Level III) code.

If service provided requires a modifier, enter up to three modifiers in the spaces provided after the procedure code. If more than three modifiers apply, enter Modifier 99 first.

Two lines on the CMS-1500 cannot be billed with same information. One line will deny as a duplicate.

Procedure code and diagnosis code must match.

Item 24E. Diagnosis Code

Enter the diagnosis code reference numbers from locator 21 (maximum 4). Only specific reference numbers (1, 2, 3, 4) will be accepted.

Item 24F. Charges

Enter the total charges for the procedure code billed on each line.

Item 24G. Days or Units

Enter the number of times the procedure for which you are billing was performed.

For general anesthesia, show the elapsed time in units in Item 24G. Each 15 minutes equals one unit. Base units are programmed in the system and are not to be entered on the claim form. Do NOT bill in minutes.

Item 24H. EPSDT/Family Planning for Providers Participating in EPSDT and Family Planning Programs Only

Valid values include:
Spaces = not applicable
1 = Full screen, with referral
2 = Full screen, no referral
3 = Partial screen, with referral
4 = Partial screen, no referral

5 = Family planning, physician
6 = Family planning, mid-level
7 = Family planning, nurse

Item 24J. **Coordination of Benefits (COB)**

Indicate whether or not the member has other health coverage. Enter "1" if no other insurance; enter "2" if Medicare; enter "3" if there is any other health insurance.

Item 24K. **Reserve for Local Use**

Indicate any amounts paid toward these charges by other insurance, or member. If other insurance, attach "Explanation of Benefits" if (1) insurance denied the claim or (2) the insurance company billed is not listed on the medical card or is not the same as the one listed.

Item 25. **Federal Tax I.D. Number**

Enter Federal Tax I.D. Number.

Item 26. **Member's Account Number**

Enter your member account number. Alpha and numeric characters may be used (maximum of 20). It is especially useful in locating files if the case number is incorrect, not on file, all zero numbers, etc. This information will appear on the remittance voucher. If using member's name: Last name first.

Item 27. **Accept Assignment**

Billing Medicaid indicates acceptance of assignment. (In order for Medicaid to pay the co-insurance and/or deductible owed, assignment must be accepted for Medicare members.)

Item 28. **Total Charge**

Enter total charge for the claim.

Item 29. **Amount Paid**

Enter total amount paid by other insurance.

Item 30. **Balance Due**

Not required for Medicaid.

Item 31. **Signature of Physician or Supplier**

Signature of person authorized to certify this claim. By signing the BMS Provider Enrollment Agreement (included in the Enrollment/Re-enrollment Packet) you have certified all information listed on a claim for reimbursement from Medicaid is true, accurate, and complete. Therefore, you may endorse your claim with a computer-generated, manual, or stamped signature.

Item 32. **Name and Address of Facility Where Services Were Rendered**

Enter the name and address of the facility, if a member was in an institutional setting (i.e., hospital, nursing home, etc.).

Item 33. **Physician or Supplier Name, Address, Zip Code, Provider Number and Phone Number**

Enter name, address, and Medicaid 10 digit provider number.

GRP # (Group Number)

Enter the 10 digit Medicaid group pay to provider number, if applicable.

STATUS CODES

A Active code: These are covered services for which payment is made using Medicaid's

physician fee schedule. Services with "relative value units" covered by Medicaid have an "A" status.

B Bundled code: Payment for covered services is bundled into payment for other unspecified services. Separate payment for the provision of these services is never made.

C Carrier-priced procedure code: Medicaid will establish the "relative value units" services considered unlisted CPT procedure codes, CPT codes that end in "99", and for services for which CMS has not established "relative value units", typically low-volume services. The "C" is also used to indicate services typically covered by Medicaid, but for which there are no "relative value units" in Medicaid's database.

P Bundled and non-incident services: there are two instances in which no fee schedule payment is made for a covered service, but instead payment for the particular service is bundled into the payment for another covered service. The first instance occurs when a service is considered as incident to a physician service and is furnished on the same date of service, such as the provision of an elastic bandage. Payment for the service is considered bundled into the second service's payment. The second instance occurs when a service is not considered "incident" to a physician service, such as the provision of colostomy supplies. In this latter case, payment for the service is made under other provisions.

T Injections and other minor services: There services are only paid if there are no other services payable and billed on the same date by the same provider. Services the same provider bills on the same date are bundled into the service for which separate payment is made.

Global Surgery Indicators

The WV Medicaid Program adopted Medicare's pre-operative and post-operative global surgical package windows for surgeries. During these global surgery periods, payment for office visits associated with the surgical procedure will not be made. The Global Indicator Variable indicates the post-operative period.

CODE	EXPLANATION
MMM	Global surgery period does not apply; maternity code
XXX	Global surgery period concept does not apply
YYY	Global surgery period determined by carrier
ZZZ	Code falls within global surgery period for another service
90	Global surgery period includes day before, day of, and 90 days after surgical procedure.
10	Global surgery period includes day of and 10 days after surgery
0	Global surgery period includes day of procedure only.

Payment Policy Indicators

Multiple Surgeries

A "Y" indicates these services may be billed as multiple procedures.

Bilateral Surgery

A "Y" indicates these services may be billed as bilateral procedures. When billing Modifier 50, use "1" in "Days or Units", Block 24G.

Assistant at Surgery

A "Y" indicates payment may be made for assistants at surgery, if medically necessary.

A "D" indicates payment may be made for assistant at surgery if documentation supports medical necessity.

Co-surgeons

A "Y" indicates physicians may bill as co-surgeons for the service, with or without supporting documentation depending on the procedure.

A “D” indicates physicians may bill as co-surgeons with supporting documentation to be reviewed for medical necessity.

Team Surgery

A "Y" indicates physicians may bill as team surgeons for this service, with supporting documentation depending on the procedure.

A “D” indicates physicians may bill as team surgeons for this service with supporting documentation to substantiate medical necessity.

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ATTACHMENT 15
APPROVED HCPCS J CODES
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West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0120	Injection tetracycline up to 250mg	Achromycin Sumycin Panmycin	Antibiotic	None	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0128	Injection abarelix 10mg	Plenaxis	Gonado-tropin	68158-0149-51	None	X	X												New code 1/1/05. Maximum dosage 100 mg on days 1, 15 & 29, then maximum 100 mg every 4 weeks thereafter. ICD-9-CM 185 required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0130	Injection abciximab 10mg	ReoPro	Antiplatelet	00002-7140-01															Not Covered
J0135	Injection adalimumab 20mg	Humira	Antirheu-matic	00074-3799-02															Not Covered
J0150	Injection adenosine 6mg	Adenocard	Antiarrhy-thmic	54569-3745-00															Not covered
J0152	Injection adenosine for diag. use 30mg	Adenocard	Diagnostic agent	00469-0871-20 00469-0871-30	None	X	X									X			Replaces J0151. **Use only for stress testing**. Separate billing when test provided in physician's office or IDTF. Adults only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0170	Injection adrenalin epi-nephprine up to 1ml	Adrenalin Chloride, SusPhrine	Respiratory	54868-1363-00' 54868-2065-00' 54868-2065-01 61570-0418-81	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0180	Injection agalsidase beta 1mg	Fabrazyme	Enzyme	58468-0040-01 58468-0041-01	None	X	X											X	New code 1/1/05. **Requires Prior Authorization for children 16<years of age.** Submit copies of physician's medical records, specialist's medical records (as appropriate), member's weight, signs and symptoms and diagnostic test results to confirm diagnosis of ICD-9-CM code 272.7 to BMS Medical Director. Children 16> years of age, do not require prior authorization. ICD-9-CM Code 272.7 must be documented on the CMS 1500 claim form when submitting to Unisys for payment consideration.. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0190	Injection biperiden lactate 5mg	Akineton		None	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0200	Injection alatroflaxacin mesylate 100mg	Trovan Trova-floxacin	Antibiotic	'00049-3890-28 '00049-3900-28															Not Covered
J0205	Injection alglucerase 10U	Ceredase	Enzyme	58468-1060-01	None	X	X												ICD-9-CM code 272.7 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0207	Injection amifostine 500mg	Ethyol	Antineo-plastic	'58178-0017-01 '58178-0017-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0210	Injection methyldopate HCl up to 250mg	Aldomet Aldoril	Antihyper-tensive	00517-8905-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0215	Injection alefacept 0.5mg	Amevive	Monoclonal Antibody	59627-0020-01 59627-0021-03	see Special Instruc-tions	X	X												30 units per week X 12 weeks in a 6 month period per lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0256	Injection alpha 1 protein-ase inhibitor human 10mg	Prolastin	Alpha anti-tripsin I deficiency	00026-0601-30 '00026-0601-35 '49669-5800-01 '49669-5800-02	8 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J0270	Injection alprostadil 1.25mcg	Prostin VR Pediatric	Prostaglan-din	00009-3169-06 '00703-1501-02 '55390-0503-10 '55390-0506-05 '55390-0506-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0275	Alprostadil urethral suppository	Muse	Prostaglan-din	62541-0110-01 '62541-0110-06															Not Covered
J0280	Injection aminophyllin up to 250mg	Phyllocontin	Broncho-dilator	00074-7385-01 '00223-7128-02 '00223-7128-10 '00223-7130-00 '00223-7130-10 '54868-0004-00	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0282	Injection amiodarone HCl 30 mg	Cordarone	Antiarrhy-thmic	00008-0814-01 '10019-0131-01 '55390-0057-01 '55390-0058-10 '60505-0722-00 '61703-0241-03 '63323-0616-03 '63323-0616-13															Not Covered
J0285	Injection amphotericinB 50mg		Antibiotic	00003-0437-30 '00013-1405-44 '00703-9785-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0287	Injection amphotericinB lipid complex 10mg		Antibiotic	61799-0101-31 '61799-0101-41	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0288	Injection amphotericinB cholesteryl sulfate com-plex 10mg	Amphotec	Antibiotic	61471-0110-12 '61471-0115-12	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0289	Injection amphotericinB liposome 10mg.	Ambisome	Antibiotic	00469-3051-30	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0290	Injection ampicillin sodi-um 500mg.	Totacillin-N Omnipen-N	Antibiotic	00015-7403-20 '00015-7403-99 '54868-4047-00 '55045-1204-03 '55045-1204-09 '63323-0388-10	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0295	Injection ampicillin sodi-um sulbactam sodium 1.5g	Unasyn	Antibiotic	00049-0013-83 '59911-5901-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0300	Injection amobarbital up to 125mg.	Amytal	Anticonvul-ant	63304-0303-10 '63304-0303-25	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0330	Injection succinylcholine chloride up to 20mg.	Anectine Quelicin Sucostrin	Neuromus-cular blocker	00052-0445-10 54868-4380-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0350	Injection anistreplase 30U	Eminase		None															Not Covered
J0360	Injection hydralazine HCl up to 20mg	Apresoline	Antihyper-tensive	00517-0901-25 '63323-0614-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0380	Injection metaraminol bitartrate 10mg	Aramine	Adrenergic agonist	00006-3222-10 '54868-3692-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0390	Injection chloroquine HCl up to 250mg	Aralen	Antiinfec-tive	00024-0074-01															Not Covered
J0395	Injection arbutamine HCl 1 mg	GenESA		00703-1105-01	None	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J0456	Injection azithromycin 500 mg.	Zithromax	Antibiotic	00069-3150-14 '00069-3150-83 '54868-4527-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0460	Injection atropine sulfate up to 0.3mg	AtroPen	Antichole-nergic	00074-7897-15 '00517-0805-25	3 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0470	Injection dimercaprol 100 mg.	BAL in oil	Antidote	11098-0526-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0475	Injection baclofen 10mg	Lioresal	Skeletal muscle relaxant	58281-0560-01 58281-0561-02 '58281-0561-04	4 per day	X	X										X		A4220 bundled into refill/maintenance services. ICD-9-CM 342.1, 343.0 - 344.9, 345.60 - 345.61, 434.91, or 781.0 must be documented on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0476	Injection baclofen 50mg	Lioresal for intrathecal trial	Skeletal muscle relaxant	58281-0562-01	1 per year	X	X										X		For intrathecal trial only. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0500	Injection dicyclomine HCl up to 20mg	Bentyl Antispas Dilomine Dibent DiSpaz Neoquess	Anticholenergic	00068-0809-23	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0515	Injection benztropine mesylate 1mg	Cogentin	Anticholenergic	00006-3275-16 '00006-3275-38 '54868-2429-01	None	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J0520	Injection bethanechol chloride up to 5mg	Urecholine Mytonachol	Cholenergic	00006-7786-29	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0530	Injection penicillinG benzathine & penicillinG procaine up to 600K U	Bicillin CR	Antibiotic	61570-0139-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0540	Injection penicillinG benzathine & penicillinG procaine up to 1.2m U	Bicillin CR	Antibiotic	61570-0140-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0550	Injection penicillinG benzathine & penicillinG procaine up to 2.4m U	Bicillin CR	Antibiotic	61570-0142-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0560	Injection penicillinG benzathine up to 600K U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0570	Injection penicillinG benzathine up to 1.2m U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0580	Injection pennicillinG benzathine up to 2.4m U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0583	Injection bivalirudin 1mg	Angiomax	Anticoagulant	65293-0001-01	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0585	Botulinum toxin type A per unit.	Botox	Neuromus-cular blocker	00023-1145-01 '54868-4123-00	None	X	X											X	**Requires Prior Authorization.** Submit documentation of diagnostic treatment plan, failed therapies, adjunctive/concurrent therapies to BMS Medical Director for review prior to providing services. **Not covered for headache or cosmesis**. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0587	Botulinum toxin type B per 100 U	Myobloc	Neuromus-cular blocker	59075-0710-10 59075-0711-10 '59075-0712-10	None	X	X											X	**Requires Prior Authorization** Submit documentation of diagnostic treatment plan, failed therapies, adjunctive/concurrent therapies to BMS Medical Director for review prior to providing services. **Not covered for headache or cosmesis.** Medical necessity documentation of services provided must be maintained in the member's individual file.
J0592	Injection buprenorphine HCl 0.1mg	Buprenix	Analgesic narcotic	12496-0757-01	6 per day														Close code effective 7/1/05.
J0595	Injection butorphanol tartrate 1mg	Stadol	Analgesic narcotic	00015-5645-15 00015-5645-20 10019-0461-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0600	Injection edetate calcium disodium up to 1000mg.	Calcium Disodium Versenate, Calcium EDTA	Antidote	00089-0510-06	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J0610	Injection calcium gluco-nate 10ml	Kaleinate	Electrolyte Supplement	00223-7280-00 '00223-7280-10	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0620	Injection calcium glycer-ophosphate & calcium lactate 10ml	Calphosan	Electrolyte Supplement	00516-0060-60	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0630	Injection calcitonin sal-mon up to 400 U	Miacalcin Caalcimar	Antidote	00078-0149-23	1 per day	X	X												Not covered effective 7/1/05
J0636	Injection calcitrol 0.1mcg	Calcijex	Vitamin fat soluble	00074-8110-31 63323-0731-01 '66591-0315-12	30 per day	X	X												Not covered effective 7/1/05
J0637	Injection caspofungin acetate 5mg	Cancidas	Antifungal	00006-3822-10 '00006-3823-10	14 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0640	Injection Leucovorin calcium 50mg	Wellcovorin	Antidote	55390-0051-10	25 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0670	Injection mepivacine HCL 10ml.	Carbocaine Polocaine Isocaine HCL	Local Anesthetic	00074-1038-50' 00074-2047-50 '00186-0410-01 '00186-0420-01 '54569-4782-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0690	Injection cefazolin sodium 500mg.	Ancef Kefzol Zolicef	Antibiotic	00015-7338-99 '54569-4431-00	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0692	Injection cefepime HCL 500mg	Maxipime	Antibiotic	00003-7731-99 '51479-0053-01 '51479-0053-10	8 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0694	Injection cefoxitin sodium 1g	Mefoxin	Antibiotic	00006-3356-45 '59911-5963-02	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0696	Injection ceftriaxone sodium 250mg	Rocephin	Antibiotic	00004-1962-01 '00004-1962-01 '00004-1962-02 '00004-1962-02 '54868-0934-00 '54868-0934-00 '58016-9453-01 '58016-9453-01	8 per day	X	X	X	X								X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0697	Injection sterile cefurox-ime sodium 750mg	Kefurox Zinacef	Antibiotic	00002-5357-25 '00002-7271-01 '00002-7271-25 '00002-8994-25 '00173-0352-31 '00781-3918-96	2 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0698	Cefotaxime sodium per g	Claforan	Antibiotic	00039-0018-10 '00039-0018-25 '00039-0018-50 '54868-3429-00 54868-3429-01 '63323-0331-15	1 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0702	Injection betamethasone acetate & betametha-sone sodium phosphate 3mg	Celestone	Antiinflam-matory	00085-0566-05 '54868-0206-00 '58016-9191-01	9 per day	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J0704	Injection bemethasone sodium phosphate 4mg.	Celestone Phosphate Betameth Cel-U-Jec Selestoject	Antiinflam-matory	00223-7265-05	2 per day	X	X	X	X			X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J0706	Injection caffeine citrate 5 mg	Cafcit		00597-0060-11 '00597-0061-11	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0710	Injection cephapirin sodium up to 1g	Cefadyl		None	1 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0713	Injection ceftazidime 500 mg	Fortaz Tazidime	Antibiotic	00173-0377-31 '00173-0377-31															Not Covered
J0715	Injection ceftizoxime sodium 500 mg	Ceflzox	Antibiotic	00469-7251-01 '00469-7253-02 '00469-7255-10	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0720	Injection chloramphenicol sodium succinate up to 1 g	Chloromycetin Sodium Succinate	Antibiotic	61570-0405-71	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0725	Injection, chorionic gonadotropin per 1000 USP units	Novarel Profasi Pregnyl	Gonado-tropin	00052-0315-10 '00223-7760-10 '00223-7770-10 44087-8010-03 '52637-0126-10 '54569-1986-00 '54868-3910-00 '55566-1501-01 '63323-0025-10	5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0735	Injection clonidine HCl 1mg	Catapres	Alpha Adrenergic Agonist	00054-8233-01 '00054-8234-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0740	Injection cidofovir 375mg	Vistide	Antiviral	61958-0101-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0743	Injection cilastatin sodium imipenem 250 mg.	Primaxin	Antiinfec-tive	00006-3514-58	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0744	Injection ciprofloxacin for IV infusion 200mg	Cipro Ciloxan	Antibiotic	00026-8527-36 '00026-8552-36 '00026-8562-20	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0745	Injection codeine phos-phate 30mg		Analgesic-narcotic	00074-1102-02 '00074-1102-32	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0760	Injection colchicine 1mg		Antigout	55390-0605-02	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0770	Injection colistimethate sodium up to 150mg.	Coly-Mycin M	Antibiotic	39822-0615-01 '61570-0414-51	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0780	Injection prochlorperazine up to 10mg	Compazine Compa-Z Contrazine	Antiemetic	00641-0491-25 '54868-0261-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0800	Injection cotricotropin up to 40U	Cortrosyn ACTH Acthar	Diagnostic agent	63004-7731-01	None		X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0835	Injection cosyntropin 0.25mg	Cortosyn	Diagnostic agent	00548-5900-00	3 per day		X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0850	Injection cytomegalovirus immune globulin IV (human) per vial	CytoGam	Immune globulin	60574-3101-01															Not covered. Refer to CPT 90291
J0878	Injection daptomycin 1mg.	Cubicin	Antibiotic	67919-0011-01	4 per day X 14 days	X	X												New code 1/1/05. Maximum dose 4mg per day X 14 days. Adults only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0880	Injection darbepoetin alfa 5mcg	Aranesp	Anti-anemic	55513-0010-01 '55513-0011-01 '55513-0011-04 '55513-0012-01 '55513-0012-04 '55513-0013-01 '55513-0013-04 '55513-0014-01 '55513-0014-04 ''55513-0015-01 '55513-0054-01 55513-0054-04	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0895	Injection deferoxamine mesylate 500mg	Desferal	Antidote	00083-3801-04	12 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0900	Injection testosterone enanthate & estradiol valerate up to 1cc	Andro-Estro 90-4 Androgyn LA	Androgen	00314-0786-70	1 every 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0945	Injection brompherina-mine maleate10mg	ND Stat		52637-0926-10	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0970	Injection estradiol valerate up to 40mg	Delestrogen Estradiol LA Valergen Estra-L	Contracep-tive	00223-7607-10 '00314-0784-70 '54569-1394-00 '55553-0244-10 '61570-0182-01	1 every 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1000	Injection depoestradiol cyplonate up to 5mg	Estradiol Cypionate Estra-D Estra-Cyp Estro-LA	Hormonal Replace-ment	00009-0271-01 '52637-0332-10 '54569-2580-00 '54868-1729-00	1 per 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1020	Injection methylpredniso-lone acetate 20mg	DepoMedrol	Antiinflam-matory	00009-0274-01	None	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1030	Injection methylpredniso-lone acetate 40mg	DepoMedrol MPrednisol Rep-Pred	Antiinflam-matory	00009-0280-02 '00009-0280-03 '00009-0280-51 '00009-0280-52 '00009-3073-01 '00009-3073-03 '54868-3896-00	None	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J1040	Injection methylpredniso-lone acetate 80mg	DepoMedrol Medralone Prednisol RedPred	Antiinflam-matory	00009-0306-02 '00009-0306-12 '00009-3475-01 '00009-3475-03 '54868-1185-00 '54868-1994-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1051	Injection medroxyproges-terone acetate 50mg	Depo-Provera	Contracep-tive	00009-0626-01 '00009-0746-30 '00009-0746-35 '54868-3348-01	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1055	Injection medroxyproges-terone acetate 150 mg	Depo-Provera	Contracep-tive	None	1 per day	X	X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1056	Injection medrosyproges-terone acetate/estradiol cypionate 5mg/25mg	Lunelle	Contracep-tive	00009-3484-04 00009-3484-05 '54569-5272-00 '54868-4660-00	1 per day	X	X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1060	Injection testosterone cypionate & estradiol cypionate up to 1ml	Depo-Testadiol Andro/Fem	Androgen	00009-0253-02 '54569-4199-00	1 per 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1070	Injection testosterone cypionate up to 100mg.	Depo-Testoster-one Depotest	Androgen	00009-0347-02	1 per 3 weeks	X	X	X											Male only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1080	Injection testosterone cypionate 1cc 200mg.	Depo-Tester-one Depotest Andro-Cyp 200	Androgen	00009-0417-01 '00009-0417-02	1 per week	X	X	X											Male only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1094	Injection dexamethasone acetate 1mg	Dalalone LA	Antiinflam-matory	00223-7390-05 '25332-0011-05 '54868-3977-00	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1100	Injection dexamethosone sodium phosphate 1mg	Cortastat Dalalone	Antiinflam-matory	Too numerous to list	10 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1110	Injection dihydroergota-mine mesylate 1mg	DHE 45	Anti-migraine	66490-0041-01	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1120	Injection acetazolamide sodium up to 500mg	Diamox	Glaucoma	55390-0460-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1160	Injection digoxin up to 0.5 mg	Lanoxin	Antiarrhy-thmic	00173-0260-10 '00173-0260-35 '00641-1410-35 54569-1523-00 '54569-1523-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1165	Injection phenytoin sodi-um 50mg	Dilantin	Anticonvul-ant	00074-1317-01 '00074-1317-02 '00641-0493-25 '00641-2555-45	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1170	Injection hydromorphone up to 4mg	Dilaudid	Analgesic narcotic	00074-2332-11 '00074-2333-11 '00074-2333-26 00074-2334-11 00641-0121-25	12 units per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1180	Injection dyphylline up to 500mg	Lufyllin Diler		00281-1112-31	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1190	Injection dexrazoxane HCl per 250mg	Zinecard	Cardio-protective agent	00013-8715-62	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1200	Injection diphenhydra-mine HCl up to 50mg.	Benadryl	Anti-histamine	00071-4259-03 '54868-0554-00 '54868-2048-00 '54868-2048-01 '54868-3644-00 63323-0664-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1205	Injection chlorothiazide sodium 500mg	Diuril Sodium	Antihyper-tensive	00006-3619-32	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1212	Injection DMSO di-methylsulfoxide 50%, 50 ml	Rimso		00433-0433-05 '49072-0433-05	1 per day	X	X												ICD-9-CM code 595.1 (intersilial cystitis) required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1230	Injection methadone HCl up to 10mg	Dolphine HCL	Analgesic narcotic	00054-1218-42	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1240	Injection dimenhydrinate up to 50mg	Dramamine	Antiemetic	00223-7475-10															Not Covered
J1245	Injection dipyridamole 10 mg	Persantine	Antiplatelet	00703-1652-02 '55390-0555-10 '63323-0613-02	8 per day	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1250	Injection dobutamine HCl 250mg.	Dobutrex	Adrenergic agonist	00074-2025-20	None	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J1260	Injection dolasetron mesylate 10mg	Anzemet	Antiemetic	00088-1206-32	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1270	Injection doxercalciferol 1mcg.	Hectorol	Vitamin D analog	64894-0840-50	20 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1320	Injection amitriptyline HCl up to 20mg	Elavil Enovil	Anti-depressant	00310-0049-10	1 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1325	Injection epoprostenol 0.5mg.	Flolan	Prostaglan-din	00173-0517-00	None	X	X												Requires ICD-99-CM code 416.XX on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1327	Injection eptifibatide 5mg	Integrillin	Antiplatelet	00085-1136-01 '00085-1177-01 '00085-1177-02	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J1330	Injection ergonovine maleate up to 0.2mg	Ergotrate Maleate	Anti-migraine	None	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1335	Injection ertapenem sodium 500mg	Invanz	Antibiotic	00006-3843-71	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1364	Injection erythromycin lactobionate 500 mg		Antibiotic	00074-6365-02 '00074-6482-01	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1380	Injection estradiol valerate up to 10mg	Delestrogen Estradiol Gynogen	Contracep-tive	00223-7606-10 '00223-7607-10 '25332-0117-10 '54569-1394-00 '55553-0244-10 61570-0180-01 '61570-0181-01 '61570-0182-01															Not Covered
J1390	Inection estradiol valerate up to 20mg	Delestrogen Dioval Estradiol Gynogen Valergan Estra L	Contracep-tive	00223-7606-10 00223-7607-10 '00314-0784-70 '25332-0117-10 '54569-1394-00 55553-0244-10 '61570-0180-01 '61570-0181-01 '61570-0182-01	None		X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1410	Injection estrogen conju-gated 25mg	Premarin IV	Estrogen Derivative	00046-0749-05	1 per day	X	X												Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J1435	Injection estrone 1mg	Theelin Aqueous Estone 5 Kestrone 5		00223-7660-10 00223-7670-10 '25332-0019-10 '52637-0313-10															Not Covered
J1436	Injection etidronate disod ium 300mg	Didronel	Bone Res-tortive agent	58063-0457-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1438	Injection etanercept 25mg	Enbrel	Antirheu-matic	58406-0425-34 '58406-0425-41	2 per day	X	X												Not covered effective 7/1/05
J1440	Injection filgrastim (G-CSF) 300mcg	Neupogen	Colony stimulating factor	54868-2522-00 '55513-0530-01 '55513-0530-10	5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1441	Injection filgrastim (G-CSF) 480mcg	Neupogen	Colony stimulating factor	'55513-0546-01 55513-0546-10	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1450	Injection fluconazone 200mg	Diflucan	Antifungal	00049-3371-26 '00049-3435-26 '00049-3437-26	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1452	Injection omivirsen sodi-um intraocculur 1.65mg.	Vitavene		58768-0902-35															Not Covered
J1455	Injection foscarnet sodi-um 1000mg	Foscavir	Antiviral	00186-1905-01 00186-1906-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1457	Injection gallium nitrate 1 mg	Ganite		66657-0301-01 66657-0301-05															Not Covered
J1460	Injection gamma globulin IM 1cc	Gammar Gamastan	Immune globulin	00026-0635-04 00026-0635-12 54569-5275-00 54569-5275-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1470	Injection gamma globulin IM 2cc	Gammar Gamastan	Immune globulin	00026-0635-04 '00026-0635-12 '54569-5275-00 54868-4193-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1480	Injection gamma globulin IM 3cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1490	Injection gamma globulin IM 4cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1500	Injection gamma globulin IM 5cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1510	Injection gamma globulin IM 6cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1520	Injection gamma globulin IM 7cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1530	Injection gamma globulin IM 8cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1540	Injection gamma globulin IM 9cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1550	Injection gamma globulin IM 10cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1560	Injection gamma globulin IM over 10cc	Gammar Gamastan	Immune globulin	54868-4193-00 54569-5275-00 14362-0115-02 00026-0635-12 00026-0635-04	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1563	Injection immune globulin IV 1g		Immune globulin	00026-0648-20 '00026-0648-71 '00053-7486-05 00053-7486-10 00944-2620-03 '00944-2620-04 '44206-0507-56 52769-0268-66 '52769-0471-75 '52769-0471-80 '64193-0250-50	50 per day	X	X												Close code effective 7/1/05 - Replaced with Q9941 and Q9943
J1564	Injection immune globulin IV 10mg		Immune globulin	00026-0635-12 '00026-0646-12 '00026-0646-20 '00026-0646-24 '00026-0646-25 '00026-0646-71 '00026-0648-12 '00026-0648-15 '00026-0648-20 00026-0648-24 '00026-0648-71 49669-1612-01 '49669-1623-01 '49669-1624-01	None	X	X												Close code effective 7/1/05 - replaced with Q9942 and Q9944
J1565	Injection RSV immune globulin IV 50mg	RespiGam	Immune globulin	60574-2101-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1570	Injection ganciclovir sodium 500mg	Cytovene	Antiviral	00004-6940-03 '54569-4738-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1580	Injection Garamycin gentamicin up to 80mg	Gentamine Sulfate Jenamicin	Antibiotic	00085-0069-04 '00223-7719-02 '00223-7719-25 00223-7721-02 00641-0395-25 '00641-2331-43 '63323-0010-02 '63323-0010-20	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1590	Injection gatifloxacin 10 mg	Tequin Zymar	Antibiotic	00015-1179-80	40 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1595	Injection glatiramer acetate 20mg	Copaxone	Biological Misc	00088-1153-30	1 per day	X	X												Not covered effective 7/1/05
J1600	Injection gold sodium thiomalate up to 50mg	Aurolate Myochrysine	Antirheu-matic	11098-0533-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1610	Injection glucagon HCl 1mg.	Glucagon GlucaGen	Antidote	54569-2239-00 '54569-4734-00 '55390-0004-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1620	Injection gonadorelin HCl 100mcg	Factrel Lutrepulse	Gonado-tropin	00046-0507-05	1 per day	X	X												Not for fertility treatment and diagnosis. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1626	Injection granisetron HCl 100mcg	Kytril	Antiemetic	00004-0239-09 '00004-0240-09	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1630	Injection haloperidol up to 5mg	Haldol	Anti-psychotic	00045-0255-01 '00703-7041-03 '54868-3459-00 '55390-0147-10 55390-0447-10 '63323-0474-01 '63323-0474-91	2 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1631	Injection haloperidol decanoate 50mg	Haldol Decanoate 50	Anti-psychotic	00045-0254-14 '00144-0544-51 '00703-7021-03 '55390-0413-01 55390-0423-01 '63323-0471-01	1 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1642	Injection heparin sodium (heparin lock flush) 10U.	HepLock HepLock U/P	Anticoagu-lant	00223-7861-01 '00223-7863-02 '00641-0392-25 00641-0393-25 '00641-2438-45 '00641-2442-45 '63323-0544-11 '63323-0544-31	None									X	X				Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1644	Injection heparin sodium 1000U	Heparin Sodium Liqusemin Sodium	Anticoagu-lant	00223-7801-01 '00223-7810-10 00223-7843-10 '00223-7844-30 '00641-0391-25 '00641-2436-45 '00641-2440-45 '00641-2450-45 '11743-0210-02 '49072-0291-30 63323-0540-11 63323-0540-31	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1645	Injection dalteparin sodi-um 2500IU	Fragmin	Anticoagu-lant	00013-2406-91	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1650	Injection enoxaparin sodium 10mg	Lovenox	Anticoagu-lant	00075-0626-03	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1652	Injection fondaparinux sodium 0.5 mg	Atrixtra	Anticoagu-lant	66203-2300-01	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1655	Injection tinzaparin sodium 1000 IU.	Innohep	Anticoagu-lant	00056-0342-08 '00056-0342-53	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1670	Injection tetanus immune globulin human up to 250U	BayTet	Immune globulin	00026-0634-02	1 per 10 years	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1700	Injection hydrocortisone acetate up to 25mg	Hydrocortone Acetate	Antiinflam-matory	00463-1036-10	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1710	Injection hydrocortisone sodium phosphate up to 50mg	Hydrocortone Phosphate	Antiinflam-matory	00006-7633-04	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1720	Injection hydrocortisone sodium succinate up to 100mg	Solu-Cortef A-Hydrocort	Antiinflam-matory	00009-0825-01 '00009-0825-01 00074-5671-02 '00223-7893-02 '54868-0605-00 '54868-0605-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1730	Injection diazoxide up to 300mg	Hyperstat IV	Antihyper-tensive	00085-0201-05	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1742	Injection ibutilide fumarate 1mg	Corvert	Antiarrhy-thmic	00009-3794-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1745	Injection infliximab 10mg	Remicade	Antirheu-matic	57894-0030-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1750	Injection iron dextran 50 mg	Infed Dexferrum	Iron salt	00517-0134-10	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1756	Injection iron sucrose 1mg IV	Venofer	Iron supple-ment	00517-2340-10	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1785	Injection imiglucerase per unit	Cerezyme	Enzyme	58468-1983-01 58468-4663-01	None	X	X												ICD-9-CM code 172.7 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.
J1790	Injection droperidol up to 5mg	Inapsine	Antiemetic	00074-1187-01 00517-9702-25 11098-0010-02	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1800	Injection propranolol HCl up to 1mg.	Inderal	Antianginal	00046-3265-10 '54569-2232-01 '55390-0003-10 '63323-0604-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1810	Injection droperidol & fentanyl cit-rate up to 2ml ampule	Innovar	Antiemetic	00186-1230-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1815	Injection insulin 5U	Humalog Humulin Lispo	Antidiabetic	00002-8501-01	20 per day	X	X	X											ICD-9-CM code 250.00 - 250.9X required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1817	Insulin for administration thru insulin pump per 50 U.	Humalog	Antidiabetic	Too numerous to list															Not Covered
J1825	Injection interferon beta 1a 33mcg	Avonex	Biological Response Modulator	None	None	X	X												Not covered effective 7/1/05
J1830	Injection interforon beta 1b 0.25mg	Betaseron	Biological Response Modulator	50419-0523-15	2 per day	X	X												Not covered effective 7/1/05
J1835	Injection itraconazole 50 mg.	Sporonox	Antifungal	50458-0298-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1840	Injection kanamycin sul-fate up to 55mg	Kantrex Klebcil	Antibiotic	00015-3503-20 00015-3503-99 '63323-0359-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1850	Injection kanamycin sul-fate up to 75mg	Kantrex Klebcil	Antibiotic	00015-3503-20 63323-0359-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1885	Injection ketoralac tro-methamine 15mg	Toradol	Analgesic	00004-6925-06 '55390-0480-01 '60505-0705-00 '63323-0161-01	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1890	Injection cephalothin sodium up to to 1g	Cephalothin Sodium Keflin	Antibiotic	00338-0525-41	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1931	Injection laronidase 0.1 mg	Aldurazyme	Enzyme	58468-0070-01	None	X	X												ICD-9-CM code 277.5 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.
J1940	Injection furosemide up to 20mg.	Lasix Furomide	Antihyper-tensive Diuretic	00074-6101-02 '00223-7700-02 00223-7701-02 52637-0010-10 '63323-0280-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1950	Injection leuprolide ace-tate 3.75mg.	Lupron Depot	Antineo-plastic	00300-3641-01 54868-2825-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1955	Injection levocarnitine1g.	Carnitor	Nutritional Supplement	00517-1045-25 '00703-0404-02 54482-0146-09 '54482-0147-01 '55390-0136-05 '55390-0436-05			X												Not Covered
J1956	Injection levoflaxacin 250 mg	Levaquin	Antibiotic	00045-0067-01	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1960	Injection levorphanol tartrate up to 2mg	Levo Dromoran	Analgesic narcotic	00004-1911-06 '00187-3072-10	1.5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1980	Injection hyoscyamine sulfate up to 0.25mg.	Levsin	Anticholе-nergic	00091-1536-05	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1990	Injection chlordiazepoxide HCL up to 100mg.	Librium	Benzodiaze-pine	00187-3755-74 '54868-2362-01															Not Covered
J2001	Injection lidocaine HCl IV infusion 10mg		Antiarrhy-thmic	00548-1192-00	None	X													Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2010	Injection lincomycin HCl up to 300mg	Lincocin	Antibiotic	00009-0555-01 '00009-0555-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2020	Injection linezolid 200 mg	Zyvox	Antibiotic	00009-5137-01	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2060	Injection lorazepam 2mg	Ativan	Antianxiety	00008-0581-15 '00074-1985-01 '10019-0102-01 '54868-3566-01	2 per day	X	X	X		X							X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2150	Injection mannitol in 25% in 50ml	Osmitrol	Diuretic	00074-4031-01 '00517-4050-25 '63323-0024-25	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2175	Injection meperidine HCl per 100mg	Demerol	Analgesic narcotic	00074-1180-69 '00074-1201-20 '00074-1256-01 00074-2046-01 '00641-1150-35 '10019-0158-68 '54868-3610-00	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2180	Injection meperidine & promethazine HCl up to 50mg	Mepergan	Analgesic combo narcotic	54868-4136-00	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2185	Injection meropenem 100 mg	Merrem	Antibiotic	00310-0321-30 00310-0325-20	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2210	Injection methylergonovine maleate up to 0.2mg.	Methergine	Ergot alkaloid & derivative	00078-0053-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2250	Injection midazolam HCl per 1mg	Versed	Benzodiaze-pine	10019-0028-05 '10019-0028-10 '59911-5912-02 59911-5913-02 '60505-0711-01 '60505-0711-02 '60505-0711-03 '63323-0411-05 '63323-0411-10 '63323-0411-12															Not Covered
J2260	Injection milrinone lactate 5mg	Primacor	Enzyme	00024-1200-05 '00024-1200-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2270	Injection morphine sulfate up to 10mg	Roxanol	Analgesic narcotic	00641-0180-25 '00641-1180-35 '00641-2343-41 '10019-0178-44 '10019-0178-62 '10019-0178-68 '54868-4189-00	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2271	Injection morphine sulfate 100mg.	Roxanol	Analgesic narcotic	00641-2343-41 '10019-0178-62	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2275	Injection,morphine sulfate (preservative-free sterile solution)10mg	Astramorph PF Duramorph	Analgesic narcotic	00074-1135-03 '00641-1132-31 '61703-0224-72	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2280	Injection moxifloxacin 100 mg	Avelox	Antibiotic	00026-8582-31	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2300	Injection nalbuphine HCl per 10mg	Nubain	Analgesic narcotic	00074-1463-01 '54868-3471-00 '54868-3608-00 '54868-3686-00 '54868-3686-01 '58016-9384-01 '63481-0432-10 '63481-0508-05	6 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2310	Injection naloxone HCl per 1mg	Narcan	Antidote	63481-0368-05 '63481-0377-10	None	X	X	X											Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2320	Injection nandrolone decanoate up to 50mg.	Decaduraboli n	Anabolic steroid	00052-0697-02 '00052-0698-01 '00364-6717-47	1 per week	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2321	Injection nandrolone decanoate up to 100mg.	Decaduraboli n Hybolin Decanoate	Anabolic steroid	00052-0697-02	1 per week	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2322	Injection nandrolone decanoate up to 200mg	Decaduraboli n Neo-burabolic	Anabolic steroid	00052-0697-02 '00052-0698-01 00364-2186-46 '00364-6717-47	1 per week	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2324	Injection nesiritid 0.5mg	Natrecor	Vasodilator	65847-0205-25	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J2352	Injection octreotide acetate 1mg																		Code deleted 12/31/03
J2353	Injection octreotide depot form for IM 1mg	Sandostatin	Anti-diarrheal	00078-0342-84	None	X	X												Replaced J2352. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2354	Injection onctreotide non-depot form for SQ or IV 25 mcg	Sandostatin	Anti-diarrheal	00078-0180-01 00078-0181-01 00078-0182-01 00078-0183-25 00078-0184-25	7 conse-cutive days	X	X												Replaced J2352. For IV route only. Physician reimbursement for administration is limited to 7 consecutive days per Medicaid member per lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file..
J2355	Injection oprelvekin 5 mg	Neumega	Platelet growth factor	58394-0004-01 '58394-0004-02	2 per day	X	X												ICD-9-CM code 287.4 must be documented on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file..

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J2357	Injection omalizumab 5 mg.	Xolair	Anti-asthmatic	50242-0040-62	None	X	X												New code 1/1/05. Requires ICD-9-CM code 493.XX on CMS 1500 claim form for payment consideration.. Age limit 12> years. For children: the first dose may be split into 2 doses the first week. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2360	Injection orphenadrine citrate up to 60 mg.	Norflex	Muscle relaxant	00089-0540-06 '11584-1016-02 '11584-1016-05 '52959-0179-06	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2370	Injection phenylephrine HCl up to 1ml	Neo-Synephrine	Adrenergic agonist	00074-1800-01 '00517-0299-25 '00703-1631-04 '10019-0163-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2400	Injection chloroprocaine HCl 30ml	Nesacaine Nesacaine MPF	Local Anesthetic	00074-4169-01 '00074-4170-01 '00186-0971-66 '00186-0972-66	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2405	Injection ondansetron HCl 1mg	Zofran	Antiemetic	00173-0442-00 '00173-0442-02 '54868-4509-00	32 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2410	Injection oxymorphone HCl up to 1 mg	Numorphan	Analgesic-narcotic	63481-0444-10	9 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2430	Injection amidronate disodium 30 mg	Aredia	Antidote	00083-2601-04 '00703-4075-19 '55390-0127-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2440	Injection papaverine HCL up to 60 mg.	Para-Time SR	Vasodilator	00517-4002-05 '00517-4010-01 '55390-0107-10 '60793-0015-02 '60793-0015-10	1 per day	X	X												Not covered effective 7/1/05
J2460	Injection oxytetracycline HCl up to 50 mg	Terramycin	Antibiotic	00049-0750-77	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2469	Injection palonesetron HCl 25mcg	Aloxi	Antiemetic	58063-0797-25	10 units per week	X	X												New code 1/1/05. Requires ICD-9- CM code V58.0, V58.1, 140.0 - 208.91, 230.0, OR 239.9 on CMS 1500 claim form for payment consideration.. Maximum dosage 0.25mg per week. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2501	Injection paricalcitol 1 mcg	Zemplar	Vitamin D analog	00074-4637-01	None	X	X										X		Requires ICD-9-CM 588.XX on CMS 1500 claim form for payment consideration. Medical necessity documentation (including weight of member) of services must be maintained in the member's individual file.
J2505	Injection pegfilgrastim 6mg	Neulasta	Colony stimulating factor	55513-0190-01	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2510	Injection penicillinG pro-caine aqueous up to 600K U	Wycillin Pfizerpen AS	Antibiotic	61570-0085-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2515	Injection pentobarbital sodium per 50 mg.	Nembutal	Anti-convulsant	00074-3778-04 '00074-3778-05	10 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2540	Injection penicillinG pot-assium up to 600K U	Pfizerpen	Antibiotic	00049-0520-83 '00049-0530-28 '00338-1021-41 '00338-1023-41 '00338-1025-41 '00781-6135-95 '00781-6136-94 '54868-3480-00 '54868-4488-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2543	Injection piperacillin sodium/tazobactam sodium 1g/0.125g (1.125 g)	Zosyn	Antibiotic	00206-8452-16 '00206-8454-55 '00206-8455-25 '00206-8620-11	24 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2545	Pentamidine isethionate inhalation solution 300mg	Nebupent Pentam 300	Antibiotic	00074-4548-01 '00074-4548-49 '54868-2528-00 '63323-0113-10 '63323-0877-15															Not Covered
J2550	Injection promethazine HCl up to 50mg	Phenergan Prorex-25	Antiemetic	00008-0746-01 '00223-8394-01 '00641-0929-25 '00641-1496-35 '00703-2201-04 '54868-0262-00 '54868-2695-00	6 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2560	Injection phenobarbital sodium up to 120mg	Luminal Sodium	Anticonvul-ant	00641-0476-25	3 per day	X	X												20/mg/kg for status epilepticus. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2590	Injection oxytocin up to 10U.	Pitocin	Oxytocic agent	60793-0416-05 '61570-0416-03 '61570-0416-05 '63323-0012-01 '63323-0012-10	1 per day	X	X												May increase to maximum 4 units for post partum hemorrhage. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2597	Injection desmopressin acetate 1mcg	DDAVP Stimate		00074-2265-01 '00075-2451-01 '00075-2451-53 '00703-5051-03 '00703-5054-01 '54868-3889-00 '55566-5040-01			X												Not Covered
J2650	Injection prednisolone acetate up to 1ml	AK-Pred Inflammase Forte Pediapred Prelone Key-Pred Predcor Predoject Predalone	Antiinflam-matory	00223-5346-10 '00223-8341-30 '00223-8345-10 00223-8345-30 '00223-8346-10 '00223-8346-30 '00463-1019-30 '00463-1020-10 '52637-0325-10 '55553-0249-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2670	Injection tolazoline HCl up to 25mg	Priscoline	Alpha-adrenergic blocking agent	00083-6733-04	8 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2675	Injection progesterone 50 mg	Crinone Progestasert	Progestin	00591-3128-79 '63323-0261-10	8 per day	X	X	X	X										Not for fertility treatment and diagnosis. For menorrhagia, amenorrhea. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2680	Injection fluphenazine decanoate up to 25mg	Prolixin Decanoate	Anti-psychotic	00003-0569-15 '00144-0644-56 '00703-5003-01 '55390-0465-05 '60505-0664-02 '63323-0272-05 '63323-0272-55	2 per day	X	X	X		X							X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2690	Injection procainamide HCl up to 1g	Pronestyl Procanbid	Antiarrhy-thmic	00074-1902-01 '00074-1903-01	None	X	X												Weight based 50mg/kg/day. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2700	Injection oxacillin sodium up to 250mg	Bactocill Prostaphlin PCN Methylphenyl Isoxazolyl	Antibiotic	00015-7103-28 '00015-7103-98 '00015-7970-20 '00015-7970-99 '00015-7981-20 '00015-7981-99	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2710	Injection neostigmine methylsulfate up to 0.5 mg	Prostigmin	Acetychol-inesterase inhibitor	00187-3101-30 '00517-0033-25 '00517-0034-25 '00703-2711-03 '00703-2714-03 '10019-0271-02 '10019-0271-10 '63323-0382-10	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2720	Injection protamine sul-fate 10mg		Antidote	11743-0250-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2725	Injection protirelin 250 mcg	Relefact TRH Thypi-nome		55566-0081-05	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2730	Injection pralidoxime chloride up to 1g	Protopam Chloride	Antidote	00641-0374-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2760	Injection phentolamine mesylate up to 5mg	Regitine	Diagnostic agent	55390-0113-01	1 per day	X	X												Not covered effective7/1/05
J2765	Injection metoclopramide HCl up to 10mg	Reglan	Antiemetic	00074-3413-01 '00703-4502-04 '10019-0450-02 '54868-4167-00	8 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2770	Injection quinupristin/dalfopristin 500mg (150/350)	Synercid	Antibiotic	00075-9051-10															Non Covered
J2780	Injection ranitidine HCl 25mg	Zantac	Anti-histamine	00173-0362-38 '00173-0363-00 '00173-0363-01	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2783	Injection rasburicase 0.5 mg	Elitek	Enzyme	00024-5150-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2788	Injection Rhod immune globulin human minidose 50 mcg	BAYRho-D MicrhoGam Hyprho-D	Immune globulin	00562-7808-06 '00562-7808-26															See CPT code 90385
J2790	Injection Rhod immune globuliln human full dose 300 mcg	Gamulin RH	Immune globulin	00026-0631-02 '00562-7807-06 '00562-7807-26															See CPT code 90384
J2792	Injection RhoD immune globulin IV human solvent detergent 100 IU	BAYrho-D Winrho SDF	Immune globulin	60492-0024-01															See CPT code 90386
J2794	Injection Risperidone long acting 0.5mg	Risperdal Consta IM	Anti-psychotic	50458-0308-11 50458-0307-11 50458-0306-11	100 every 2 weeks	X	X	X		X									New code 1/1/05. Requires ICD-9-CM code 295XX.on CMS 1500 claim form for payment consideration. Age limit 18>years. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2795	Injection ropivacaine HCl 1mg	Naropin	Local Anesthetic	'00186-0859-44 00186-0859-54 '00186-0863-44 '00186-0863-54 '00186-0867-44 '00186-0867-54 '00186-0868-44 '00186-0868-54															Not Covered
J2800	Injection methocarbamol up to 10ml	Robaxin	Skeletal muscle relaxant	00031-7409-87 '00031-7409-94 '00223-8150-10	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2810	Injection theophylline 40 mg	Theo-Dur	Broncho-dilator	Too numerous to list															Not Covered
J2820	Injection sargramostim (GM-CSF) 50mcg	Leukine Prokine	Colony stimulating factor	58406-0050-14 '58406-0050-30	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2910	Injection aurothioglucose up to 50mg	Solganal		54868-1133-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2912	Injection sodium chloride 0.9% per 2ml			00074-2102-02	None									X	X				Medical necessity documentation of services provided must be maintained in the member's individual file.
J2916	Injection sodium ferric gluconate complex in sucrose injection 12.5mg	Ferriecit	Iron supple-ment	52544-0922-26	20 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2920	Injection methylprednisolone sodium succinate up to 40mg	SoluMedrol Ametha-Pred	Antiinflam-matory	00009-0113-12 '00009-0113-19 '00074-5684-01 '00223-8160-01 '54868-0768-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2930	Injection methlprednisolone sodium succinate up to 125mg	SoulMedrol Ametha-Pred	Antiinflam-matory	00009-0190-09 '00009-0190-16 '00074-5685-02 '00223-8160-02 '00223-8161-02 '54569-1555-01 '54868-3637-00 '54868-3637-01 '58016-9452-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2940	Injection somatrem 1mg	Protropin		50242-0015-64 50242-0016-65 '50242-0028-49 '50242-0030-50															Not Covered
J2941	Injection somatropin 1mg	Humatrope Genotropin Nutropin		00013-2653-02															Not Covered

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J2950	Injection promazine HCl up to 25mg	Sparine Prozine-50		00223-8397-10	40 per day	X	X			X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J2993	Injection reteplase 18.1 mg	Retavase	Fibrinolytic	57894-0040-01 '57894-0040-02															Not Covered
J2995	Injection streptokinase per 250KIU	Streptase	Fibrinolytic	00053-1770-01	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2997	Injection alteplase recombinant 1mg	Activase	Fibrinolytic	50242-0041-64 '50242-0041-65															Not Covered
J3000	Injection streptomycin up to 1g	Streptomycin Sulfate	Antibiotic	39822-0706-01 '39822-0706-02	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3010	Injection fentanyl citrate 0.1mg	Sublimaze Duragesic	Analgesic narcotic	00074-9093-32 '11098-0030-02 '54868-3738-00 '54868-3738-01	1 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J3030	Injection sumatriptan succinate 6mg	Imitrex	Anti-migraine	00173-0449-02 '54569-3704-00 '54569-4505-00 '54868-2652-00	1 per day	X	X												Not covered effective 7/1/05
J3070	Injection pentazocine 30 mg	Talwin	Analgesic narcotic	00074-1941-01	12 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3100	Injection tenecteplase 50 mg	TNKase	Fibrinolytic	50242-0038-61	1 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J3105	Injection terbutaline sulfate up to 1mg	Brethine	Broncho-dilator	00028-7507-01 '00028-7507-23	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3110	Injection teriparatide 10 mcg	Forteo	Parathyroid hormone																Not Covered
J3120	Injection testosterone enanthate up to 100mg	Delatestryl	Androgen	54396-0328-16 '54396-0328-40	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3130	Injetion testosterone enanthate up to 200mg	Delatestryl	Androgen	54396-0328-16 '54396-0328-40	2 per week	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3140	Injection testosterone suspension up to 50mg	Andronaq 50	Androgen	00314-0083-10 '00314-0771-70 '00463-1069-10	3 per week	X	X	X											May increase to 4 doses for post partum breast engorgement. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3150	Injection testosterone propionate up to 100mg	Testex	Androgen	00314-0772-70 '00463-1073-10 '54569-2363-00	3 per week	X	X	X											May increase to 4 doses for post partum breast engorgement. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3230	Injection chlorpromazine HCl up to 50mg	Thorazine	Anti-psychotic	00223-7325-02 '00223-7334-01 '00641-1398-35	10 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3240	Injection thyrotropin alpha 0.9 mg provided in 1.1 mg vial	Thyrogen	Diagnostic agent	58468-1849-04	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3245	Injection tirofiban HCl 12.5 mg	Aggrastat	Antiplatelet	None		X													Code closed 1/1/05
J3246	Injection tirofiban HCL 0.25mg IV	Aggrastat	Antiplatelet	00006-3739-43 61379-0120-05 00006-3739-96 00006-3739-55	1 per day	X	X												New code 1/1/05. Replaces J3245. Note dosage change. Must be billed daily. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3250	Injection trimeth-obenzamide HCl up to 200mg	Tigan	Antiemetic	54868-0608-00 '61570-0540-02															Not Covered
J3260	Injection tobra-mycin sulfate up to 80mg	Nebcin	Antibiotic	00002-1499-25 '00002-7090-01 '00002-7090-16 '00002-8989-25 '00003-2725-10 '00003-2725-30 '00703-9402-04 '00703-9416-01 '54868-4106-00	2 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3265	Injection torsemide 10mg/ml	Demadex	Antihyper-tensive	00004-0267-06 '00004-0268-06															Not Covered
J3280	Injection thiethylperazine maleate up to 10mg	Torecan Norzine	Antiemetic	54868-4579-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3301	Injection triamcinolone acetonide 10mg	Kenalog-10 Kenalog-40 Triam-A	Antiinflam-matory	00003-0494-20 '54868-0234-00	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3302	Injection triamcinolone diacetate 5mg	Aristocort Intralesional Aristocort Forte Cinolone Trilone Clinacort	Antiinflam-matory	00469-5116-01 '00469-5116-05 '00469-5117-05 '54868-0926-00	8 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3303	Injection triamcinolone hexacetonide 5mg	Aristoospan Intralesional Aristospan Intra-articular	Antiinflam-matory	00469-5118-05 '00469-5119-01 '00469-5119-05 54868-3344-00	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3305	Injection trimetrexate glucoronate 25mg	Neutraxin	Antiinflam-matory	58178-0020-10 '58178-0020-50 '58178-0021-01	None	X	X												Weight based. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3310	Injection perphenazine up to 5mg	Trilafon	Anti-psychotic		3 per day	X	X	X		X						X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J3315	Injection triptorelin pamoate 3.75mg	Trelstar LA	Luteinizing hormone-releasing hormone	00009-5215-01 00009-7664-01	3 per month	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3320	Injection spectinomycin dihydrochloride up to 2g	Trobicin	Antibiotic	00009-7664-01		OHP	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3350	Injection urea up to 40g	Ureaphil	Diuretic	00009-0566-01															Not Covered
J3360	Injection diazepam up to 5mg	Valium	Benzodiaze-pine	54569-5351-00 '54868-0617-00 '54868-4061-00															Not Covered
J3364	Injection urokinase 5000 IU vial	Abbokinase open cath	Fibrinolytic	00074-6111-01	2 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3365	Injection IV urokinaase 250000 IU vial	Abbokinase	Fibrinolytic	00074-6109-05															Not Covered
J3370	Injection vancomycin HCl 500mg	Varocin Vancocin	Antibiotic	00002-1444-25 '00074-4332-01 '00074-4332-49 '00074-6534-01 '00074-6534-49		X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3395	Injection verteporfin 15mg	Visudyne																	Code close 1/1/05
J3396	Injection, verteporfin 0.1mg	Visudyne		58768-0150-15	None	X	Ophthal-mologist only												New code 1/1/05. Replaces J3395. Requires ICD-9-CM code 115.02, 115.12, 115.92, 360.21, 362.16, OR 362.52 and meter square on CMS 1500 claim form for payment consideration. . Only bill CPT codes 67221 or 67225 with J3396. Must be billed daily. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3400	Injection triflupromazine HCl up to 20mg	Vesprin		None	150mg per day	X	X			X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3410	Injection hydroxyzine up to 25mg	Vistaril Hyzine-50 Atarax	Antianxiety	00223-7885-01 '00517-4201-25 '54868-0858-00 '63323-0021-01	None	X	X	X		X									Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3411	Injection thiamine HCL 200mg	Thiamilate	Vitamin supplement	63323-0013-02	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3415	Injection pyridoxine HCl 100mg		Vitamin supplement	00223-8403-10 00223-8404-30 00223-8410-10 25332-0073-30 63323-0180-01	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3420	Injection vitamin B-12 cyanocobalamin up to 1000mcg	Sytobex Residol Rubramin PC	Vitamin supplement	00223-8860-30 '00223-8861-01 '00223-8862-25 '00517-0031-25 '00517-0130-01 '49072-0145-30 '52637-0282-10 '52637-0312-30 '54569-2130-00 '63323-0044-01	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3430	Injection phytonadione (viatamin K) per 1mg	Aqua Mephyton Konakion	Vitamin supplement	00006-7784-33 '00074-9157-01 '54868-4434-00	25 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3465	Injection voriconazole 10mg	VFEND	Antifungal	00049-3190-28	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3470	Injection hyaluronidase up to 150units	Wydase		None	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3475	Injection magnesium sulphate 500mg			00074-4075-32 '49072-0475-50 '63323-0064-20 '63323-0064-50															Not Covered
J3480	Injection potassium chloride 2mEq	Kdur Kaon-Cl	Electrolyte Supplement	00074-1513-02 '00074-3907-03 '00074-3934-02 '00223-8322-30 '00223-8330-01 '00223-8330-10 '00223-8331-20 '00223-8332-30 '00264-1940-10 '00264-1940-20 '00338-0318-02 '49072-0571-30 '54868-0767-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3485	Injection zidovudine 10mg	Retrovir	Antiretro-viral	00173-0107-93															Not Covered
J3486	Injection zipraosidone mesylate 10mg	Geodon	Anti-psychotic	00049-3920-83	10 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3487	Injection zoledronic acid 1mg	Zometa	Antidote	00078-0350-84	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J3490	**Unclassified drugs. Used only if a more specific code is not available.**																		Refer to the list of Approved Drugs Billed with HCPCS Code J3490 by WV Medicaid. Cost invoice may be required. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3520	Edetate disodium 10mg	Endrate Disotate	Antidote		None	X	X												Covered only for treatment for lead poisoning or heavy metal poisoning; duration <2 weeks. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3530	Nasal vaccine inhalation																		Not Covered
J3535	Drug administered thru a metered dose inhaler.																		Not Covered
J3570	Laetrile amygdalin vitamin B-17.																		Not Covered
J3590	**Unclassified biologics. Used only if a more specific code is not available.**																		Close code effective 7/1/05.
J7030	Infusion normal saline solution 1000cc			00074-1583-02 '00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7040	Infusion normal saline solution sterile (500ml = 1 unit)			00074-1583-02 '00074-7101-02 '00074-7983-02 '00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03 '00338-0049-04 '54868-0710-00 '54868-0710-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7042	5% dextrose/normal saline (500ml - 1 unit)			Too numerous to list		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7050	Infusion normal saline solution 250cc			00074-1583-02 '00074-7983-02 00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03 '00338-0049-04 '54868-0710-00 '54868-0710-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7051	Sterile saline or water up to 5cc			Too numerous to list	1 per day			X						X					Medical necessity documentation of services provided must be maintained in the member's individual file.
J7060	5% dextrose/water (500 ml = 1 unit)			00074-1522-03 '00074-7922-03 '00074-7922-55 '00264-1101-55 '00264-7510-10 '00338-0016-03 '00338-0017-03 '54868-0296-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7070	Infusion D-5-W 1000cc			00074-1500-05 '00074-7922-09 '00264-1107-55 '00264-1110-00 '00264-7510-00		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7100	Infusion dextran 40 500ml	Rheomacrodex Gentran 75		00338-0271-03 61563-0212-65 61563-0211-65 00338-0272-03 00074-7419-03 00338-0270-03 00264-1962-10 00264-1963-10	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7110	Infusion dextran 75 500ml	Gentran 75		00338-0265-03 00338-0263-03 00074-1505-03 00074-1507-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7120	Ringer's lactate infusion up to 1000cc			00074-7953-09 '00264-3500-55 '00264-7750-00 '00338-0117-04	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7130	Hypertonic saline solution 50 or 100 mEq 20cc vial			Too numerous to list	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7190	Factor VIII human per IU	Monarc-M Koate HP Hemofil-M Alphanate SD Humate P Koate DVI MonoclateP vonWille-brand dise-ase	Antihemo-philic	00026-0664-20 '00026-0664-30 '00026-0664-50 '00026-0664-60 '00026-0665-20 '00026-0665-30 '00026-0665-50 '00053-7656-01 '00053-7656-02 '00053-7656-04 '00944-2935-01 '49669-4600-01 '49669-4600-02 '52769-0460-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7191	Factor VIII porcine per IU	Hyate-C	Antihemo-philic	55688-0106-02	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7192	Factor VIII recombinant per IU	Recombi-nate Kogenate Helixate FS Refacto Advate	Antihemo-philic	00944-2938-01 '00944-2938-02 '00944-2938-03 '58394-0005-01 '58394-0006-01 '58394-0007-01 '58394-0011-01 52769-0464-02 52769-0464-05 52769-0464-10 00026-0372-20 00026-0372-30 00026-0372-50 00944-2940-01 00944-2940-02 00944-2940-03 00944-2940-04 00053-8130-01 00053-8130-02 00053-8130-04	None	X	X				X				X	HS			Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7193	Factor IX purified, non-combinant per IU	AlphaNine SD Mononine	Antihemo-philic	00053-7668-01 '00053-7668-02 '00053-7668-04 '49669-3600-02 68516-3600-02	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7194	Factor IX complex per IU	Bevulin VH Profilnine HT Konyne-80 Proplex T, SX-T	Antihemo-philic	00944-0581-01 '49669-3200-02 '49669-3200-03 '64193-0244-02 58394-0001-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7195	Factor IX recombinant per IU	Benefix	Antihemo-philic	58394-0001-01 '58394-0002-01 '58394-0003-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC#and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration.. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7197	Antithrombin III human per IU	Throbate III Atnativ	Antihemo-philic	00026-0603-20 '00026-0603-30	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7198	Anti-inhibitor per IU	Autoplex T FEIBA	Anti-inhibitor coagulant complex	59730-6059-07 '64193-0222-04	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7199	**Hemophilia clotting factor NEC. Used only if a more specific code is not available.**		Antihemo-philic																Close code effective 7/1/05.
J7300	Intrauterine copper contraceptive.	Paragard T380A	Contracep-tive	None	None	X	X	X	X										Medical necessity documentation of services provided must be maintained in the member's individual file.
J7302	Levonorgest releasing intrauterine contraceptive system 52 mg	Minera	Contracep-tive	None	None	X	X	X	X										Medical necessity documentation of services provided must be maintained in the member's individual file.
J7303	Contraceptive supply hormone containing vaginal ring each		Contracep-tive																Not Covered
J7304	Contraceptive supply, hormone containing vaginal patch each		Contracep-tive																Not Covered
J7308	Aminolevulinic acid HCl for topical administra-tion 20%, single unit dosage form (354mg)	Kerastick Levulan	Photosensi-tivity agent	67308-0101-01 '67308-0101-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7310	Ganciclovir 4.5 mg long-acting implant	Vitrasert Cytovene	Antiviral	61772-0002-01	None	X	Ophthal-mologist only												One per each eye per 5 months. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7317	Sodium hyaluronate per 20 to 25 mg dose for intra-articular injection	Hyalgan 20 Supartz 25	Osteoarth-ritic	08024-0724-12 '08363-7765-01	1 per week X 5	X	X	X											Requires ICD-9-CM code 715.XX or 716.XX on CMS 1500 claim form for payment consideration. Maximum 10 injections (5 per knee) in a 6 month period. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7320	Hylan G-F20 16mg/2ml for intra-articular injection	Synvisc	Osteoarth-ritic	00008-9149-01 '00008-9149-02 '66267-0921-03	1 per week X 3	X	X	X											Required ICD-9-CM code 715.XX or 716.XX on CMS 1500 claim form for payment consideration. Maximum 6 inections (3 per knee) in a 6 months period. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7330	Augologous cultured chondrocytes implant	Carticel		63861-1025-01															Not Covered
J7340	Dermal & epidermal tissue human origin with or without bioengineered or processed elements with metabolically active elements per square cm	Dermagraft Dermagraft TC		09978-0001-99 '30170-0000-10	None	X	X					X							Activate code effective 7/1/05. **For diabetes:** ICD-9-CM code 250.XX plus 707.XX for **surgeons**; OR, ICD 9-CM code 250.XX plus 707.13, 707.14, or 707.15 for **podiatrists**. For **venous stasis ulcer**: ICD-9-CM code 454.0, 454.1 or 454.2 plus 707.XX for **surgeons**; OR, ICD-9-CM code 454.0, 454.1 or 454.2 plus 707.13, 707.14, or 707.15 for **podiatrists** required on CMS 1500 claim form. Service limits for diabetic ulcer: 3 applications in 9 weeks per year per ulcer. Service limits for venous stasis ulcer: 3 applications in 12 weeks per year per ulcer. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7342	Dermal tissue human origin with or without other bioengineered or pro-cessed elements with metabolically active elements per square cm.	Applegraft		38172-0202-00	None	X	X					X							Activate code effective 7/1/05. ICD-9-CM code 250.XX plus 707.XX for **surgeons** and ICD-9-CM code 250.XX plus 707.13, 707.14 or 707.15 for **podiatrists** required on CMS 1500 claim form for payment consideration. . Service limits 1 application x 8 weeks per year per ulcer. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7343	Dermal & epidermal tissue nonhuman origin with or without other bioengineered or pro-cessed elements without metabolically active elements per square cm.			84784-0040-02 84784-0040-08 84788-0040-08 84784-0040-06 84788-0040-06 84784-0040-05 84788-0040-05	None	X	X					X							For **surgeons**: ICD-9-CM code(s) 941.30 - 941.39; 941.40 - 941.49; 942.30 - 942.39; 942.40 - 942.49; 943.30 - 943.39; 943.40 - 943.49; 944.30 - 944.38; 944.40 - 944.48; 945.30 - 945.39; 945.40 - 945.49; 946.3; 946.4; 949.3; OR 949.4 required on CMS 1500 claim form for payment consideration. For **podiatrists**: ICD-9-CM code 945.X2 or 945.X3 required on CMS 1500 claim form for payment consideration..

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J7344	Dermal tissue human orgin with or without bio-engineered or processed elements without metabolically active elements per square cm	Dermagraft Dermagraft TC		85600-5X10-10 38172-0001-01 81218-6040-04 86002-X04-04 86004-X07-07 86005-X05-05	None	X	X					X							Not Covered
J7350	Dermal tissue human origin injectable with or without other bioengi-neered or processed elements but without metabolized active elements per 10mg	Dermagraft Dermagraft TC			None	X	X					X							Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7500	Azathioprine oral 50mg	Imuran	Immuno-suppress-ant	00054-4084-25 '00054-8084-25 '00781-1059-01															Not Covered
J7501	Azathioprine parenteral 100mg	Imuran	Immuno-suppress-ant	65483-0551-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7502	Cyclosporine oral 100mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0241-15 '00078-0248-15 '00185-0933-30 '50111-0920-43															Not Covered
J7504	Lymphocyte immune globulin antihymocyte globulin equine parenteral 250mg	Atgam	Immune globulin	00009-7224-02															Medical necessity documentation of services provided must be maintained in the member's individual file.
J7505	Muromonab-CD3 paren-teral 5mg.	Orthoclone OKT3	Immuno-suppress-ant	59676-0101-01	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7506	Prednisone oral per 5mg	Deltasone Meticorten Orasone	Immono-suppress-ant	Too numerous to list	None	X	X												Not Covered
J7507	Tacrolimus oral per 1mg	Prograf	Immuno-suppress-ant	00469-0617-11 '00469-0617-73															Not Covered
J7509	Methylprednisolon e oral per 4mg	Medrol	Immuno-suppress-ant	Too numerous to list															Not Covered
J7510	Prednisolone oral per 5mg	Deltacortef	Immono-suppress-ant	00223-1512-01 '00223-1512-02															Not Covered

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J7511	Lymphocyte immune globulin antithymocyte globulin rabbit parenteral 25mg	Thymoglobulin	Immune globulin	62053-0534-25		X	X												Weight based. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7513	Daclizumab parenteral 25 mg	Zenapax	Immuno-suppress-ant	00004-0501-09	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7515	Cyclosporine oral 25mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0240-15 '00078-0246-15 '00185-0932-30 '50111-0909-43															Not Covered
J7516	Cyclosporine parenteral 250mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0109-01 55390-0122-10	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7517	Mycophenolate mofetil oral 250mg	CellCept	Immuno-suppress-ant	00004-0259-01 '00004-0259-05 '00004-0259-43															Not Covered
J7518	Mycophenolic acid oral 180mg	Myfortic	Immuno-suppress-ant	00078-0386-66 00078-0385-66															Not Covered
J7520	Sirolimus oral 1mg	Rapamune	Immuno-suppress-ant	00008-1031-05 '00008-1031-10															Not covered
J7525	Tacrolimus parenteral 5 mg	Prograf	Immuno-suppress-ant	00469-3016-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7599	**Immunosuppressive drug NOS. Used only if a more specific code is not available**																		Not Covered
J7608	Acetylcysteine inhalation solution unit dose form per g	Mucomyst Mucosil		00087-0570-07 '00087-0572-03															Not Covered
J7611	Albuterol inhalation concentrated form 1mg	Albuterol Sulfate Proventil Ventolin	Broncho-dilator	Too numerous to list															Not Covered
J7612	Levalbuterol inhalation solution concentrated form 0.5mg	Xopenex	Broncho-dilator	63402-0515-30															Not Covered
J7613	Albuterol inhalation solution unit dose 1mg	Albuterol Sulfate Airet Proventil Accuneb	Broncho-dilator	Too numerous to list															Not Covered

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J7614	Levalbuterol inhalation solution unit dose 0.5mg	Xopenex	Broncho-dilator	54868-4409-00 54569-4748-00 63402-0511-24 63402-0512-24 63402-0513-24															Not Covered
J7616	Albuterol up to 5 mg and Ipratropin bromide up to 1 mg compounded inhalation solution	Duoneb	Broncho-dilator	54569-5432-00 49502-0672-60 49502-0672-30															Not Covered
J7617	Levalbuterol up to 2.5 mg and Ipratropin bromide up to 1 mg. compounded in-halation solution		Broncho-dilator	None															Not Covered
J7618	Albuterol all formulations including separated isomers inhalation solutions concentrated form per 1mg. (Albuteral) or per 0.5 mg (Levalbuterol)		Broncho-dilator	00085-0208-02 '00182-6014-65 '00472-0832-20 '00603-1006-43 '50383-0741-20 '52959-0589-00 '54569-3900-00 '54868-3407-00 '54868-3479-00 '59930-1647-02 '63874-0708-20															Code closed 1/1/05
J7619	Albuterol all formulations including separated isomers inhalation solution unit dose per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)		Broncho-dilator	00054-8063-11 '00054-8063-13 '00054-8063-21 '00603-1005-40 '49502-0697-03 '49502-0697-33 '49502-0697-60 '50383-0742-25 '54569-3899-00 '59930-1517-01 '59930-1517-02															Code closed 1/1/05
J7621	Albuterol all formulations including separated isom-ers up to 5mg (albuterol) or 2.5 mg (levoalbuterol) and ipratropium bromide up to 1 mg compounded inhalation solution		Broncho-dilator	49502-0672-30 49502-0672-60															Code closed 1/1/05

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J7622	Bethamethasone inhalation solution unit dose form per mg			38779-0364-01 '38779-0364-03 '38779-0364-06 '49452-0802-01 '49452-0802-02 '49452-0802-03															Not Covered
J7624	Bethamethasone inhalation solution unit dose form per mg																		Not Covered
J7626	Butesonide inhalation solution unit dose form 0.25mg to 0.5mg	Pulmicort Respules		54569-5163-00 00186-1988-04 00186-1989-04															Not Covered
J7628	Bitolterol mesylate inhalation solution con-centrated form per mg	Tornalate		None															Not Covered
J7629	Bitolterol mesylate inhalation solution unit dose form per mg	Tornalate		None															Not Covered
J7631	Cromolyn sodium inhaltion solution unit dose form per 10mg	Gastrocrom Intal Nasalcrom	Antiallergic	00054-8167-21 '00054-8167-23 '00172-6406-49 '00172-6406-59 '00472-0750-21 '00472-0750-60 '49502-0689-02 '49502-0689-12															Not Covered
J7633	Budesonide inhalation solution concentrated form per 0.25mg	Pulmicort	Cortico-steroid	38779-0198-00 '38779-0198-03 '38779-0198-06 '49452-1291-01 '49452-1291-02 '49452-1291-03 '51552-0668-01															Not Covered
J7635	Atropine inhalation solution concentrated form per mg.																		Not Covered
J7636	Atropine inhalation solution administered through DME unit dose form per mg			10019-0250-20															Not Covered

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J7637	Dexamethasone inhalation solution concentrated form per mg			00223-7401-25 '00223-7402-30 '00223-7403-01 '00223-7404-05 '00223-7406-25 '00223-7407-01 '00223-7408-10 '00314-0896-30 '00314-0896-70 '00314-0896-75 '00517-4901-25 '00517-4905-25 '00517-4930-25 '00641-0367-25 '00703-3524-01 '00703-3524-03 '25332-0010-05															Not Covered
J7638	Dexamethasone inhalation administered through DME unit dose form per mg			Too numerous to list															Not Covered
J7639	Dornase alpha inhalation solution unit dose form per mg	Pulmozyme		50242-0100-39 '50242-0100-40															Not Covered
J7641	Flunisolide inhalation solution unit dose per mg			38779-0406-00 38779-0406-06 '38779-0406-09 '51552-0611-01 '51552-0611-05															Not Covered
J7642	Glycopyrrolate inhalation solution concentrated form per mg			00031-7890-06 '00031-7890-83 00223-7722-05 '00223-7723-20 '00517-4605-25 '00517-4620-25 '10019-0016-54 10019-0016-63															Not Covered
J7643	Glycopyrrolate inhalation solution unit dose form per mg			00031-7890-06 00031-7890-83 '00223-7722-05 '00223-7723-20 00517-4605-25 00517-4620-25 '10019-0016-54 '10019-0016-63															Not Covered

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J7644	Ipratropium bromide inhalation solution unit dose form per mg	Atrovent		00054-8402-11 '00054-8402-13 00054-8402-21 '00054-8404-11 '00054-8404-13 '00054-8404-21 '00472-0751-23 '00472-0751-30 '00472-0751-60 '00597-0080-62 '49502-0685-03 '49502-0685-33 '49502-0685-60															Medical necessity documentation of services provided must be maintained in the member's individual file.
J7648	Isoetharine HCl inhalation solution concentrated form per mg																		Not Covered
J7649	Isoetharine HCl inhalation solution unit dose form per mg																		Not Covered
J7658	Isoproterenol HCl inhalation solution con-centrated form per mg	Isuprel HCl Medihaler-150		00641-1438-35															Not Covered
J7659	Isoproterenol HCl inhalation solution unit dose form per mg	Isuprel HCl Medihaler-150		00641-1438-35															Not Covered
J7668	Metaproterenol sulfate inhalation solution con-centrated form per 10mg	Alupent																	Not Covered
J7669	Metaproterenol sulfate inhalation solution unit dose form per 10 mg	Alupent																	Not Covered
J7674	Methacholine chloride as inhalation solution through a nebulizer per 1mg	Provocho-line		64281-0100-12 64281-0100-06															Not Covered
J7680	Terbutaline sulfate inhalation solution con-centrated form per mg	Brethine Bricanyl																	Not Covered

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J7681	Terbutaline sulfate inhalation solution unit dose form per mg	Brethine Bricanyl																	Not Covered
J7682	Tobramycin unit dose form 300mg inhalation solution	Tobi		53905-0065-01															Not Covered
J7683	Triamcinolone inhalation solution concentrated form per mg	Azmacort		00003-0293-05 '00003-0293-20 '00003-0293-28															Not Covered
J7684	Triamcinolone inhalation solution unit dose form per mg	Azmacort		00003-0293-05 '00003-0293-20 '00003-0293-28															Not Covered
J7699	**NOC drugs in-halation drugs. Used only if a more specific code is not available.**																		Not Covered
J7799	**NOC drugs other than inhalation drugs. Used only if a more specific code is not available**																		Not Covered
J8499	**Prescription drug oral non-chemotherapeut ic NOS**																		Not Covered
J8501	Aprepitant oral 5mg	Emend Emend Tri-Fold	Antiemetic	00006-0462-30 00006-0461-30 00006-0462-05 00006-0461-05 00006-3862-03															Not Covered
J8510	Bulsulfan oral2 mg	Myleran	Anti-neoplastic	00173-0713-25															Not Covered
J8520	Capecitabine oral 150mg	Xeloda	Anti-neoplastic	00004-1100-51 00004-1100-20															Not Covered
J8521	Capecitabine oral 500mg	Xeloda	Anti-neoplastic	00004-1101-16 00004-1101-50															Not Covered
J8530	Cyclophosphamid e oral 25mg	Cytoxan Procytox	Anti-neoplastic	00015-0503-01 00015-0503-02 00015-0504-01 00054-4129-25 00054-4130-25 00054-8089-25 00054-8130-25															Not Covered

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J8560	Etoposide oral 50mg	VePesid	Anti-neoplastic	00015-3091-45 00378-3266-94 51079-0965-05															Not Covered
J8565	Gefitnib oral 250mg	Iressa	Anti-neoplastic																Not Covered
J8600	Melphalan oral 2mg	Alkeran		00173-0045-35 59572-0302-50															Not Covered
J8610	Methotrexate oral 2.5mg	Rheumatrex Dose Pack		00005-4507-04 00005-4507-05 00005-4507-07 00005-4507-09 00005-4507-91 00054-4550-15 00054-4550-25 00054-8550-25 00378-0014-01 00378-0014-50 00555-0572-02 00555-0572-35 00555-0572-45 00555-0572-46 00555-0572-47 00555-0572-48 00555-0572-49 00555-0927-01 00555-0928-01 00555-0929-01 00555-0945-01 00603-4499-21 00904-1749-60 51079-0670-05	N/C														Not Covered
J8700	Temozolomide oral 5mg	Temodar		00085-1244-01 00085-1244-02 00085-1248-01 00085-1248-02 00085-1252-01 00085-1252-02 00085-1259-01 00085-1259-02															Not Covered
J8999	**Prescription drug oral chemotherapeutic NOS. Used only if a more specific code is not available.**																		Not Covered

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J9000	Doxorubicin HCl 10mg	Adriamycin	Anti-neoplastic	00703-5043-03 '55390-0231-10 '55390-0235-10 '55390-0241-10 '55390-0245-10	20 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9001	Doxorubicin HCl all lipid formulation 10mg	Doxil	Anti-neoplastic	17314-9600-01 '17314-9600-02	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9010	Alemtuzumab 10mg	Campath	Anti-neoplastic	50419-0355-10	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9015	Aldesleukin per single use vial.	Proleukin	Biological Response Modulator	53905-0991-01	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9017	Arsenic trioxide 1mg	Trisenox	Anti-neoplastic	60553-0111-10	15 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9020	Asparaginase 10000U	Elspar	Anti-neoplastic	00006-4612-00 00247-1289-10	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9031	BCG live (intravesical) per instillation	TheraCys Tice BCG	Biological Response Modulator	00052-0602-02 49281-0880-01 00052-0603-02	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9035	Injection bevacizumab 10 mg	Avastin		50242-0061-01 50242-0060-02 50242-0060-01	None	X	X												New code 1/1/05. Requires ICD-9-CM code 153.0 - 154.8 on CMS claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9040	Bleomycin sulfate 15U	Blenoxane	Anti-neoplastic	00015-3010-20 '00703-3154-01 '00703-3154-91 '61703-0332-18 61703-0323-22 55390-0006-01 00703-3155-91 00703-3155-01 55390-0005-01	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9041	Injection bortezomib 0.1 mg	Velcade	Proteasome Inhibitor	63020-0049-01	None	X	X												New code 1/1/05 Activate 1/1/05. Must have ICD-9-CM code 203.00 on CMS claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9045	Carboplatin 50mg	Paraplatin	Anti-neoplastic	00015-3213-30	18 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9050	Carmustine 100mg	BICNU	Anti-neoplastic	00015-3012-38	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9055	Injection Cetuximab 10 mg	Erbitux		66733-0948-23	None	X	X												Code opened 1/1/05. Must have ICD-9-CM code 153.0-154.8 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9060	Cisplatin powder or solution per 10mg	Plantinol AQ	Anti-neoplastic	00703-5747-11 '00703-5748-11 '10019-0910-01 '10019-0910-02 '55390-0112-50 '55390-0112-99 '55390-0414-50 '55390-0414-99 '63323-0103-91 '63323-0103-95	18 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9062	Cisplatin 50mg	Plantinol AQ	Anti-neoplastic	00703-5747-11 '10019-0910-01 '55390-0112-50 '55390-0414-50 '63323-0103-91	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9065	Injection cladribine per 1 mg	Leustatin	Anti-neoplastic	55390-0115-01 '55390-0124-01 '59676-0201-01	40 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9070	Cyclophosphamide 100mg	Cytoxan Neosar	Anti-neoplastic	00013-5606-93	68 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9080	Cyclophosphamide 200 mg	Cytoxan Neosar	Anti-neoplastic	00013-5616-93	34 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9090	Cyclophosphamide 500 mg	Cytoxan Neosar	Anti-neoplastic	00013-5626-93 '00015-0547-41	14 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9091	Cyclophosphamide 1g	Cytoxan Neosar	Anti-neoplastic	00013-5636-70 '00015-0548-41	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9092	Cyclophosphamide 2g	Cytoxan Neosar	Anti-neoplastic	00013-5646-70 '00015-0549-12	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9093	Cyclophosphamide lyophilized 100mg	Cytoxan Lyophilized	Anti-neoplastic	00015-0546-41	68 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9094	Cyclophosphamide lyophilized 200 mg	Cytoxan Lyophilized	Anti-neoplastic	00015-0546-41	34 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9095	Cyclophosphamide lyophilized 500 gm	Cytoxan Lyophilized	Anti-neoplastic	00013-5626-93 '00015-0547-41	14 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9096	Cyclophosphamide lyophilized 1g	Cytoxan Lyophilized	Anti-neoplastic	00013-5636-70 '00015-0548-41	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9097	Cyclophosphamide lyophilized 2g	Cytoxan Lyophilized	Anti-neoplastic	00015-0549-12 '00015-0549-41	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9098	Cytarabine liposome 10 mg	DepoCyt	Anti-neoplastic	53905-0331-01	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9100	Cytarabine 100mg	Cytosar-U	Anti-neoplastic	00009-0373-01	75 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9110	Cytarabine 500mg	Cytosar-U	Anti-neoplastic	00009-0473-01 '55390-0132-10 '55390-0807-10	15 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9120	Dactinomycin 0.5mg	Cosmegen	Anti-neoplastic	00006-3298-22	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9130	Dacarbazine 100mg	DTIC-Dome	Anti-neoplastic	63323-0127-10	9 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9140	Dacarbazine 200mg	DTIC-Dome	Anti-neoplastic	00026-8151-20 '00703-5075-01 '00703-5075-03 '55390-0090-10 '63323-0128-12 '63323-0128-20	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9150	Daunorubicin HCl 10mg	Cerubidine	Anti-neoplastic	55390-0281-10 '55390-0805-10	11 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9151	Daunorubicin citrate liposomal formulation 10 mg	Daunoxome	Anti-neoplastic	61958-0301-01	11 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9160	Denileukin diftitox 300mcg	Ontak	Anti-neoplastic	64365-0503-01															Not Covered
J9165	Diethylstilbestrol diphosphate 250 mg	Stilphostrol			4 per day	X	X												Cannot bill with 96545. Only for cancer diagnosis. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9170	Docetaxel 20mg	Taxotere	Anti-neoplastic	00075-8001-20	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9178	Injection epirubicin HCl 2 mg	Ellence	Anti-neoplastic	00009-5091-01 00009-5093-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9181	Etoposide 10mg	VesPesid Toposar	Anti-neoplastic	00013-7336-91 '00013-7346-94 '00013-7356-88 '00015-3061-20 '00015-3062-20 '00015-3084-20 '00015-3095-20 '10019-0930-01 '55390-0291-01 '55390-0292-01 '55390-0293-01 '55390-0491-01 '55390-0492-01 '55390-0493-01 '63323-0104-05 '63323-0104-25 '63323-0104-50	25 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9182	Etoposide 100mg	VesPesid Toposar	Anti-neoplastic	00013-7336-91 '00015-3095-20 '55390-0291-01 '55390-0491-01 '63323-0104-05	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9185	Fludarabine phosphate 50mg	Fludara	Anti-neoplastic	50419-0511-06	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9190	Fluorouracil 500 mg	Adrucil	Anti-neoplastic	00013-1036-91 '00187-3953-64	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9200	Floxuridine 500 mg	FUDR	Anti-neoplastic	55390-0135-01 '55390-0435-01 '61703-0331-09 '63323-0145-07	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9201	Gemcitabine HCl 200mg	Gemzar	Anti-neoplastic	00002-7501-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9202	Goserelin acetate implant per 3.6mg	Zoladex	Anti-neoplastic	00310-0960-36 00310-0951-30 00310-0950-35	1 per month	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9206	Irinotecan 20mg	Camptosar	Anti-neoplastic	00009-7529-01 '00009-7529-02	35 per day	X	X												Requires ICD-9-CM code 153.0 - 154.8.on CMS 1500 claim form for payment consideratin. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9208	Ifosfamide per 1g	Ifex	Anti-neoplastic	00015-0556-05 '63323-0142-10 '63323-0142-12 00015-0557-41	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9209	Mesna 200mg	Mesnex	Anti-neoplastic	00015-3563-02 '00015-3563-03 '00703-4805-03 '63323-0733-10 '63323-0733-11 '63323-0733-12	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9211	Idarubicin HCl 5mg	Idamycin Pfs	Anti-neoplastic	00703-4154-11	12 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9212	Injection interferon alfa-con1 recombinant 1mcg	Infergen	Antiviral	'55513-0562-01 55513-0562-06 '64116-0031-01 '64116-0031-06	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9213	Interferon alfa-2A recombinant 3 million U	Roferon-A	Antiviral	00004-2015-07 '00004-2015-09	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9214	Interferon alfa-2B recombinant 1 million U	Intron-A	Antiviral	00085-0539-01 '00085-0571-02 '00085-1110-01	19 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9215	Interferon alfo-n3 human leukocyte derived 250,000 IU	Alferon-N	Biological Response Modulator	54746-0001-01	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9216	Interferon gamma 1B 3 million U	Actimmune	Biological Response Modulator	64116-0011-01 '64116-0011-12	2 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9217	Leuprolide acetate for depot suspension 7.5mg	Lupron Depot Eligard Lupron Depot Ped	Anti-neoplastic	00024-0597-07 '00300-3642-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9218	Leuprolide acetate 1mg	Lupron	Anti-neoplastic	00182-3154-99 '00185-7400-14 '00185-7400-85 '00300-3612-24 '00300-3612-28 '00703-4014-18 '00703-4014-19	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9219	Leuprolide acetate implant 65mg	Viadur	Anti-neoplastic	00026-9711-01	1 per 3 months	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9230	Mechlorethamine HCl nitrogen mustard 10mg	Mustargen	Anti-neoplastic	00006-7753-31	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9245	Injection melphalan HCl 50mg	Alkeran Lphenylalanine mustard	Anti-neoplastic	00173-0130-93	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9250	Methotrexate sodium 5mg	Rheumatrex Trexall Methotrexate sodium Lpf	Anti-neoplastic	54569-4983-00 '63323-0123-02 '63323-0123-10 '66479-0137-21 '66479-0139-29	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9260	Methotrexate sodium 50mg	Rheumatrex Trexall Methotrexate sodium Lpf	Anti-neoplastic	63323-0123-02	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9263	Injection oxaliplatin 0.5mg	Eloxatin	Anti-neoplastic	00024-0596-02 00024-0597-04	None	X	X												Requires ICD-9-CM code 153.0 - 154.8 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9265	Paclitaxel 20mg	Taxol Onxol	Anti-neoplastic	00015-3475-30 '00015-3479-11 '00172-3753-77 '00172-3753-96 '00172-3754-73 '00172-3754-94 '00172-3756-75 '00172-3756-95 '51079-0961-01 '51079-0962-01 '51079-0963-01 '55390-0114-05 '55390-0114-20 '55390-0114-50	20 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9266	Pegaspargase per single dose vial	Oncaspar	Anti-neoplastic	57665-0002-02	8 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9268	Pentostatin per 10mg	Nipent	Anti-neoplastic	62701-0800-01	1 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9270	Plicamycin 2.5mg	Mithracin Mithramycin	Anti-neoplastic	00026-8161-15	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9280	Mitomycin 5mg	Mutamycin	Anti-neoplastic	00015-3001-20 '55390-0251-01 '55390-0451-01 '62701-0010-01	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9290	Mitomycin 20mg	Mutamycin	Anti-neoplastic	00015-3002-20 '55390-0252-01 '55390-0452-01 '62701-0011-01 '63323-0191-40	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J9291	Mitomycin 40mg	Mutamycin	Anti-neoplastic	00015-3059-20 '55390-0253-01 '55390-0453-01		X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9293	Injection mitaxan-trone HCl 5mg	Navatrone	Anti-neoplastic	58406-0640-03 '58406-0640-05 '58406-0640-07	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9300	Gemtuzumab ozogamicin 5mg	Mylotarg	Anti-neoplastic	00008-4510-01	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9305	Injection pemetrexed 10mg	Alimta	Anti-neoplastic	00002-7673-01	None	X	X												New code 1/1/05. Must have ICD-9-CM code 162-163.9 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9310	Rituximab 100mg	RituXan	Anti-neoplastic	50242-0051-21 50242-0053-06	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9320	Streptozocin 1g	Zanosar	Anti-neoplastic	00247-1394-01 00703-4636-01	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9340	Thiotepa 15mg	Thioplex	Anti-neoplastic	00703-4301-02 '55390-0030-10 '58406-0662-01 58406-0662-36	10 per day	X	X												For Bone Marrow Transplants. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9350	Topotecan 4mg	Hycamtin	Anti-neoplastic	00007-4201-01 '00007-4201-05															Not Covered
J9355	Trastuzumab 10mg	Herceptin	Anti-neoplastic	50242-0134-60	40 per day	X	X												Canot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9357	Valrubicin intravesical 200mg	Valstar	Anti-neoplastic	53014-0216-04 '53014-0216-24	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9360	Vinblastine sulfate 1mg	Vinblastine Sulfate Velban	Anti-neoplastic	63323-0278-10 61703-0310-18 55390-0091-10	46 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9370	Vincristine sulfate 1mg	Oncovin Vincasar Pfs	Anti-neoplastic	00013-7456-86 '00703-4402-11	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9375	Vincristine sulfate 2mg	Oncovin Vincasar Pfs	Anti-neoplastic	00013-7466-86 '00703-4412-11	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9380	Vincristine sulfate 5mg	Vincasar Pfs	Anti-neoplastic	00013-7456-86 '00013-7466-86 '00703-4402-11 '00703-4412-11	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9390	Vinorelbine tartrate 10mg	Navelbine	Anti-neoplastic	00173-0656-01 '00703-4182-01 '00703-4183-01 '59911-5958-01	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9395	Injection fulvestrant 25mg	Faslodex	Antineo-plastic	00310-0720-25 00310-0720-50	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

West Virginia Department of Health and Human Resources
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HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J9600	Porfimer sodium 75mg	Photofrin	Antineo-plastic	58914-0155-75	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9999	**NOC antineoplastic drug. Used only if a more specific code in not available.**					X	X											X	Requires Prior Authorization effective 7/1/05. Submit medical documentation of failed therapy(ies) and confirmation of diagnosis to BMS Medical Director for review prior to providing services. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 16
DRUGS APPROVED TO BE BILLED WITH HCPCS CODE J3490

West Virginia Department of Health and Human Resources
Office of Healthcare Policy Managed Care Coordination
Unlisted J3490 Medications
July 1, 2005

Description	Brand Name	Dosage	Reimbursable To	Special Instruction
Allopurinal Sodium	Aloprim Zyloprim	500mg	Outpatient Hospital and Physician	ICD-9-CM 174.9 or 790.6 plus ICD-9-CM for Neoplasm and NDC# required on claim. Drug must be billed with the code for Chemotherapy.
Amikacin Sulfate	Amikin	50mg	Physician and Nurse Practitioner	NDC# required on claim form.
Azacitidine	Vidaza	1mg	Outpatient Hospital and Physician	ICD-9-CM 238.7 and NDC# required on claim.
Aztreonam	Azactam	500mg	Physician and Nurse Practitioner	NDC# required on claim.
Bretylium	Tosylate	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Bumetanide	Bumex	0.25mg	Physician and Nurse Practitioner	NDC# required on claim.
Bupivicaine 0.75%, 1ml	Marcaine Sensorcaine	1ml	Physician and Nurse Practitioner	0.75%/10ml allowed when billed with 62310, 62311, 62318, 62319, 64400 - 64484, 64505 - 64530. Not payable when billed with other procedures. NDC# required on claim.
Cimetidine HCl	Tagamet	150mg	Physician and Nurse Practitioner	ICD-9-CM 787.01, 787.02 OR 787.03 and NDC# required on claim.

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Clavulanate Potassium/Ticarcillin Disodium	Timentin	0.1-3G	Physician and Nurse Practitioner	NDC# required on claim.
Clindamycin Phosphate	Cleocin Clindamax	150mg	Physician and Nurse Practitioner	NDC# required on claim.
Dantrolene Sodium	Dantrium	20mg	Physician and Nurse Practitioner	NDC# required on claim.
Dextrose 50%		50%	Physician and Nurse Practitioner	NDC# required on claim.
Diltiazem HCl	Cardizem	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Edrophonium Chloride	Tensilon Reverso	10mg	Physician and Nurse Practitioner	ICD-9-CM 358.0 and NDC# required on claim.
Esmolol HCl	Brevibloc	10mg	Physician and Nurse Practitioner	ICD-9-CM 427.89 and NDC# required on claim.
Ethacrynate Sodium	Edecrin	50mg	Physician and Nurse Practitioner	NDC# required on claim.
Famotidine	Pepcid	10mg	Physician and Nurse Practitioner	NDC# required on claim.
Flumazenil	Romazicon Mazicon	0.1mg	Physician and Nurse Practitioner	ICD-9-CM 977.9 and NDC# required on claim.
Folic Acid	Folate	5mg	Physician and Nurse Practitioner	NDC# required on claim.

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Glycopyrrolate	Robinul	0.2mg	Physician and Nurse Practitioner	NDC# required on claim.
Heparin Sodium		100U	Physician and Nurse Practitioner	NDC# required on claim.
Histrelin Implant	Vantas	5mg	Physician	ICD-9-CM code 185 and NDC# required on claim. Service limits 1 per year. Males only.
Isoproterenol HCl	Isuprel	0.2mg	Physician and Nurse Practitioner	NDC# required on claim.
Labetalol HCl	Trandate Normodyne	20mg	Physician and Nurse Practitioner	Covered for IV in office only with ICD-9-CM 401.0 and NDC# required on claim.
Lidocaine		1ml	Physician	Covered separately when billed on same day as 62310, 62311, 62318, 62319, 64400-64484, 64505-64530. Not payable when billed with other procedures. NDC# required on claim.
Metoprolol Tartrate	Lopressor	1mg	Outpatient Hospital, Physician, IDTF	Covered only when given IV with Dobutamine J1250 during Dobutamine Stress Test. Bill with both J3490 & J1250. NDC# required on claim.
Metronidazole in NACL	Flagyl	500mg	Physician and Nurse Practitioner	NDC# required on claim.
Minocycline HCl	Dunacin Minocin	100mg	Physician and Nurse Practitioner	NDC# required on claim.

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Nafcillin Sodium	Unipen Nallpen	IG	Physician and Nurse Practitioner	NDC# required on claim.
Nitroglycerin	Nitrostat	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Paclitaxel protein-bound particles	Abraxane	1mg	Outpatient Hospital and Physician	New code 04/01/05. Mjust be billed with Chemo. NDC# required on claim.
Pantoprazole Sodium	Protonix	40mg	Physician and Nurse Practitioner	NDC# required on claim.
Pegaptanib Sodium	Macugen	0.3mg	Ophthalmol-ogist ONLY	ICD-9-CM 362.52 and NDC# required on claim. Service limit 1 every 6 weeks. Must be billed with CPT 67028-RT or CPT 67028-LT
Potassium Acetate	Klor-Con	2mEq	Physician and Nurse Practitioner	NDC# required on claim.
Rifampin	Rifacin Rimactane	600mg	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Acetate		2mEq	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Bicarbonate		8.4% in 50ml	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Hyaluronate for Intra-Articular Injection	Orthovisc	30mg	Outpatient Hospital and Physician	ICD-9-CM 715.16, 715.26, 715.36 OR 715.96 and NDC# required on claim. Must be billed with CPT 20610. Service limit 1 injection per knee per week x 6months.

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Valproate Sodium	Depacon	100mg	Physician and Nurse Practitioner	ICD-9-CM code 345.00-345.91 and NDC# required on claim.
Vasopressin	Pitressin	20U	Physician and Nurse Practitioner	NDC# required on claim.
Verapamil HCl	Calan Calan SR IsoptinSR	2.5mg	Physician and Nurse Practitioner	NDC# required on claim.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 17
OUTPATIENT SURGERY PA REQUIREMENTS
PAGE 1 OF 15

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: ____________________ Member's Medicaid ID #:____________________

A. **Member** Name: ____ Date of Birth: __________
Last First MI
Member Address: ____
Street City State Zip

B. **Surgical Procedure** Requested: ____
CPT Code (**Required**): _________ ICD-9-CM Code (**Required**): _________ Assistant surgeon? ☐ Yes ☐ No
Diagnosis Related to Surgical Procedure: ____

C. **Facility** Performing Surgical Procedure: ____
Facility ID # (10 digits): ________________________ Facility is: ☐ In WV ☐ Outside WV

Referring Physician Name: ____
Mailing Address: ____
Street City State Zip
Surgeon Name: ____
Mailing Address: ____
Street City State Zip

Contact Name: ________________________ Phone# (____)______-__________ Ext: __________
Fax # (____)______-______________

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): ____
____
____
____ Date of Onset: __________

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):____
____
____

F. **Related Medications, Treatments, and Therapies (include duration):** ________________________
____
____
____

G. If procedure routinely performed in office, please document need for OP surgical setting: __________
____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For WVMI Use Only:
Approved: ___ **Authorization Number:** ________________________ **Date*:** ______________
***(Authorization expires 90 days from this date)**
Denied: ____ **Detailed letter to follow**

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X
11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X

11471	Removal, sweat gland lesion	X	X
11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X
12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	

14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	
14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	
19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	

19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	
19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	

21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	
21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	

22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	
22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	
25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	

26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	
26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	
27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	

28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	
28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	
29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	

29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	
42810	Excision of nect cyst	X	

42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	
43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	
49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	
54409	Removal of inflatable penile prosthesis	X	

54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	
57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	
58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	
64555	Implant neuroelectrodes	X	

64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	
64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervation of extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	
69632	Rebuild eardrum structures	X	

69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	
76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	
51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	

CHAPTER 519

PRACTITIONER SERVICES

JANUARY 16, 2012

ATTACHMENT 18

INFANT AND CHILD ORAL HEALTH FLUORIDE VARNISH PROGRAM FOR PRIMARY CARE PRACTITIONERS

PAGE 1 OF 4

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Governor

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Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

Bureau for Medical Services
Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners
Coverage Criteria

Physician fluoride varnish (FV) services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations specified below in this document. The American Dental Association (ADA) expert panels have reviewed evidence-based (class 1a) studies and concluded that "Fluoride varnish applied every six months is effective in preventing caries in the primary and permanent dentition of children and adolescents." Please see JADA executive Summary 2006 recommendations attached.

Fluoride varnish is a thin coating of resin that is applied to the tooth surface to protect it from decay. According to the Food & Drug Administration (FDA), fluoride varnish falls under the category of "drugs and devices" that presents minimal risk and is subject to the lowest level of regulation. The purpose of applying fluoride varnish is to retard, arrest, and reverse the process of cavity formation.

Fluoride varnish is easy to apply, does not require special dental equipment or a professional cleaning prior to application. It also requires minimal training, and is inexpensive. Fluoride varnish dries immediately upon contact with saliva and is safe and well tolerated by infants, young children, and individuals with special needs.

Effective January 16, 2012, the Bureau for Medical Services (BMS) will start reimbursing primary care providers who have been certified through a face-to-face training for fluoride varnish application offered through the West Virginia University School of Dentistry for the application of fluoride varnish to children ages 6 months to 36 months (3 years) who are at high risk of developing dental caries. The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist.

A child is considered at high risk of developing cavities if he or she:

- ✓ Has had cavities in the past or has white spot lesions and stained fissures
- ✓ Continues to use the bottle past one year of age or sleeps with a bottle containing liquids other than water
- ✓ Breastfeeds on demand at night
- ✓ Has a developmental disability
- ✓ Chronically uses high sugar oral medications
- ✓ Has family members with histories of caries
- ✓ Engages in prolonged or ad lib use throughout the day of a bottle or "sippy" cup containing liquids other than water

Who is not Covered:

- ✓ Children with a low risk of cavity formation who consume optimally fluoridated water or children who receive routine fluoride treatments through a dental office.

BMS recognizes the following types of primary care providers to be eligible for payment of this service:

- ✓ Pediatricians
- ✓ General and Family Practice Doctors
- ✓ Nurse Practitioners
- ✓ Physician Assistants (in FQHC settings only)

Provider Eligibility to Bill for Program Services

Providers must have completed a certified training course from the WVU School of Dentistry prior to performing and billing for these services. The WVU School of Dentistry will provide a list of all current certifications monthly in 2011 and thereafter to BMS and its fiscal agent in order to create a file of reimbursable providers. Information about this course is available at www.hsc.wvu.edu/sod/oral-health.

Reimbursement for the Services

BMS allows coverage of two fluoride varnish applications per year (one every six months). The first application must be provided and billed in conjunction with a comprehensive well-child exam as reported under the CPT codes listed in the table below. The second fluoride varnish application can be reimbursed during the 12-month subsequent period, and may be billed in conjunction with the HCPCS code outlined in the table below.

BMS will use the following codes to reimburse primary care providers for fluoride varnish application:

Code	Description	Comments
99381-99382 99391-99392	Comprehensive well-child exam codes for children less than 1 year and up to age 4 (note FV coverage under this program is only through age 3)	Oral evaluation and counseling are components of comprehensive well –child exams
T1503	Administration of medication, other than oral and/or injectable by a health care agency/professional, per visit Note: Use this code to bill for the topical fluoride varnish; therapeutic application for moderate to high caries risk patients. By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D1206-Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	Covered 2 times per year for children up to age 3; 1st application must be billed in conjunction with one of the comprehensive well child exam codes listed above
T1503-DA	Use Code T1503 with modifier-DA (Oral health assessment by a licensed health professional other than a dentist) to bill for oral evaluation of patient under three years of age and counseling with primary caregiver. Note: By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D0145 – Oral Evaluation for patient under three years of age and counseling with primary caregiver.	Covered once per year in conjunction with 2nd fluoride varnish application; cannot be covered when comprehensive well-child exam is billed on the same day and at least 180 days after billing for the comprehensive well child-exam
V20.2	Routine infant or child health check	Primary diagnosis used when billing well-child exam
V82.89	Special screening for other specified conditions	Secondary diagnosis used when billing comprehensive well-child exam
V72.2	Dental Exam	Primary diagnosis used when billing D0145 – dental exam; cannot report in combination with V20.2

Reimbursement will be made using the dental fee schedule effective on the date of service. The current fee for T1503 (D1206) will be $20.00 and T1503-DA (D0145) will be $25.00.

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

HELP IN YOUR LANGUAGE

If you do not speak English, call us at 800-782-0095 (TTY 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: Si usted no habla inglés, llámenos al 800-782-0095 (TTY 711). Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

For Help in Your Language — Discrimination is Against the Law

UniCare Health Plan of West Virginia, Inc. follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important
For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Customer Care Center number on your ID card. Or you can call our Grievance Coordinator at 1-800-782-0095 (TTY 711).

Your rights
Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail or fax:

Grievance Coordinator
P.O. Box 91
Charleston, WV 25321-0091

Phone: 1-800-782-0095 (TTY 711)
Fax: 1-877-833-5729

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F, HHH Building
  Washington, DC 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

For a complaint form, visit **www.hhs.gov/ocr/office/file/index.html**.

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-800-782-0095 (TTY 711).

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-800-782-0095 (TTY 711).

Vous avez besoin d'aide pour vos soins médicaux, pour communiquer avec nous ou pour lire les documents que nous vous envoyons ? Nous fournissons nos publications dans d'autres langues et sous d'autres formats, et c'est gratuit. Appelez-nous sans frais au 1-800-782-0095 (TTY 711).

Benötigen Sie Hilfe bei Ihrer medizinischen Versorgung, der Kommunikation mit uns oder beim Lesen unserer Unterlagen? Unsere Materialien sind auf Anfrage auch in anderen Sprachen und Formaten kostenlos erhältlich. Rufen Sie uns gebührenfrei an unter 1-800-782-0095 (TTY 711).

您需要醫療保健的幫助嗎？請向我們諮詢，或是閱讀我們寄給您的資料。我們以其他語言和格式提供我們的資料，您無需支付任何費用。請撥打免費電話 1-800-782-0095 (TTY 711)。

هل تحتاج إلى مساعدة في رعايتك الصحية أو في التحدث معنا أو قراءة ما نقوم بإرساله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى بدون تكلفة عليك. اتصل بنا على الرقم المجاني 1-800-782-0095 (TTY 711).

In caso si necessiti di assistenza con il servizio sanitario, per parlare con noi o comprendere le informazioni ricevute, sono disponibili materiali gratuiti in altre lingue e formati. Contattare il numero gratuito 1-800-782-0095 (TTY 711).

Kailangan ninyo ba ng tulong sa inyong pangangalagang pangkalusugan, sa pamamagitan ng pakikipag-usap sa amin, o pagbasa kung ano ang ipinapadala namin sa inyo? Nagbibigay kami ng aming mga materyal sa ibang mga wika at anyo na wala kayong gagastusin. Tawagan kami nang walang bayad sa 1-800-782-0095 (TTY 711).

의료 서비스, 당사와의 소통 또는 당사에서 보내는 자료 읽기와 관련해 도움이 필요하십니까? 무료로 자료를 다른 언어나 형식으로 제공해 드립니다. 무료 전화 1-800-782-0095 (TTY 711) 번으로 문의해 주십시오.

Quý vị có cần chúng tôi giúp với việc chăm sóc sức khỏe của quý vị, trao đổi với chúng tôi, hoặc đọc những tài liệu chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp các tài liệu bằng các ngôn ngữ và định dạng khác, miễn phí cho quý vị. Hãy gọi cho chúng tôi theo số miễn phí 1-800-782-0095 (TTY 711).

Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Мы можем бесплатно предоставить вам материалы на других языках и в других форматах. Позвоните в нам по бесплатному телефону 1-800-782-0095
(TTY 711).

ヘルスケアに関してご質問やご相談はありませんか？当社からお送りした資料のことでお困りですか？資料は英語以外の言語や別のフォーマットでもご用意しています。いずれも無料です。ご希望の方はフリーダイヤル 1-800-782-0095 (TTY 711)

คุณต้องการความช่วยเหลือในการดูแลทางด้านสุขภาพของคุณ การพูดคุยกับเรา หรือการอ่านสิ่งที่เราส่งให้คุณหรือไม่ เรามีคู่มือของเราในภาษาและรูปแบบอื่นๆ ให้กับคุณโดยไม่เสียค่าใช้จ่าย โทรหาเราได้ฟรี 1-800-782-0095 (TTY 711)

کیا آپ کو اپنی ہیلتھ کیئر سے متعلق مدد کی ضرورت ہے، یا ہم سے بات کرنے یا وہ پڑھنے میں جو ہم نے آپ کو ارسال کیا ہماری مدد درکار ہے؟ ہم اپنے مواد آپ کو دیگر زبانوں اور فارمیٹس میں بلامعاوضہ فراہم کرتے ہیں۔
1-800-782-0095 (TTY 711).

Χρειάζεστε βοήθεια σχετικά με την υγειονομική σας περίθαλψη, να μιλήσετε μαζί μας ή να διαβάσετε ό,τι σας έχουμε αποστείλει; Παρέχουμε το υλικό μας σε άλλες γλώσσες και μορφές χωρίς καμία επιβάρυνση για εσάς. Καλέστε μας χωρίς χρέωση στο 1-800-782-0095 (TTY 711).

Precisas de ajuda com a tua assistência à saúde, para falar connosco ou acerca do que enviamos para ti? Fornecemos os nossos materiais em outros idiomas e formatos sem custo algum. Liga-nos gratuitamente pelo número 1-800-782-0095 (TTY 711).

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WELCOME

Welcome to UniCare Health Plan of West Virginia, Inc.'s managed care program for Medicaid and West Virginia Children's Health Insurance Program (WVCHIP)! We are glad you have enrolled with us. This handbook will provide you with the information you need to know about your health care plan, also known as a managed care plan. Please read this handbook from cover to cover to understand the way your plan works. This handbook will help you get the most from UniCare. It will answer many of the questions that come up about your benefits and the services offered by UniCare. You can also ask us any questions you may have by calling the Customer Care Center at 800-782-0095. If you are speech or hearing impaired, please dial 711.

ABOUT YOUR PLAN

UniCare has contracts with the West Virginia Department of Health and Human Resources (DHHR) and WVCHIP. Under managed care, we are able to select a group of health care providers to form a provider network. Usually provider networks are made up of doctors and specialists, hospitals, and other health care facilities. UniCare's providers help to meet the health care needs of our members. Search for network providers and specialists anytime using the Find a Doctor tool on our website at unicare.com/wv.

The Provider Directory also lists all of our network providers you can use to get services statewide. It can be found online at our website, unicare.com/wv. If you would like a copy mailed to you, please call the Customer Care Center at 800-782-0095 (TTY 711).

CONTACT US

You can call the Customer Care Center toll free Monday through Friday, 8 a.m. to 6 p.m. Eastern time if you have a question about your health plan or a health problem. It will speed up the process if you have your or your child's member identification (ID) number with you when you call. You can find this number on the member ID card. You can visit our website, unicare.com/wv, for other information.

You can also call or drop by our office in Charleston to talk with our staff. Our people are here to listen — we want to understand what's important to you so we can guide you to helpful benefits. We're here Monday through Friday from 8 a.m. until 5 p.m. except on holidays.

Case Management services

UniCare has nurses, case managers, counselors, and social workers to help you with your health care needs. They can help you set health goals. They can help make sure you're seeing the right providers. Our social workers will also help you find assistance for community resources like housing, food, and utilities. To enroll in case management or to speak with a social worker, call our Customer Care Center at 800-782-0095 (TTY 711).

Have questions about a health issue? Call our 24-hour nurse help line, 24 hours a day, seven days a week at 888-850-1108 (TTY 711).

Help in other languages
We provide free oral interpretation services in more than 200 languages. We want you to have the right care, so we have:

- Staff members who can get you help in your language.
- 24-hour telephone interpreters.
- Sign language interpreters.
- Face-to-face interpreters.
- Providers who can get you help in your language.

If you need help in a language other than English during your medical visit, you can ask for an interpreter at no cost. Call the Customer Care Center Monday through Friday, 8 a.m. to 6 p.m., and we'll get someone who speaks your language.

You can call our 24-hour nurse help line at 888-850-1108 (TTY 711) if you or your child needs someone to interpret for you in an emergency or after regular office hours.

If you need the member handbook in a language other than English, we can translate it for you at no cost. Call the Customer Care Center at 800-782-0095 (TTY 711).

Help for members with hearing or speech loss
If you have hearing or speech loss, you may call our toll-free TTY line from 8 a.m. to 6 p.m. Eastern time, Monday through Friday, at 711. To get the help you need between 5 p.m. and 8 a.m., and on weekends, call the West Virginia Relay Service at 800-982-8772 (TTY 800-982-8771). After regular business hours, you can also call our 24-hour nurse help line at 888-850-1108 (TTY 711).

We can give this member handbook and other important plan materials in different formats. This is for people who need more help to learn about their plan. Here are the ways we can do this:

- Large print
- A CD for listening to plan information
- Braille
- Audiotape (cassette) for listening to plan information

Please call the Customer Care Center to get these other formats, or for help reading this handbook.

Americans with Disabilities Act
We meet the terms of the Americans with Disabilities Act (ADA) of 1990. This law protects you from unfair actions by your health plan because of a disability. Please call us if you feel you haven't been treated the same as others because of a disability.

Customer Care Center Department
Hours of Operation: Monday through Friday, 8 a.m. to 6 p.m. Eastern time
Toll-free: 800-782-0095
TTY: 711
Online: unicare.com/wv

You can visit us online to:

- Change your primary care provider (PCP) or get help choosing a provider
- View, print, or replace your member ID card
- Live chat with us or send us a secure message
- Complete your health risk screener
- View your claims (if applicable)
- View eligibility and redeem value-added services
- Ask about any change that might affect your or your family's benefits

You can also call to:

- Ask questions about services and benefits, eligibility, claims, prior authorization requests, or utilization management (more information on utilization management procedures is available upon request)
- Request interpreter services or help for people with disabilities
- File a complaint
- Let us know if you are pregnant
- Let us know if you give birth to a new baby

If you do not understand or speak English, we can help. Please call the Customer Care Center toll free at 800-782-0095 (TTY 711). We can answer questions about your benefits in your language. We have free interpreter services and can help you find a health care provider who can communicate with you in any language.

For people with disabilities, we can help. UniCare offers services so that you can communicate effectively with us and your provider. We have access to free sign language interpreter services and a TTY phone number: 711. We can offer this handbook and all written materials in many formats, such as large print, at no cost to you. Please call the Customer Care Center toll free at 800-782-0095 (TTY 711) to ask for materials in another format.

For other important phone numbers, please see the list in the back of this handbook.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your right to privacy. We will never give out your medical information or Social Security number without your written permission, unless required by law or for utilization review, quality assurance, or peer review. To learn more about your rights to privacy, please call the Customer Care Center at 800-782-0095 (TTY 711) or visit our website at unicare.com/wv.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act, you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East
Charleston, WV 25305
304-558-4331

DEFINITIONS

Appeal: A way for you to request the review of UniCare's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Adverse Benefit Determination: An adverse benefit determination is defined to mean any of the following actions taken by the health plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit.
2. The reduction, suspension or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one health plan, the denial of the beneficiary's request to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability.

Benefits: These are the health care services covered by UniCare.

BMS: Stands for the Bureau for Medical Services. This is the West Virginia agency that runs the Medicaid program.

Copayment: A fixed amount you pay each time you get a covered service or supply. For example, if you use the emergency room when it is not an emergency, you might pay $8.

Cosmetic Surgery: Surgery done to change or reshape normal body parts so they look better.

DHHR: The Department of Health and Human Resources for the state of West Virginia. This agency takes care of carve-out services not covered by UniCare such as personal care services.

Disenroll: To stop using the health plan because you are no longer eligible or you change your health plan.

Durable Medical Equipment (DME): Certain items your provider orders for everyday or extended use. Examples of these items are wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers and walkers.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. An emergency medical condition would make you think that without medical attention, it might: place your health (or a pregnant woman's unborn child's health) in serious jeopardy; or lead to death, serious dysfunction of a body part or organ or serious impairment of bodily functions. Examples of an emergency medical condition include severe pain, difficulty breathing or uncontrolled bleeding.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you receive in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are given by a qualified provider and needed to evaluate or stabilize an emergency medical condition.

Excluded Services: Health care services that UniCare does not pay for or cover.

Grievance: A complaint you make, either in writing or orally, about any aspect of service delivery provided or paid for by UniCare or our providers. For example, you might complain about the quality of your care.

Habilitation Services and Devices: Health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include occupational therapy, speech therapy and other services for people with disabilities in inpatient and/or outpatient settings.

Health Insurance: A contract that requires UniCare to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies and other services.

Hospice Services: Services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social and spiritual needs.

Hospitalization: Care in a hospital that requires admission as an inpatient and requires an overnight stay for more than two nights. An overnight stay for observation can be outpatient care and is allowed for up to 48 hours. Usually, inpatient care is required for very bad sickness, trauma, or if you do not get better within 48 hours.

Hospital Outpatient Care: Care in a hospital that usually does not require inpatient admission. You may stay the night in observation care for up to 48 hours. This is usually not considered inpatient care.

Inpatient Care: Means you have to stay the night in the hospital or other facility for the medical care you need. Sometimes, you may need to stay the night in the hospital so you can be watched (observation) without a full inpatient admission.

Medical Home: A West Virginia provider who is a general practice doctor, family practice doctor, internist, or pediatrician who has enrolled with UniCare as a primary care provider (PCP).

Medically Necessary: Health care services or supplies needed to diagnoses or treat an illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development.

Member: A person approved by the state of West Virginia to enroll in UniCare.

Network: A group of providers who has contracted with UniCare to give care to members. The list of UniCare providers can be found in our Provider Directory on our website. It will be updated whenever there are changes.

Non-participating Provider: A doctor, hospital, facility, or other licensed health care professional who has not signed a contract agreeing to provide services to UniCare members. Also known as an Out-of-Network provider.

OK by UniCare: Means you received an approval ahead of time from us. You can learn more about this in the *Getting to know your health plan* section, under the heading *Prior authorization (an OK from UniCare)* for health care services.

Peer Recovery Support Specialist (PRSS): A Peer Recovery Support Specialist is a person who uses their personal experience of recovery from addiction and skills learned in formal training to deliver services in substance use disorder settings.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, UniCare.

Prior Authorization: Approval from UniCare that may be required before you get certain services or treatments in order for them to be covered. To get prior authorization, make sure to ask the Customer Care Center. If the care is medically necessary and is a covered benefit, then it will be covered.

Participating Provider: A doctor, hospital, facility or other licensed health care professional who has signed a contract agreeing to provide services to UniCare members. They are listed in our Provider Directory.

Premium: The amount you pay for your health insurance every month based on your income. In addition to the premium, you may have to pay a copayment.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs and medications. UniCare does not provide prescription drug coverage, but the State of West Virginia does.

Primary Care Physician: A UniCare doctor who directly provides and coordinates your health care services.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant or other participating provider you have chosen to be your personal provider. Your PCP works with you to coordinate your health care, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed or admitting you to the hospital. For WVCHIP members, a PCP is also called a Medical Home.

Provider: A person who is trained and licensed or place that is licensed to give health care. Examples are doctors, nurses and hospitals.

Here are some types of health care providers:

- An audiologist is a provider who tests your hearing.
- A certified nurse-midwife is a registered nurse who cares for you during pregnancy and childbirth.

• A certified registered nurse anesthesiologist is a registered nurse certified to give you anesthesia.

• A chiropractor is a provider who treats problems of the spine.

• A dentist is a doctor who takes care of your teeth and mouth.

• A family practitioner is a provider who treats general medical conditions for people of all ages.

• A general practitioner is a doctor who treats common medical problems for people of all ages.

• A licensed vocational nurse is a licensed nurse who works with your provider.

• A nurse practitioner or physician assistant is a person who works in a clinic, hospital or provider's office and finds out what's wrong with you. They also treat you, within limits.

• An obstetrician/gynecologist (OB-GYN) is a doctor who takes care of a woman's health (this includes when she is pregnant or giving birth).

• An occupational therapist is a provider who helps you regain daily skills and activities after an illness or injury.

• An optometrist is a doctor who takes care of your eyes and vision.

• A pediatrician is a doctor who treats children from birth through their teen years.

• A physical therapist is a provider who helps you build your body's strength after an illness or injury.

• A podiatrist or chiropodist is a doctor who takes care of your feet.

• A psychiatrist is a doctor who treats behavioral health issues and prescribes medication.

• A registered nurse is a nurse with more training than a nurse who has a license to perform certain duties with your provider.

• A respiratory therapist is a provider who helps you with your breathing.

• A speech pathologist is a provider who helps you with your speech.

• A surgeon is a doctor who can operate on you.

Reconstructive Surgery: is done to correct a problem with a part of your body. This problem could be caused by:

- A birth defect
- Disease
- Injury

Making that part look or work better must be medically necessary.

Recovery Support Services: Recovery Support Services (RSSs) are non-clinical services that assist individuals to recover from alcohol or drug problems.

Rehabilitation Services and Devices: Health care services and devices that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. Examples include occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/or outpatient settings.

Skilled Nursing Care: From licensed nurses in your own home or in a nursing home.

Skilled Nursing Facility: A place that gives you 24-hour-a-day, skilled professional nursing care.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Substance Use Disorder (SUD) Services: SUD services are behavioral health treatment services provided to members with a known or suspected substance use disorder when medically necessary.

Urgent Care: Care you get for a sudden illness, injury or condition that is not an emergency, but needs care right away. You can get urgent care from out-of-network providers when network providers are unavailable or you cannot get to them. Out-of-network care always requires an OK from us. Examples of when to get urgent are a sprained ankle, a bad splinter or the flu.

Utilization Review: A process that allows UniCare and your health care providers to work together to decide if a service you ask for is medically necessary.

WVCHIP: Stands for West Virginia Children's Health Insurance Program. This is the West Virginia agency that runs the CHIP program.

YOUR RIGHTS

Each year, UniCare submits its annual report to the Bureau for Medical Services (BMS) of the West Virginia Department of Health and Human Resources by April 1. This report includes a description of the services, personnel, and the financial standing of UniCare.

The annual report is available to members by request only. To get a copy of the report, you can call our Customer Care Center or find it on our website at unicare.com/wv. You can also get a copy of the report from the West Virginia Department of Health and Human Resources.

As a member of UniCare, you have rights around your health care. You have the right to:

- Ask for and obtain all information included in this handbook
- Be told about your rights and responsibilities
- Get information about UniCare, our services, our providers, and your rights in a way that you understand
- Be treated with respect and dignity

- Not be discriminated against by UniCare
- Access all services that UniCare must provide
- Choose a provider in our network that is taking new patients
- Take part in decisions about your health care
- Refuse treatment and choose a different provider in our network
- Be part of honest talks about your health care needs and treatment options, no matter the cost and whether your benefits cover them
- Have your privacy respected
- Accessible services
- Ask for and to get your medical records as allowed by law
- Ask that your medical records be changed or corrected if needed, as allowed by law
- Be sure your medical records will be kept private
- Recommend changes in policies and procedures
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are homeless
- Refer yourself to in-network and out-of-network family planning providers
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services within our network
- Get emergency post-stabilization services
- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment and to make an advance directive
- Have your parent or a representative make treatment decisions when you can't
- Have problems taken care of fast, including things you think are wrong, as well as issues about getting an OK from us, your benefits, or payments for service
- Question a decision we make about benefits you got from your provider
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook
- Get the help you need to understand this handbook
- Ask for this handbook and other member materials in other formats such as large print, audio CD, or Braille at no cost to you
- Disenroll from your health plan
- Ask us about our Quality Improvement (QI) program and tell us how you would like to see changes made
- Ask us about our utilization review process and give us ideas on how to change it

- Ask us about our member rights and responsibilities policy and give us ideas on how to change it
- Know that the date you joined our health plan is used to decide your benefits
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for an oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends
- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your OK

YOUR RESPONSIBILITIES

As a member of UniCare, you also have some responsibilities:

- Read through and follow the instructions in this handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care
- Give information about your health to UniCare and your PCP
- Do your best to use providers who are in the UniCare network
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep your appointments
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know
- Follow your PCP's instructions of care that you have agreed to, as well as recommendations about appointments and medicines
- Go back to your PCP or ask for a second opinion if you do not get better
- Call the Customer Care Center at 800-782-0095 (TTY 711) whenever anything is unclear to you or you have questions
- Treat health care staff and others with respect
- Tell us right away if you get a bill that you should not have gotten or if you have a complaint
- Tell UniCare and the DHHR right away if you have had a transplant or if you are told that you need a transplant and you are a Medicaid member
- Tell UniCare and the DHHR when you change your address, family status, or other health care coverage
- Know that laws guide your health plan and the services you get

- Know that we do not take the place of workers' compensation insurance

STEPS TO YOUR GETTING CARE

YOUR MEMBER ID CARD

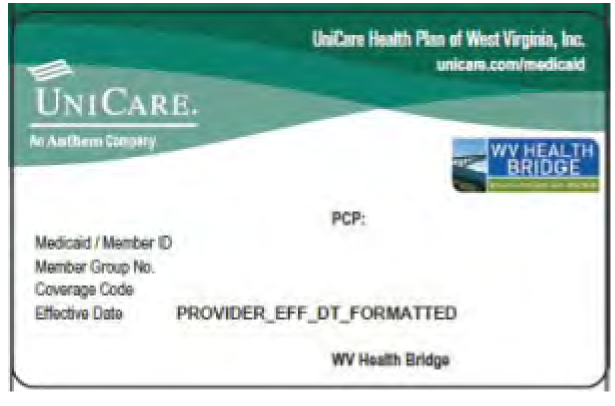
After you join UniCare, we will send you your member ID card in the mail. Each member of your family who has joined UniCare will receive his or her own card. If you have not received your member ID card after five days, please call the Customer Care Center at 800-782-0095 (TTY 711). You can view or print your member ID card on our member website. Download the UniCare mobile app to always have your member ID card with you.

It is important to always keep your member ID card with you. You will need it anytime you get care. Your card is your proof that you are a member of UniCare. Medicaid members should also keep their Medicaid Benefit card. You need it to get care that is not covered by UniCare.

Your card should look like this:

Medicaid

WV Health Bridge



WVCHIP

You will find some useful information on your card like your Medicaid or WVCHIP ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. WVCHIP members will find their copay group at the bottom of your ID card. Having your card out when you call the Customer Care Center can help us serve you faster.

You will get a new UniCare ID card if:

- You change your PCP
- Your PCP's address or phone number changes
- You lose your ID card
- Your coverage or copay group changes

Please call the Customer Care Center immediately at 800-782-0095 (TTY 711) if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You have a baby or add a new member to your family
- Someone in your family dies

Please call your county DHHR immediately if you move. Find the contact information for the DHHR (not your county DHHR) in the **Important Contact Information** section of this handbook. We may still be your health plan if you stay in state.

You are the only one who can get services with your UniCare member ID card. If you let someone else use your card, you may not be able to stay in our plan.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Each member of UniCare can choose a primary care provider (PCP). A PCP is a specific clinician responsible for coordinating your health care needs. For WVCHIP members, a PCP is also called

a Medical Home. You will need to choose a PCP who is taking new patients. If you do not pick a PCP, we will choose one for you.

You can select or change your PCP anytime by:

- Using the Find a Doctor tool on our website at unicare.com/wv. You can then register or log in to your account to select or change your PCP.
- Downloading the UniCare mobile app from the App Store® or Google Play™. Access the Find a Doctor tool and register or log in to your account to select or change your PCP.
- Calling the Customer Care Center at 800-782-0095 (TTY 711).
- Filling out and mailing back the *PCP Selection Form* found at the end of this handbook.

If you have a chronic illness, then you may be able to select a specialist as your PCP. Please call the Customer Care Center at 800-782-0095 (TTY 711). If you already have a PCP and believe you need a specialist, you or your provider should call the Customer Care Center. Women can also receive women's health care services from an obstetrical/gynecological practitioner (OB/GYN) without a referral from your PCP.

Upon request from the Customer Care Center, a description of the method of physician compensation is available to UniCare members.

Provider Directory

The Provider Directory is a list of all the doctors, hospitals, dental and specialty care providers, and other providers who work with UniCare. It tells you their address, phone number, office hours, and languages spoken. You can always find the most up to date Provider Directory at unicare.com/wv. You can also call the Customer Care Center to request one be mailed to you.

Look in the Provider Directory or the Find a Doctor tool at unicare.com/wv to find a PCP who is right for you or your family member.

- PCPs for children are listed under *Family Practice*, *Pediatrics*, or *General Practice*.
- PCPs for women are listed under *Family Practice*, *Obstetrics and Gynecology*, or *General Practice*. You may choose a certified nurse-midwife from the *Obstetrics* section.
- PCPs for adults are listed under *Family Practice*, *Internal Medicine*, or *General Practice*.

To find out more about a provider (such as specialty, medical school background, residency training, or board certifications), visit these websites:

- West Virginia Board of Medicine at www.wvdhhr.org/wvbom
- American Medical Association (AMA) at ama-assn.org

PCPs for pregnant women and newborn babies

If you're pregnant, call us right away. If you're in the last trimester of your pregnancy and you just joined our health plan, you may be allowed to stay with your current provider, even if he/she isn't in our plan.

If you're pregnant, you can also get support from our prenatal program, Taking Care of Baby and Me®. Read more in the **Pregnancy and Maternity Care** section.

If you haven't called UniCare to choose a PCP for your baby, you can call us after your baby is born. If you don't choose a PCP for your baby, we'll choose one for you.

ENROLLING NEWBORNS AND CHANGES TO FAMILY MAKEUP

Any newborn whose mother has UniCare will have UniCare for a minimum of 60 to 90 days. The newborn is enrolled on the first day of the month of their birth. The 60-day minimum starts from their day of birth. As soon as your baby is born, Medicaid members can call your Department of Health and Human Resources (DHHR) caseworker if you have one, or tell the Change Center at 877-716-1212. WVCHIP members can contact 877-982-2447 to inform them of changes in your family size status.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all of your routine health care needs. You can schedule your appointments by calling the PCP's office phone number. Your PCP's name and office phone number will be listed on your member ID card. You can call 24 hours a day, seven days a week. **On the day of your visit, remember to bring your member ID card and your Medicaid ID card if you are a Medicaid member.** Please show up on time and call to cancel an appointment if you cannot make it.

You shouldn't have to wait more than 45 minutes after you get to your provider's office. Your PCP may not be able to see you if you're late. If you cancel your appointment, someone at your PCP's office can help you set up a new one.

To schedule a visit with a specialist, first contact your PCP for a referral. Your PCP will make a referral to a specialist in our network.

UniCare requires that all routinely used sites, such as PCP offices and frequently used specialists, be located within 30 minutes travel time of an enrollee. Basic hospital services must be within 45 minutes travel time, and all other services must be within 60 minutes travel time. UniCare will ensure hours of operation are convenient and do not discriminate against enrollees.

UniCare requires emergency cases to be seen or referred immediately. Urgent cases must be seen within 48 hours. Routine cases must be seen within 21 days.

Non-emergency medical transportation (Medicaid members only):

If you need to schedule a ride to and from your provider visit, call the non-emergency medical transportation (NEMT) vendor, LogistiCare, at 844-549-8353, Monday through Friday from 8 a.m. to 6 p.m. Call at least five business days before your visit, unless it's urgent.

If you are unable to call LogistiCare within the normal business hours, or if you have additional questions regarding a ride request, ride services, or special needs for transportation, please call LogistiCare's Ride Assist Line at 844-549-8354.

If you are having a medical emergency, call 911 immediately and request an ambulance.

NEMT services include gas mileage reimbursement, passes for fixed route buses, and transportation supplied by private transportation providers.

Non-emergency transportation services are not covered under WVCHIP.

Your first appointment:
All new members should set up an initial health assessment (IHA) or a first exam with your PCP as soon as you can. This first visit with your PCP is important. It is a time to get to know each other, review your health history and needs, and come up with a plan to keep you healthy that works for you. If you're an adult, your first health review should be within 90 days of joining UniCare. A child should be seen by a PCP within 60 days of joining. If you're an SSI member, you should visit your PCP or specialist who handles your care within 45 days of joining UniCare. During the first exam, the PCP can learn about your health care needs and teach you ways to stay healthy.

CHANGING YOUR PCP

If you need to, you can change your PCP for any reason. Let us know right away by calling the Customer Care Center at 800-782-0095 (TTY 711) or by going to unicare.com/wv. You can change your PCP at any time. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so they can get to know you and your medical history. Call us before going to a provider who isn't your PCP. We can try to make them your PCP.

Sometimes PCPs leave our network. If this happens, we will let you know by mail within 7-10 days of us learning the provider is leaving our network. We can assign you a new PCP or you can pick a new one. If we need to assign you a new PCP for another reason, we will let you know.

If you want to change your PCP, please note:

- When choosing a new PCP, you must choose a provider who will see new patients. We can help you find one. A request to change your PCP may be denied if the PCP you want is not taking new patients.
- If you choose a PCP who is not taking new patients, we'll help you choose another one.
- Changing PCPs often can make your health care experience more complicated.
- Your PCP change will be effective on the date the change is made.
- You can begin seeing your new PCP on the day you ask for the change.
- You will get a new UniCare member ID card with your new PCP's name on it.

- It's important to have your medical records sent to your new PCP.

UniCare, or your PCP, may ask you to change your PCP if:

- UniCare no longer works with your PCP.
- You and your PCP aren't able to get along or agree.
- You are unable to keep appointments or often arrive late.
- You do not respect the staff of UniCare or your PCP's office.

We'll tell you in writing if we need to change your PCP.

If you want to change your PCP, you can:

1. Search for a new PCP using the Find a Doctor Tool at unicare.com/wv and register or log in to your secure account to change your PCP.
2. Download the UniCare mobile app from the App Store® or Google Play™. Access the Find a Doctor tool and register or log in to your account to select or change your PCP.
3. Call the Customer Care Center at 800-782-0095 (TTY 711).
4. Fill out and send us the *PCP Selection Form* found at the end of this book.

Our Provider Directory also lists the providers who work with UniCare. It also tells you their address, phone number, office hours, and languages spoken. You can find our Provider Directory at unicare.com/wv. You can also call us to request one be mailed to you.

GETTING A SECOND OPINION

You might have questions about your illness or the care your PCP says you need. You may want to get a second opinion from another provider. You should speak to your PCP if you want a second opinion. You or your PCP also may ask us for help. You must get services from a provider in our plan. If there is no provider in our plan that fits the care you need, we'll let you get a second opinion from a provider outside of our plan. Seeing a provider outside of our plan requires an OK from UniCare before you see them. There is no additional cost to you for a second opinion.

Getting a second opinion is helpful if:

- You have questions about a surgery your PCP or specialist says you need.
- You have questions about finding the cause or treatment for an ongoing problem or a health issue that could cause death.
- If you think your problem could greatly weaken you or cause loss of a limb or body function.
- Your PCP's advice is not clear or is hard for you to understand.
- Your PCP can't find the cause of your condition, or isn't sure because test results aren't the same.
- The treatment you are getting has not helped your medical problem within the time frame it should.

- You have tried to follow the treatment plan or talked with your PCP because you're concerned about the cause or the treatment plan.

You may use the UniCare grievance and appeal process if your PCP or specialist doesn't allow you to get a second opinion. See the **Letting Us Know When You're Unhappy** section to learn how to file a grievance or appeal.

This is only a summary of the UniCare policy on second opinions. You can call the Customer Care Center to request a full copy of the policy.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care to get in different situations.

You can also call our 24-hour nurse help line at 888-850-1108 (TTY 711) to speak privately to a nurse to help decide where you should go for care.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diseases such as diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need.

- Well care visits — A well care visit is when you or your child sees your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit, even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health, too. You can learn more about well care visits under the section titled *"More Information about Your Coverage."*
- Health management — Visits to manage your health, such as diabetes, asthma, or high blood pressure. These visits are to treat your diseases or help you get better.
- After hours care — You can reach your PCP, even if it is after normal business hours. Just leave a voicemail with your name and phone number. Your PCP or another PCP from the same office will call you back as soon as possible or during office hours.
- Specialist care — Your PCP can refer you to a specialist if you need care that your PCP cannot provide. You do not need an OK from UniCare to see a specialist who is in our network.

PREGNANCY CARE

Call us when you know you're pregnant. Our staff will make sure your provider and hospital are with UniCare. If you're pregnant, you can also get support from our maternity program, Taking Care of Baby and Me®. If you're in your last three months of pregnancy, you should set up a time to see your provider within three business days from the time you call.

It's important to schedule your first visit quickly so your provider can check on your pregnancy as soon as possible. If you think you have a high-risk medical problem that will affect your pregnancy, ask your provider if you can be seen right away. We want to make sure you get the best care for you and your baby.

Family planning

Family planning can help teach you how to:

- Be as healthy as you can before you become pregnant.
- Avoid getting pregnant.
- Avoid diseases.

Any member (including minors) may see a licensed family planning provider without getting an OK from UniCare first, even if he/she isn't in the UniCare plan. Licensed family planning providers could be:

- Clinics
- OB-GYNs
- PCPs
- Certified nurse-midwives

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs prompt care, but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- The flu
- Ear or sinus pain
- Stitches
- Eye swelling, irritation, redness, or pain

You can also get urgent care if you are traveling and are too far from your PCP's office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do. Our 24-hour nurse help line is available 24 hours a day, seven days a week at 888-850-1108 (TTY 711) to help you decide what to do.

When you visit one of the urgent care centers in our network, UniCare will help cover the cost. Before you go, call the center and ask:

- What are your hours?
- Do you give the care I need?

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think their life is at risk without treatment right away. Some examples of an emergency are:

- A heart attack or severe chest pain
- Severe shortness of breath
- Seizures when you have never had them before or if they will not stop
- Rape
- High fever with stiff neck, mental confusion, or difficulty breathing
- Coughing up or vomiting blood

You should not go to the emergency room (ER) for things like:

- Colds
- Minor cuts and bruises
- Sprained muscles
- Minor fevers or colds
- Headaches

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or UniCare. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or UniCare at 800-782-0095 (TTY 711). **Remember to use the ER only if you have an emergency.** You are always covered for emergencies.

If you are unsure where to go for care, call our 24-hour nurse help line toll free at 888-850-1108 (TTY 711). A nurse will help you decide which type of care makes the most sense. Plus, you may find out how to treat yourself at home.

If you need to stay in the hospital after an emergency, please make sure UniCare is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call UniCare. If you are able, call your PCP to let him or her know that you have a medical emergency. You will need to schedule follow-up services with your PCP.

For more information about emergency transportation and post-stabilization services, please see the Mountain Health Trust, West Virginia Health Bridge, and WVCHIP Covered Benefits table.

URGENT CARE CENTERS

EZ Care
324 A/B Penco Road
Weirton, WV 26062
304-224-1096

MedExpress Urgent Care Weirton
218 Three Springs Drive
Weirton, WV 26062
304-723-3627

MedExpress Urgent Care Wheeling
620 National Road, Ste. 300
Wheeling, WV 26003
304-233-3624

EZ Care
260 Russell Ave.
New Martinsville, WV 26155
304-398-4949

Ohio Valley Medical Quick Care, Inc.
517 36th St.
Parkersburg, WV 26101
304-485-1044

MedExpress Urgent Care South Charleston
4812 Maccorkle Ave. SW S. Charleston, WV 25309
304-768-3627

MedExpress Urgent Care Beckley Crossing
520 Beckley Crossing Ctr.
Beckley, WV 25801
304-252-6639

Ohio Valley Medical Quick Care, Inc.
324 Pike St.
Marietta, OH 45750
740-374-4540

MedExpress Urgent Care Parkersburg
1500 Grand Central Ave., Ste. 115
Vienna, WV 26105
304-485-3627

MedExpress Urgent Care Martinsburg
1355 Edwin Miller Blvd. Ste. A
Martinsburg, WV 25404
304-263-6753

MedExpress Urgent Care Charleston
5430 Maccorkle Ave. SE
Charleston, WV 251304
304-925-3627

Braxton Health Associates
617 River St.
Gassaway, WV 26624
304-364-8941

MedExpress Urgent Care Elm Grove
10 Elm Grove Crossing Mall
Wheeling, WV 26003
304-242-4228

MedExpress Urgent Care Bridgeport
120 Medical Park Drive, Ste. 100
Bridgeport, WV 26330
304-842-3278

EZ Care
2107 Pike St., Ste. 5
Parkersburg, WV 26101
304-424-7200

MedExpress Urgent Care Huntington
3120 US Rte. 60
Huntington, WV 25705
304-522-3627

Teays Urgent Care
113 Liberty Square Shopping Center
Hurricane, WV 25526
304-757-4007

MedExpress Urgent Care Beckley
1709 Harper Road
Beckley, WV 25801
304-256-8671

Community Care of WV Inc.
11 N. Locust St.
Buckhannon, WV 26201
304-473-1440

Whitehall Medical
60 Roxbury Road
Fairmont, WV 26554
304-363-6600

MedExpress Urgent Care Winchester Gateway
207 Gateway Drive
Winchester, VA 22603
540-535-1029

Medpointe of Harrison County
469 Emily Drive
Clarksburg, WV 26301
304-423-5180

MedExpress Urgent Care
Cross Lanes
5161 Washington St. W.
Cross Lanes, WV 25313
304-755-5323

Primecare 12
702 Stafford Drive
Princeton, WV 24740
304-425-0085

Bridgeport Express Care, Inc.
2 Chenoweth Drive
Bridgeport, WV 26330
304-842-3330

MedExpress Urgent Care
Morgantown
215 Don Knotts Blvd.
Ste. 130
Morgantown, WV 26501
304-291-3627

MedExpress Urgent Care
Princeton
277 Greasy Ridge Road
Princeton, WV 24740
304-425-7615

MedExpress Urgent Care
South Parkersburg
2832 Pike St., Ste. 1
Parkersburg, WV 26101
304-489-3815

WVU Fast Care Center
1075 Van Voorhis Road Ste. 100
Morgantown, WV 26505
304-599-2273

MedExpress Urgent Care
Lewisburg
1318 Jefferson St. N., Ste. A
Lewisburg, WV 24901
304-645-2164

MedExpress Urgent Care
Bridgeport
1370 Johnson Ave.
Bridgeport, WV 26330
304-842-7186

Elkins Express Care
1513 Harrison Ave.
Ste. 18
Elkins, WV 26241
304-637-0180

Direct Care of Elkins
720 Beverly Pike
Elkins, WV 26241
304-636-4585

Health Matters Urgent Care
14302 Barton Blvd. SW
Cumberland, MD 21502
301-729-3278

SE Emergency Physicians
124 Brookshire Lane
Beckley, WV 25801
304-255-9205

Direct Care of Parsons
307 Main St.
Parsons, WV 26287
304-478-2511

Jefferson Urgent Care
Route 340 N.
84 Somerset Blvd.
Charles Town, WV 25414
304-728-8533

MedExpress Urgent Care
Fairmont
630 Fairmont Ave.
Fairmont, WV 26554
304-363-6662

MedExpress Urgent Care
Glen Dale
1585 Wheeling Ave.
Glen Dale, WV 26038
304-843-5381

MedExpress Urgent Care
Teays Valley
563 State Route 34
Hurricane, WV 25526
304-757-5063

MedExpress Urgent Care
Bluefield
4003 College Ave., Ste. B
Bluefield, VA 24605
276-322-2085

Community Care of WV Inc.
7576 Seneca Trail
Hillsboro, WV 24946
304-924-6262

EMERGENCY ROOMS

Williamson ARH Hospital
260 Hospital Drive S.
Williamson, KY 41503
606-237-1700

Boone Memorial Hospital
701 Madison Ave.
Madison, WV 25130
304-369-1230

Kings Daughters Medical Center
2201 Lexington Ave.
Ashland, KY 41101
606-408-4000

Bluefield Hospital Company LLC
500 Cherry St.
Bluefield, WV 24701
304-327-1100

Camden Clark Memorial Hospital
800 Garfield Ave.
Parkersburg, WV 26101
304-424-2111

Summersville Memorial Hospital
400 Fairview Heights Road
Summersville, WV 26651
304-872-2891

St. Joseph's Hospital
1824 Murdoch Ave.
Parkersburg, WV 26101
304-434-4111

Beckley ARH Hospital
306 Stanaford Road
Beckley, WV 25801
304-255-3000

Braxton County Memorial Hospital
1088 Hoylman Drive
Gassaway, WV 26624
304-364-5156

Broaddus Hospital
One Healthcare Drive
Philippi, WV 26416
304-457-1760

Berkley Medical Center
3500 Hospital Drive
Martinsburg, WV 25401
304-264-1000

Clinch Valley Medical Center
2949 West Front St.
Richlands, VA 24641
276-596-6000

Garrett Memorial Hospital
251 N. Fourth St.
Oakland, MD 21550
301-533-4000

Logan Regional Medical Center
20 Hospital Drive
Logan, WV 25601
304-831-1101

Summers County ARH Hospital
1500 Terrace St.
Hinton, WV 25951
304-466-1000

Buchanan General Hospital
1535 Slate Creek Road
Grundy, VA 24614
276-935-1000

Grant Memorial Hospital
117 Hospital Drive
Petersburg, WV 26847
304-257-1026

CAMC Teays Valley Hospital
1400 Hospital Drive
Hurricane, VA 25526
304-757-1792

Alleghany Regional Hospital
One ARH Lane
Low Moor, VA 24457
540-862-6011

Montgomery General Hospital
401 6th Ave.
Montgomery, WV 25136
304-442-5151

Plateau Medical Center
430 Main St.
Oak Hill, WV 25901
304-469-8600

Ohio Valley Medical Center
2000 Eoff St.
Wheeling, WV 26003
304-234-0123

Jackson General Hospital
122 Pinnell St.
Ripley, WV 25271
304-372-2731

Davis Memorial Hospital
812 Gorman Ave.
Elkins, WV 26241
304-636-3300

East Ohio Regional Hospital
90 N. Fourth St.
Martins Ferry, OH 43935
740-633-1100

Grafton City Hospital
1 Hospital Plaza
Grafton, WV 26354
304-265-0400

Monongalia County
General Hospital
200 Wedgewood Drive
Ste. 104
Morgantown, WV 26505
304-285-1460

Raleigh General Hospital
1710 Harper Road
Beckley, WV 25801
304-256-4100

Reynolds Memorial Hospital
800 Wheeling Ave.
Glen Dale, WV 26038
304-845-3211

St. Joseph's Hospital
1 Amalia Drive Buckhannon,
WV 26201
304-473-2000

Greenbrier Valley
Medical Center
1302 Maplewood Ave.
Ronceverte, WV 24970
304-647-4411

Minnie Hamilton
Health Care Center
186 Hospital Drive
Logan WV, 25601
304-354-9344

Jefferson Medical Center
300 South Preston St.
Ranson, WV 25438
304-728-1600

Monongalia County
General Hospital
1200 J.D. Anderson Drive
Morgantown, WV 26505
304-598-1200

Princeton Community Hospital
122 12th St.
Princeton, WV 24740
304-487-7000

Roane General Hospital
200 Hospital Drive
Spencer, WV 25276
304-927-4444

Rockingham Medical Center
2010 Health Campus Drive
Harrison, VA 22801
540-689-1000

Shenandoah Memorial Hospital
759 S. Main St.
Woodstock, VA 22664
540-459-1100

Hampshire Memorial
Hospital
549 Center Ave.
Romeny, WV 26757
304-822-4561

Pleasant Valley Hospital, Inc.
2520 Valley Drive
Point Pleasant, WV 25550
304-675-4340

Pocahontas Memorial
Hospital
150 Duncan Road
Buckeye, WV 24924
304-799-7400

Potomac Valley Hospital of
WV, Inc.
100 Pin Oak Lane
Keyser, WV 26726
304-597-3500

Preston Memorial Hospital
150 Memorial Drive
Kingwood, WV 26537
304-329-1400

Sistersville General Hospital
314 S. Wells St. Sistersville,
WV 26175
304-652-2399

Southeastern Ohio Regional
Medical Center
1341 Clark St.
Cambridge, OH 43725
740-435-2141

YOUR BENEFITS

You can get many services through UniCare's managed care program in addition to those that come with regular Medicaid or WVCHIP. For most benefits, you will need to go through your primary care provider (PCP). There are some services that do not require a referral from your PCP. This means you do not need approval from your PCP. To get these services, access the Find a Doctor tool at unicare.com/wv or by downloading the UniCare mobile app in the App Store® or Google Play™. You can also look in our Provider Directory for the list of providers who offer these services. You can schedule the appointment yourself. If you have any questions, call the Customer Care Center at 800-782-0095 (TTY 711). The Customer Care Center can also explain how to access your services.

COVERED SERVICES

Your covered services must be medically necessary. You must get these services from providers in the UniCare network. If you have to use a provider who is not in our network, you must get an OK from UniCare before seeing them. Your PCP should provide covered services or refer you to another provider to do so. The services included fall under medical, behavioral, dental, and vision. Benefit packages differ, depending on whether you are covered under Mountain Health Trust, West Virginia Health Bridge, or WVCHIP. You can see any differences in the table below. You can get the services listed in the Mountain Health Trust, West Virginia Health Bridge, and WVCHIP Covered Benefits tables by using your UniCare member ID card.

Mountain Health Trust Covered Benefits
Medical • Primary Care Office Visits and Referrals to Specialists • Physician Services — Certain services may require prior authorization or have service limits. Some services may be delivered through telehealth (digitally using computer or mobile device). • Laboratory and X-ray Services — Includes lab services related to substance use disorder (SUD) treatment. Services must be ordered by a provider. Some services require prior authorization or have benefit limits. • Clinics — Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.
Specialty • Podiatry — Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures, and other injuries and orthotics. Routine foot care is not covered. Some services require prior authorization or have benefit limits. • Services for Children with disabilities and/or Special Health Care Needs — Provides specialty medical care, diagnosis, and treatment for children with disabilities and those who may be at risk of developing disabling conditions.

Mountain Health Trust Covered Benefits
Emergency • Emergency Room Services — covered for emergency care only • Post-stabilization Services — Includes care after an emergency health condition is under control. Care provided in a hospital or other setting. • Emergency Transportation — Includes ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary. Facility to facility ground ambulance transportation services that are medically necessary are covered. To call for Emergency Transportation, dial 911.
Preventive Care and Disease Management • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — Includes medically necessary health care services for any medical or psychological condition discovered during screening (for children only). • Tobacco Cessation — Includes therapy and counseling and Quitline services. Guidance and risk-reduction counseling are covered for children. • Sexually Transmitted Disease Services — Includes screening for a sexually transmitted disease from your PCP or a specialist.
Maternity • Right From The Start — Includes prenatal care and care coordination. No prior authorization required. • Family Planning — Includes all medically necessary family planning providers and services. Sterilizations, hysterectomies, pregnancy terminations, and infertility treatments are not considered family planning. No referral needed for out-of-network providers. • Maternity Care — Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.
Other • Federally Qualified Health Centers — Includes physician, physician assistant, nurse practitioner, and nurse midwife services. • Prosthetics — Some services require prior authorization or have benefit limits. • Durable Medical Equipment — Some services require prior authorization or have benefit limits. Diabetes supplies and equipment are covered under the retail pharmacy benefit. • Ambulatory Surgical Care — Includes services and equipment for surgical procedures. Provider services; lab and X-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs; and durable medical equipment not covered. Some services require prior authorization or have benefit limits. • Organ and Tissue Transplants — Corneal transplants only.

Mountain Health Trust Covered Benefits
• Medicines given by your provider, in an office, outpatient hospital, or infusion center are covered by UniCare. Some services require prior authorization or have benefit limits.
Nursing • Nurse Practitioner Services — Some services require prior authorization or have benefit limits. • Private Duty Nursing — Includes medically necessary nursing care (not covered for adults). Prior approval is required.
Rehabilitation • Physical Therapy — 20 visits per calendar year for habilitative and rehabilitative services (combined for physical and occupational therapy) and members will need an OK from us after 20 visits. You are allowed one evaluation and two reevaluations per year. • Occupational Therapy — 20 visits per calendar year for habilitative and rehabilitative services (combined for physical and occupational therapy) and members will need an OK from us after 20 visits. You are allowed one evaluation and two reevaluations per year. • Speech Therapy and Audiology — Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries and repairs (not covered for adults). Some services require prior authorization or have benefit limits. Speech therapy requires an OK from us after 10 visits. • Chiropractor Services — Chiropractor services includes radiological exams and corrections to partial dislocations (subluxation). Certain procedures have service limits or require prior approval. • Pulmonary Rehabilitation — Includes procedures to increase strength of respiratory muscle and functions. • Cardiac Rehabilitation — Includes supervised exercise sessions with electrocardiograph monitoring. • Inpatient Rehabilitation — Includes inpatient rehabilitation services and general medical services that meet the certification requirements. Prior authorization is required.

Mountain Health Trust Covered Benefits
Hospital • Inpatient — Includes medically necessary inpatient services (including bariatric surgery[ies]) at acute inpatient and long term acute care hospitals (LTACH). Prior authorization is required for all planned inpatient admissions. We must be told within 24 hours for an emergency admission. • Outpatient — Includes medically necessary preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services. Some services require prior authorization or have benefit limits.
Home Health Care — Includes medically necessary services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Some services require prior authorization or have benefit limits.
Hospice — If you are terminally ill, you or your PCP can ask for hospice services. Includes nursing care, physician services, medical social services, short-term care, durable medical equipment, drugs, biologicals, home health aide and homemaker, counseling and bereavement services, and medications. Requires physician certification. For adults, rights are waived to other Medicaid services related to the terminal illness. If you choose hospice, you can change your mind. We must be notified that you are receiving these services.
Dental — Includes medically necessary emergency, non-emergency, and orthodontic services for children. For adults, services are limited to treatment of fractures, biopsy, tumors, and emergency extractions. Treatment for TMJ is not covered for adults. These services are covered by SKYGEN USA. **For West Virginia Mountain Health Trust children:** Dental services are covered for children younger than age 21 when provided by a dentist, orthodontist, or oral surgeon.
Behavioral Health • Psychiatric Residential Treatment Facility (PRTF) — Includes services for children with mental illness and substance use disorder. Prior authorization is required. • Inpatient — Includes behavioral health, psychiatric, and substance use disorder hospital stays. Treatment must include an individual plan of care. Prior authorization is required. • Outpatient — Includes services for individuals with mental illness and substance use disorder. Some services require prior authorization or have benefit limits. • Psychological Services — May be delivered using telehealth. Some services require prior authorization or have benefit limits.

Mountain Health Trust Covered Benefits
Vision — Includes eye exams, lenses, frames, and repairs for children. Includes medical treatment, annual dilated retinal exam for diabetic members, one pair of glasses after cataract surgery, and certain contact lenses for adults. Does not cover prescription sunglasses or designer frames. These services are covered by Vision Service Plan (VSP).
Substance Use Disorder Services — SUD services are behavioral health treatment services provided to members with a known or suspected substance use disorder when medically necessary. Benefits include targeted case management, behavioral health assessment, drug screening, inpatient and/or outpatient services, residential adult services, Naloxone administration services, non-methadone medication assisted treatment, and recovery support services. Group Recovery Support Services are not a covered service. Some services require prior authorization or have benefit limits.

West Virginia Health Bridge Covered Benefits
Medical • Primary Care Office Visits and Referrals to Specialists • Physician Services — Certain services may require prior authorization or have service limits. Some services may be delivered through telehealth (digitally using computer or mobile device). • Laboratory and X-ray Services — Includes lab services related to substance use disorder (SUD) treatment. Services must be ordered by a provider. Some services require prior authorization or have benefit limits. • Clinics — Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.
Specialty • Podiatry — Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures, and other injuries and orthotics. Routine foot care is not covered. Some services may require prior authorization or have benefit limits. • Services for Children with disabilities and/or Special Health Care Needs — Provides specialty medical care, diagnosis, and treatment for children with disabilities and those who may be at risk of developing disabling conditions.
Emergency • Emergency Room Services — covered for emergency care only. • Post-stabilization Services — Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.

- Emergency Transportation — Includes ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary. Facility to facility ground ambulance transportation services that are medically necessary are covered. To call for Emergency Transportation, dial 911.

Preventive Care and Disease Management

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — Includes medically necessary health care services for any medical or psychological condition discovered during screening (for children only).
- Tobacco Cessation — Includes therapy and counseling and Quitline services. Guidance and risk-reduction counseling covered for children.
- Sexually Transmitted Disease Services — Includes screening for a sexually transmitted disease from your PCP or a specialist.

Maternity

- Right From The Start — Includes prenatal care and care coordination. No prior authorization required.
- Family Planning — Includes all medically necessary family planning providers and services. Sterilizations, hysterectomies, pregnancy terminations, and infertility treatments are not considered family planning. No referral needed for out-of-network providers.
- Maternity Care — Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.

Other

- Federally Qualified Health Centers — Includes physician, physician assistant, nurse practitioner, and nurse midwife services.
- Prosthetics — Customized special equipment is considered. Some services may require prior authorization or have benefit limits.
- Durable Medical Equipment — Customized special equipment is considered. Some services may require prior authorization or have benefit limits.
- Ambulatory Surgical Care — Includes services and equipment for surgical procedures. Provider services; lab and X-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs; and durable medical equipment not covered. Some services may require prior authorization or have benefit limits.
- Organ and Tissue Transplants — Corneal transplants only.
- Medicines given by your provider, in an office, outpatient hospital, or infusion center are covered by UniCare. Some services may require prior authorization or have benefit limits.

Nursing

- Nurse Practitioner Services — Some services may require prior authorization or have benefit limits.

- Private Duty Nursing — Includes medically necessary nursing care (not covered for adults). Prior approval is required.

Rehabilitation

- Physical Therapy — 30 visits per calendar year (combined for physical and occupational therapy) and members will need an OK from us after 30 visits. You are allowed one evaluation and two re-evaluations every year.
- Occupational Therapy — 30 visits per calendar year (combined physical and occupational therapy) and members will need an OK from us after 30 visits. You are allowed one evaluation and two re-evaluations every year.
- Speech Therapy and Audiology — Habilitative and rehabilitative services, including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (not covered for adults). Some services may require prior approval or have benefit limits. Speech therapy requires an OK from us after 10 visits.
- Chiropractor Services — Chiropractor services include radiological exams and corrections to partial dislocations (subluxation). Some services may require prior authorization or have benefit limits.
- Pulmonary Rehabilitation — Includes procedures to increase strength of respiratory muscle and functions.
- Cardiac Rehabilitation — Includes supervised exercise sessions with electrocardiograph monitoring.
- Inpatient Rehabilitation — Includes inpatient rehabilitation services and general medical services that meet the certification requirements.

Hospital

- Inpatient — Includes all medically necessary inpatient services (including bariatric surgery[ies]) at acute inpatient and long term acute care hospitals (LTACH). Prior authorization is required for all planned inpatient admissions. We must be told within 24 hours for an emergency admission.
- Outpatient — Includes preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services. Some services may require prior authorization or have benefit limits.

Home Health Care — Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Some services may require prior authorization or have benefit limits.

Hospice — If you are terminally ill, you or your PCP can ask for hospice services. Includes nursing care, physician services, medical social services, short-term care, durable medical equipment, drugs, biologicals, home health aide and homemaker, counseling and bereavement services, and medications. Requires physician certification. For adults, rights are waived to other Medicaid services related to the terminal illness. If you choose hospice, you can change your mind. We must be notified that you are receiving these services.

Dental — Includes medically necessary emergency, non-emergency, and orthodontic services for children. Includes treatment of fractures, biopsy, tumors, and emergency extractions for adults. Treatment for TMJ is not covered for adults. These services are covered by SKYGEN USA.

Behavioral Health

- Psychiatric Residential Treatment Facility (PRTF) — Includes services for children with mental illness and substance use disorder. Prior authorization is required.
- Inpatient — includes behavioral health, psychiatric, and substance use disorder hospital stays. Treatment must include an individual plan of care. Prior authorization is required.
- Outpatient — Includes services for individuals with mental illness and substance use disorder. Some services require prior authorization or have benefit limits.
- Psychological Services — May be delivered using telehealth. Some services require prior authorization or have benefit limits.

Vision — Includes eye exams, lenses, frames, and repairs for children. Includes medical treatment, annual dilated retinal exam for diabetic members, one pair of glasses after cataract surgery, and certain contact lenses for adults. Does not cover prescription sunglasses or designer frames. These services are covered by Vision Service Plan (VSP).

Substance Use Disorder Services — SUD services are behavioral health treatment services provided to members with a known or suspected substance use disorder when medically necessary. Benefits include targeted case management, behavioral health assessment, drug screening, inpatient and/or outpatient services, residential adult services, Naloxone administration services, non-methadone medication assisted treatment, and recovery support services. Group Recovery Support Services are not a covered service. Some services require prior authorization or have benefit limits.

Benefits Under Fee-for-Service Medicaid
Abortion — Includes drugs, devices, and procedures for termination of pregnancy. Abortion covered services are limited to specific conditions. Visit BMS website for details on coverage at https://dhhr.wv.gov/bms/Pages/default.aspx.
Early Intervention Services for Children 3 and Under — Early intervention services provided to children 3 years and under through the Birth to Three (BTT) program.
Nursing Facility Services — Includes nursing, social services, and therapy.
Personal Care Services — Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization. Not covered for West Virginia Health Bridge members.

Benefits Under Fee-for-Service Medicaid
Personal Care for Aged/Disabled — Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.
ICF/IID Intermediate Care Facility — Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for individuals with intellectual disabilities. Requires physician or psychiatrist certification.
Prescription Drugs — Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Weight gain, cosmetic, hair growth, fertility, and less than effective and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.
Organ Transplant Services — Generally safe, effective, and medically necessary transplants covered when no alternative is available. Cannot be used for investigational/research nature or for end-stage diseases. Must be used to manage disease.
School-based Services — Service limitations are listed in the fee-for-service Medicaid provider manual.
Transportation — Non-emergency medical transportation. Includes multi-passenger van services and common carriers (buses, cabs, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: 844-549-8353.

Mountain Health Trust and West Virginia Health Bridge Medicaid members: Be sure to use your regular Medicaid card for services that are not covered by UniCare.

WVCHIP Covered Benefits
Medical • Primary Care Office Visits and Referrals to Specialists • Provider Services — Physician or other licensed provider for treatment of an illness, injury, or medical condition. Includes outpatient and inpatient services. Some services may require prior authorization or have benefit limits. Some services may be delivered through telehealth (digitally using computer or mobile device). • Laboratory and X-ray Services — Includes lab services related to substance use disorder (SUD) treatment. Services must be ordered by a provider. Some services require prior authorization or have benefit limits. • Clinics — Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.

Specialty

- Podiatry — Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures, and other injuries and orthotics. Routine foot care is not covered. Some services may require prior authorization or have benefit limits.

Emergency

- Emergency Room Services — covered for emergency care only.
- Post-stabilization Services — Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- Emergency Transportation — Includes ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary. Facility to facility ground ambulance transportation services that are medically necessary are covered. To call for Emergency Transportation, dial 911.

Preventive Care and Disease Management

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — Includes covered, medically necessary health care services for any medical or psychological condition discovered during screening.
- Immunizations — Standard immunizations recommended by the Centers for Disease Control and Prevention (CDC).
- Tobacco Cessation — Tobacco cessation services are available to members for two 12-week cycles per lifetime. WVCHIP will provide 100% coverage for the tobacco cessation benefit for pregnant members during their pregnancy. WVCHIP will cover an initial and follow-up visit to the member's provider at no cost to the member.
- Medical Foods — When it is the only means of nutrition and prescribed by your physician or a prescription, amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related.

Maternity

- Family Planning Services — Includes all medically necessary family planning providers and services. Sterilizations, hysterectomies, pregnancy terminations, and infertility treatments are not considered family planning. No referral needed for out-of-network providers.
- Maternity Care — Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.

Other

- Durable Medical Equipment — Some services require prior authorization or have benefit limits. Equipment and supplies which can be purchased over the counter (OTC) are not covered.

- Continuous Glucose Monitors — Devices that monitor glucose continuously. Covered when medically necessary. Prior authorization is required. Other glucose monitors covered under outpatient pharmacy benefit.
- Hemophilia Program — WVCHIP has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide quality hemophilia services at a reasonable cost to WVCHIP members.
- Organ Transplants and Tissue Transplants — Organ transplants are covered when deemed medically necessary and non-experimental.

Nursing

- Nurse Practitioner Services — Some services require prior authorization or have benefit limits.
- Facility based nursing services to those who require twenty-four (24)-hour nursing level of care. Confinement in a skilled nursing facility including a semi-private room, related services, and supplies. Confinement must be prescribed by a physician. Prior authorization is required.

Rehabilitation

- Physical Therapy — The initial 20 therapy visits do not require an OK from us, but must be for an acute condition, new or recent diagnosis, or an exacerbation that requires active therapy.
- Occupational Therapy — The initial 20 therapy visits do not require an OK from us, but must be for an acute condition, new or recent diagnosis, or an exacerbation that requires active therapy.
- Speech Therapy and Audiology — Habilitative and rehabilitative services, including hearing aid evaluations, hearing aids and supplies, batteries, and repairs. Some procedures have service limits or require prior approval. Speech therapy requires an OK from us after 20 visits.
- Chiropractor Services — For acute treatment of a neuromuscular-skeletal condition, including office visits and X-rays. For members under 16, member must receive an OK from us after the initial evaluation visit and before treatment begins. Maintenance services are not covered. Prior authorization required after 20 visits for all members.
- Pulmonary Rehabilitation — Includes procedures to increase strength of respiratory muscle and functions.
- Cardiac Rehabilitation — Includes supervised exercise sessions with electrocardiograph monitoring.
- Inpatient Rehabilitation — Services related to inpatient facilities that provide rehabilitation services. Prior authorization is required.

Hospital

- Inpatient — Medically necessary services provided by physician or other licensed provider for treatment of illness, injury, or medical condition in hospital setting. Covered services include semi-private room, special care units, and related services

and supplies during confinement. Prior authorization is required for all planned inpatient admissions. We must be told within 24 hours for an emergency admission.
- Outpatient — Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service. Some services may require prior authorization or have benefit limits.

Home Health Care — Includes services given at member's residence. This does not include intermittent health services of a home health agency when prescribed by a physician, services must be provided in the home, or by or under the supervision of a registered nurse, for care and treatment. Some services may require prior authorization or have benefit limits.

Hospice — If you are terminally ill, you or your PCP can ask for hospice services. Includes nursing care, physician services, medical social services, short-term care, durable medical equipment, drugs, biologicals, home health aide and homemaker, counseling and bereavement services, and medications. Requires physician certification. If you choose hospice, you can change your mind. We must be notified that you are receiving these services.

Dental — These services are covered by SKYGEN USA.
- Dental Services — Provided by a dentist, orthodontist, or oral surgeon. Includes medically necessary emergency, non-emergency, and orthodontic services for children. These services may be provided by a dentist, or oral surgeon and are covered by SKYGEN USA.

Behavioral Health
- Applied Behavioral Analysis — For members with a primary diagnosis of Autism Spectrum. Medically necessary ABA treatment is limited to $30,000 per member per year for three consecutive years from the date treatment starts for a member with a qualifying diagnosis of ASD prior to the member's 8th birthday.
- Mental Health — This may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (including a provider's office).

Vision — These services are covered by Vision Service Plan (VSP).

- Services provided by optometrists, ophthalmologists, surgeons providing medical eye care, and opticians. Professional services, lenses including frames, and other aids to vision.
- Vision therapy — Covered benefits include annual exams and eyewear. Lenses/frames or contacts are limited to a maximum benefit of $125 per year. The year starts on the date of service. The office visit and examination are covered in addition to the $125 eyewear limit.

Substance Use Disorder Services — This may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (including a provider's office).

Benefits Under Fee-for-Service WVCHIP
Birth to Three (BTT) Program — This program can assess early child development and provide services and support for the families of children three and under who have a delay in their development or may be at risk of having a delay.
Outpatient Prescription Drugs — Must be generic drugs if available, including oral contraceptives.

VALUE-ADDED BENEFITS AND SERVICES

We want to help you get and stay healthy. In addition to your benefits, UniCare offers value-added benefits and services. We offer these services to encourage health education and to promote health. Copayments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services.

Log on to the Benefit Reward Hub to redeem your value-added benefits and view the benefits you're eligible for at unicare.com/wv or call the Customer Care Center at 800-782-0095 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. Eastern time.

Value-Added Benefits and Services
For pregnant members and new moms • Fresh Fruit & Veggies program with up to $100 in fresh produce • Diapers mail ordered to doorstep for completing six prenatal visits • Safe Sleep kit for babies under 1 year old • Convertible car seat or portable crib for completing six prenatal visits • Electric Breast Pump Accessory Kit • Preventive dental care during pregnancy and six weeks after baby's birth • Neonatal abstinence syndrome (NAS) program graduation gift • Taking Care of Baby and Me® program

Value-Added Benefits and Services
For health and wellness • Personal hygiene box with up to $50 worth of hygiene products or a voucher to purchase hygiene products • Feminine care collection for females 10-18; voucher for products or feminine care kit • Online well-being program for ages 13 and up • Up to $75 in healthy lifestyle aids • SUD Recovery Support program • WW® **(formerly known as Weight Watchers)** program for qualifying members 18 and older (online included) • Youth club memberships at participating clubs, such as Boys & Girls Club (excluding camps) • Active & Fit® program — Eligible members ages 18 and up can receive vouchers for gym memberships to participating gyms or home fitness kits WW® is a registered trademark of Weight Watchers International, Inc. Active & Fit® is a registered trademark of American Specialty Health Incorporated.
For dental health • Oral care essentials box with items like an electric toothbrush, toothpaste, and dental floss
For members with diabetes • Scholarships to Camp Kno Koma for children ages 7-15 • Diabetes education classes • Free glucometers
For members with asthma • One-on-one education with an asthma nurse educator to create an action plan • Certified Disease Management program to manage asthma and COPD • Scholarships to Camp Catch Your Breath for children ages 8-13

Value-Added Benefits and Services

For peace of mind

24-hour nurse help line

Our 24-hour nurse help line lets you talk in private with a nurse about your health. You can reach a nurse 24 hours a day, seven days a week at 888-850-1108 (TTY 711). You also can call and listen to audiotapes on over 300 health topics such as:

- Preventive health care
- High blood pressure
- Diabetes
- Sexually transmitted infections like HIV/AIDS
- Alcohol and drug problems
- How to be tobacco-free
- Pregnancy

Behavioral Health Crisis Line

If you're having a mental health crisis, call our 24-hour Behavioral Health Crisis Line at 833-434-1261 (TTY 711) for help. **If a situation is life-threatening, always call 911.**

For tobacco cessation

West Virginia's Tobacco Quit Line is a free, phone-based counseling service. If you're interested in this program, please call 877-966-8784, Monday through Friday, 8 a.m. to 8 p.m., and Saturday and Sunday 8 a.m. to 5 p.m. Services include:

- Individual coaching.
- Resources for providers who want to improve patient outcomes.
- Support for family and friends who want to help loved ones stop smoking.

Phone services

- Free cellphone through the federal Lifeline program, with free monthly minutes, data, and text messages, plus unlimited calls to the Customer Care Center and free health reminder texts for eligible members. (Eligible for Medicaid members only)

Other benefits and services

- $100 gas card for members ($25 every three months per household)
- Free laptop for members graduating high school with a 3.5 or higher GPA or complete/pass TASC/GED
- Family activity coupon book (one family activity coupon book per household per year)

Community Resource Link

The Community Resource Link helps to find resources in your community by ZIP code. Get help finding food, jobs, housing, and other things you may need at unicare.com/wv.

HEALTHY REWARDS

Healthy Rewards is a no-cost, optional program for eligible members enrolled in UniCare. You can earn rewards completing healthy activities and screenings. The program encourages you to get the care you need to create a healthy lifestyle and rewards you for doing so!

Log in to your account at unicare.com/wv and visit the Benefit Reward Hub to enroll in Healthy Rewards, see what you may be eligible to earn, and redeem your rewards, or call 888-990-8681 (TTY 711), Monday through Friday from 9 a.m. to 8 p.m. Eastern time.

MORE INFORMATION ABOUT YOUR COVERAGE

Please read below for more details about your coverage. If you have any questions, please call the Customer Care Center at 800-782-0095 (TTY 711).

MEDICAL SERVICES

We cover medically necessary provider services, including, but not limited to, office visits, specialist visits, anesthesia, outpatient services, lab tests, clinic visits, preventive care, tobacco cessation, vaccinations, and nursing services.

Some services may be delivered through telehealth (digitally using computer or mobile device).

For WVCHIP members, nutritional counseling is limited to two visits per year when prescribed by a provider for children with the following conditions:

- Diabetes, type 1 and 2
- Overweight and obesity with documentation of Body Mass Index (BMI)
- High cholesterol or other blood lipids
- High blood pressure
- Gastrointestinal disorders, such as GERD or short gut syndrome
- Celiac disease
- Food allergies
- Failure to thrive or poor growth

Some services require prior authorization or have benefit limits.

DENTAL SERVICES

Dental care is important to your overall health. UniCare uses a dental benefit manager, SKYGEN USA, to provide dental services to members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Dental services for Medicaid members

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by 12 months of

age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members up to 21 can also access the Fluoride Varnish Program, offered by providers certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your provider. Children are covered for non-emergency and emergency dental services.

For adults 21 years and older, only emergency dental services are covered. These services may be provided by a dentist or oral surgeon. Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

We cover these services for children under age 21:

- Diagnostic services
- Preventive treatment
- Restorative treatment
- Endodontic treatment
- Periodontal treatment
- Surgical procedures and/or extractions
- Orthodontic treatment (Orthodontic services will be covered for the entire time of treatment even if the child is no longer eligible.)
- Complete and partial dentures, including partial denture relines and repairs
- Oral and maxillofacial surgery services

Dental Services for WVCHIP Members:

Members under 18 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by 12 months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems.

Dental services covered under WVCHIP:

- Diagnostic services
- Preventive treatment
- Restorative treatment
- Endodontic treatment
- Periodontal treatment
- Surgical procedures and/or extractions
- Prosthodontics services
- Orthodontic treatment (Orthodontic services will be covered for the entire time of treatment even if the child is no longer eligible.)
- Complete and partial dentures, including partial denture relines and repairs

- Oral and maxillofacial surgery services

We don’t cover:

- Experimental or investigational services
- Cosmetic procedures
- Dental services for the member’s convenience or the convenience of the member’s caretaker

Fluoride varnish

Fluoride varnish is a covered benefit for children ages 6 months to 3 years who may be at high risk of developing cavities. The fluoride varnish is given during the member’s dental visit. The maximum number is two applications over one year.

Orthodontia services

Orthodontia services, covered for children up to age 21, must be medically necessary. They also need preapproval before the service is provided. Approved services will be paid for as long as treatment lasts. Medical necessity means at least one of the following needs is met:

- Overjet in excess of 7mm
- Severe malocclusion associated with dento-facial deformity
- True anterior open bite
- Full cusp classification from normal (Class II or Class III)
- Palatal impingement of lower incisors into the palatal tissue causing tissue trauma
- Cleft palate, congenital or developmental disorder
- Anterior crossbite (two or more teeth, in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited orthodontic treatment)
- Unilateral posterior crossbite with deviation or bilateral crossbite involving multiple teeth including at least one molar
- True posterior open bite (not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy)
- Impacted teeth (excluding third molars), permanent anterior teeth only

Dental Prior Authorizations

Your dentist will need to get approval from SKYGEN USA for some services. This means both SKYGEN USA and your dentist need to agree the services are medically needed. Getting an OK will take no longer than seven calendar days or two business days if requested electronically for non-urgent requests. If urgent, getting an OK will take no more than two business days OR three calendar days — whichever is shortest. Your dentist can tell you more about this. We may ask your dentist why you need this care. We may not approve the service you or your dentist asks for. We will send you and your dentist a letter that tells you why we won’t cover the service. The letter will also tell you how to appeal our decision.

If you have questions about your dental services, please call SKYGEN USA Dental at 877-408-0917 (TTY 800-508-6975).

BEHAVIORAL HEALTH SERVICES

UniCare provides inpatient and outpatient services to members. These benefits include mental health services, substance use disorder (SUD) services (alcohol and drugs), case management, rehabilitation and clinic services, and psychiatric residential treatment services.

Medicaid members do not need a referral for behavioral health services. Some services may require a prior authorization or have limitations. Your PCP is a good first resource. The Customer Care Center can also help you get these services from behavioral health providers. You can call the Customer Care Center at 800-782-0095 (TTY 711).

For WVCHIP members, a referral from your PCP is required. Prior authorization is required after 26 visits.

- Applied Behavioral Analysis (ABA) services are covered for members with a primary diagnosis of Autism Spectrum Disorder. Medically necessary ABA treatment is limited to $30,000 per member per year for three consecutive years from the date treatment starts for a member with a qualifying diagnosis of ASD prior to the member's 8th birthday.
- Mental Health — This may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (including a provider's office).
- Behavioral change and basic life skills development or "habilitation" services are not covered.

Some services require prior authorization or have benefit limits.

If you're experiencing a mental health crisis, call our Behavioral Health Crisis Line at 833-434-1261 (TTY 711) for help. If a situation is life-threatening, always call 911. If you're feeling suicidal, you should seek immediate help from an emergency room or outreach organization like the National Suicide Prevention Lifeline at 800-273-8255.

CLINIC HEALTH SERVICES

Copays may apply.
We cover these services from clinics (that are not part of a hospital):

- Health clinics
- Birthing centers
- Lab and radiology centers
- Health department clinics
- Rural health clinics
- Federally qualified health centers (FQHCs)

We cover:

- Provider services
- Nurse practitioner and physician assistant services

- Vaccines (shots) for children
- Supplies
- Visiting nurse care in certain shortage areas

Some services require prior authorization or have benefit limits.

COURT ORDERED SERVICES

Medically necessary court ordered treatment services are covered by UniCare. Court ordered services are subject to BMS review and determination.

DISEASE MANAGEMENT

A Disease Management (DM) program can help you get more out of life. As part of your UniCare benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called DM case managers. They'll help you learn how to better manage your condition, or health issue. You can choose to join a DM program at no cost to you.

What programs do we offer?
You can join a Disease Management program to get health care and support services if you have any of these conditions:

- Diabetes
- HIV/AIDS
- Behavioral health conditions
  - Bipolar Disorder
  - Major Depressive Disorder – Adult
  - Major Depressive Disorder – Child and Adolescent
  - Substance Use Disorder
  - Schizophrenia
- Heart conditions
  - Coronary Artery Disease (CAD)
  - Congestive Heart Failure (CHF)
  - Hypertension (High Blood Pressure)
- Lung conditions
  - Asthma
  - Chronic Obstructive Pulmonary Disease (COPD)

How it works
When you join one of our DM programs, a DM case manager will:

- Help you create health goals and make a plan to reach them
- Coach you and support you through one-on-one phone calls
- Track your progress
- Give you information about local support and caregivers
- Answer questions about your condition and/or treatment plan (ways to help health issues)
- Send you materials to learn about your condition and overall health and wellness
- Coordinate your care with your health care providers, like helping you with:
    - Making appointments
    - Getting to health care provider visits
    - Referring you to specialists in our health plan, if needed
    - Getting any medical equipment you may need
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco like quitting smoking)

Our DM team and your primary care provider (PCP) are here to help you with your health care needs.

How to join
We'll send you a letter welcoming you to a DM program, if you qualify. Or, call us toll free at 888-830-4300 (TTY 711), Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time.

When you call, we'll:

- Set you up with a DM case manager to get started
- Ask you some questions about your health
- Start working together to create your plan

You can also email us at dmself-referral@unicare.com.

Please be aware emails sent over the internet are usually safe, but there is some risk third parties may access (or get) these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt out (we'll take you out of the program) of the program at any time. Please call us toll free at 888-830-4300 (TTY 711) from 8:30 a.m. to 5:30 p.m. Eastern time, Monday through Friday to opt out. You may also call this number to leave a private message for your DM case manager 24 hours a day.

When you join a Disease Management program, you have certain rights and responsibilities. You have the right to:

- Get details about us, such as:
    - Programs and services we offer

- Our staff and their qualifications (skills or education)
- Any contractual relationships (deals we have with other companies)

- Opt out of DM services
- Know which DM case manager is handling your DM services and how to ask for a change
- Get support from us to make health care choices with your health care providers
- Ask about all DM-related treatment options (choices of ways to get better) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating health care providers
- Have personal data and medical information kept private
- Know who has access to your information and how we make sure your information stays secure, private, and confidential
- Receive polite, respectful treatment from our staff
- Get information that is clear and easy to understand
- File complaints to UniCare by calling 888-830-4300 (TTY 711) toll free from 8:30 a.m. to 5:30 p.m. Eastern time, Monday through Friday and:
    - Get help on how to use the complaint process
    - Know how much time UniCare has to respond to and resolve issues of quality and complaints
    - Give us feedback about the Disease Management program

You also have a responsibility to:

- Follow the care plan that you and your DM case manager agree on
- Give us information needed to carry out our services
- Tell us and your health care providers if you choose to opt-out (leave the program)

Disease Management does not market products or services from outside companies to our members. DM does not own or profit from outside companies on the goods and services we offer.

DURABLE MEDICAL EQUIPMENT, SUPPLIES, AND PROSTHETIC DEVICES

All custom-made durable medical equipment (DME) requires preapproval. Other DME may also need preapproval.

DME, supplies, and prosthetic devices given by a provider are covered when medically necessary. Some services require prior authorization or have benefit limits.

For Medicaid members, we cover:

- Medical foods for children under the age of 21 when the formula gives 100% of the child’s nutrition. For medical foods that are less than 100% of their nutrition, these foods are covered by CSHCN.

For WVCHIP, we cover:

- Continuous Glucose Monitors (CGM) — Devices that monitor glucose continuously. Covered when medically necessary. Prior authorization is required. Other glucose monitors covered under outpatient pharmacy benefit. For Medicaid members, all diabetes supplies, including CGM, are covered under the retail pharmacy benefit.
- Medical foods when it is the only means of nutrition and prescribed by your physician or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related.

For Medicaid members, we don't cover:

- Equipment and supplies only used for exercise
- Equipment and supplies only used for making a room or home more comfortable, such as:
  −Air conditioners
  −Air filters
  −Air purifiers
  −Spas
  −Swimming pools
  −Elevators
- Hygiene and beauty supplies
- Experimental or research equipment
- More than one piece of equipment that does the same thing

For WVCHIP members, we don't cover:

- Augmentative communication devices
- Bariatric beds and chairs
- Bathroom scales
- Educational equipment
- Environmental control equipment, such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors
- Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats, massage devices, elevators, stair lifts, escalators, hydraulic van or car lifts, orthopedic mattresses, walking canes with seats, trapeze bars, child strollers, lift chairs, recliners, contour chairs and adjustable beds, or tilt stands
- Equipment and supplies which are widely available over the counter, such as wrist stabilizers and knee supports
- Exercise equipment, such as exercycles, parallel bars, walking, climbing, or skiing machines
- Hygienic equipment, such as bed baths, commodes, and toilet seats
- Motorized scooters
- Nutritional supplements (unless it is the only means of nutrition or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition

that is not lactose or soy related), over-the-counter formula, food liquidizers, or food processors
- Professional medical equipment, such as blood pressure kits or stethoscopes
- Replacement of lost or stolen items
- Standing/tilt wheelchairs
- Supplies, such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads, or ice bags
- Traction devices
- Vibrators
- Whirlpool pumps or equipment
- Wigs or wig styling

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Well-child visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit covers all medically necessary and preventive health care services for Medicaid members up to age 21 and up to age 19 for WVCHIP members. Both sick and well care services are provided by your PCP at no cost.

Children should go to the provider for checkups even if they are not sick. They should have an EPSDT checkup at birth and at:
- 3 to 5 days old
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- Every year from ages 4 to 21

We cover:
- Physical exams
- Hearing screening
- Vision screening
- Dental exams
- Behavioral health screenings
- Health education
- Health and development history
- Nutritional needs
- Medically necessary health care, treatment, and other actions to correct or improve medical or psychological conditions found during an EPSDT screening
- Routine shots and immunizations

- Lab tests, like:
  −Urinalysis
  −Hemoglobin/hematocrit
  −Tuberculin test (for high-risk groups)
  −Blood lead testing

Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early, before they become more serious. Call your PCP or the Customer Care Center to schedule a well-child visit. For Medicaid members, transportation is also available upon request at no cost through the BMS NEMT program.

FAMILY PLANNING

We cover these types of care to help you if you plan to have a family, want to know how to avoid getting pregnant, or want to know how to protect yourself against sexually transmitted infections (STIs):

- Family planning, education, and counseling
- Medical visits for birth control
- Annual cervical cancer screenings
- Pregnancy tests
- Lab tests
- Tests for sexually transmitted infections (STIs)
- Screening, testing, counseling, and referral for treatment for members at risk for human immunodeficiency virus (HIV)
- Sterilization (see exceptions below)
- Contraceptives as appropriate per FDA guidelines, including but not limited to:
  - IUD and IUCD insertions, or any other invasive contraceptive procedures/devices like Mirena or Skyla
  - Implantable medications — e.g., Implanon
  - Hormonal contraceptive methods — oral, transdermal, intravaginal, injectable hormonal contraceptives
  - Barrier contraceptive methods — e.g., diaphragms/cervical caps

We don't cover:

- Sterilization for members younger than age 21.
- Sterilization for members who live in inpatient facilities.
- Treatment for members who cannot get pregnant.
- Outpatient pharmacy prescriptions.

Hysterectomy and abortion aren't considered family planning services.

You don't need to get an OK from your PCP for family planning care. Members may use any licensed family planning clinic or provider. The provider doesn't have to be part of our plan. If you choose to see a family planning provider who is not part of our plan, let your PCP know the important medical information from these appointments so you can get the best health care. Your family planning provider and your PCP will work together to make sure you get the right care.

Family planning records are kept private. PCPs and other types of health care providers should keep all family planning records private, even if the patient is a minor, unless the law says it is OK. Your provider is allowed to share your medical information with other providers who take care of you, public health officials, or government agencies. UniCare is not responsible for the privacy of medical records held by providers who aren't part of our plan.

Some services require prior authorization or have benefit limits.

HOME HEALTH SERVICES

These are visits to your home to give you care for certain illnesses or injuries when you cannot leave your home. You must get our OK for these types of visits. Service limits apply.

We cover:

- Services from a licensed home health agency or visiting nurse group
- Physical, occupational, and speech therapy
- Medical supplies
- Care from a health aide who works under a registered nurse (RN) or a therapist
- Breathing treatments

These types of buildings do not qualify as a home:

- Hospital nursing facility
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- State institution

HOSPITAL SERVICES

Your PCP can send you to any hospital in the UniCare plan. See the Provider Directory for a list of the hospitals that work with us. Go to the nearest hospital during an emergency.

Hospital services — Inpatient

Copays may apply.

These services include a stay in a hospital, usually for more than two nights. You need to get an OK from us ahead of time each time you stay overnight in a hospital. You don't need an OK for

the birth of a baby. If you are admitted for an emergency, please contact us within 24 hours to let us know.

We cover:

- A hospital room with two or more beds
- Care in special units
- Operating rooms
- Delivery rooms
- Special treatment rooms
- Supplies
- Medical testing
- X-rays
- Drugs the hospital staff give you during your stay
- Giving you someone else's blood
- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Meals and special diets
- General nursing care
- Special duty nursing for medical reasons
- Anesthesia
- Respiratory therapy
- Bariatric surgery (Medicaid members only)
- Diagnostic care
- Therapeutic care
- Rehabilitation care
- Psychiatric and substance use disorder (SUD) treatment
- Overnight hospital stay for dental work because of other medical problems or because serious dental work is needed
- Setting up discharge planning, including continuing care, if needed
- Surgery to remove a breast or dissect a lymph node
- All problems from a breast removal surgery (including lymphedema)
- Surgery to reconstruct — includes prosthetics or surgery to make your breasts look the same after a breast is removed

Hospital services — Outpatient

Copays may apply. Outpatient hospital care must be given by:

- Hospitals
- Rural health clinics

We cover:

- Emergency room use for emergencies
- Emergency dental services
- Giving you someone else's blood
- Drugs given in the emergency room
- Hospital services that can be reasonably done so the patient doesn't have to be admitted to the hospital:
  −Supplies
  −Medical testing
  −X-rays
  −Lab services
  −ER and observation stays
- Physical, occupational, and speech therapy
- Radiation therapy
- Chemotherapy
- Dialysis
- Services for dental work when a hospital outpatient facility must be used because of other medical problems or when serious dental work is needed
- Surgical services
- Behavioral health services

Some services require prior authorization or have benefit limits.

LAB AND X-RAY SERVICES (NOT RECEIVED IN A HOSPITAL)

CT, MRI, MRA, PET, and special X-rays must have an OK from us first.

We cover medically necessary:

- Lab and X-ray services ordered and done by (or under the care of) a provider
- Lab services related to substance use disorder (SUD) treatment
- X-rays of the breast (mammogram)

Some services require prior authorization or have benefit limits. All special X-rays, like CT, MRI, MRA, and PET scans must have an OK from us first.

PHYSICAL OR OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AND AUDIOLOGY

These types of care are ordered by a provider and are a part of that provider's written plan of care. Covered care includes treatment or other services given by speech, physical, or occupational therapists, or audiologists. This treatment is given to correct or improve conditions.

Limits:
For physical and occupational therapy:

- Mountain Health Trust members need an OK from us after 20 visits.
- West Virginia Health Bridge members need an OK from us after 30 visits.
- WVCHIP members need an OK from us after 20 visits.

For chiropractic services:

- Mountain Health Trust and West Virginia Health Bridge members may receive medically necessary chiropractic services. Members need an OK from us after 24 visits per rolling year.
- WVCHIP members need an OK from us after 20 visits

For audiology:

- Only members younger than age 21 may get hearing aid evaluations, hearing aids and supplies, batteries, and repairs.
- Hearing aids are limited to members younger than age 21 and need an OK from us ahead of time.
- Cochlear implants are covered for children under the age of 21 with an OK from us.

For WVCHIP members, you must be referred to by a specialist. Treatment is only for acute conditions. Maintenance therapy is not a covered benefit. It is expected that all outpatient therapy services include a home program and the plan for transition to home based therapy be explained clearly in the plan of treatment.

Some services require prior authorization or have benefit limits.

REHABILITATION SERVICES

Cardiac and pulmonary rehabilitation is a comprehensive outpatient program of medical evaluation, prescribed exercise, education, and counseling to help members with heart disease to live active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician-directed clinic or in an outpatient hospital department.

WVCHIP members: Limited to three sessions per week for 12 weeks or 36 sessions per year for the following conditions:

- Heart attack occurring in the 12 months preceding treatment
- Heart failure
- Coronary bypass surgery
- Stabilized angina pectoris

Inpatient Medical Rehabilitation Services — Services related to inpatient facilities that provide rehabilitation services. Prior authorization is required.

WVCHIP members only: Facility based nursing services to those who require twenty-four (24)-hour nursing level of care. Confinement in a skilled nursing facility including a semi-private room, related services, and supplies. Confinement must be prescribed by a physician. Prior authorization is required.

HEMOPHILIA PROGRAM (WVCHIP MEMBERS ONLY)

UniCare has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide quality hemophilia services at a reasonable cost to WVCHIP members. Members who participate in the program will be eligible for the following benefits:

- An annual evaluation by specialists in the Hemophilia Disease Management Program, which will be paid at 100% with no copay. (This evaluation is not intended to replace or interrupt care provided by your existing medical home provider or specialists.)
- Hemophilia expenses, including factor replacement products, incurred at CAMC or WVUH will be paid at 100% with no copay after prior authorization.
- Lodging and travel:
    - Lodging expenses for child and one or two adults/guardians incurred to enable the member to receive services from the Hemophilia Disease Management Program.
    - Lodging must be at an approved travel lodge and will be covered at 100% of charge.
    - Travel expenses incurred between the member's home and the medical facility to receive services in connection with the Hemophilia Disease Management Program.
    - Gas will be reimbursed at the federal rate for one vehicle. Reimbursement of meal expenses up to $30 per day per person. Receipts are required for meal reimbursement.

To learn more about how to receive reimbursement for these services, please call the Customer Care Center at 800-782-0095 (TTY 711).

Some services require prior authorization or have benefit limits.

TRANSPLANT PROGRAM (WVCHIP MEMBERS ONLY)

UniCare covers organ transplants when deemed medically necessary and non-experimental. Please notify us as soon as possible if you have been identified as needing a transplant by calling the Customer Care Center at 800-782-0095 (TTY 711).

For WVCHIP members, we cover:

- All covered expenses related to pre-transplant, transplant, and follow-up services while the child is enrolled in UniCare.

- Testing for persons other than the chosen donor is not covered.
- Travel Allowance: Because transplant facilities may be located some distance from the patient's home, benefits include up to $5,000 per transplant for patient travel, lodging, and meals related to visits to the transplant facility or physician. A portion of this benefit is available to cover the travel, lodging, and meals for a member of the patient's family or a friend providing support.
  - Receipts are required for payment of this benefit. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses. The travel allowance benefit applies only to services pertaining to the transplant.
- Transplant-related immunosuppressant prescription drugs are covered if they are filled at a network pharmacy. They are covered through the Prescription Drug Plan.

For Medicaid members, transplant services are covered by FFS Medicaid.

Some services require prior authorization or have benefit limits.

PROVIDER SERVICES

Copays may apply. These types of care may be given to a member in a hospital, clinic, or provider's office.

We cover:

- Visits to your PCP or other providers
- Routine physicals
- Fluoride varnish treatments for children between 6 months and 3 years of age
- Colorectal cancer screenings and lab tests for members age 50 and older who have no symptoms
- Colorectal cancer screenings and lab tests for members younger than age 50 who have symptoms
- Kidney disease screenings including:
  −Blood pressure monitoring
  −Lab tests for:
  - Urine albumin
  - Urine protein
  - Serum creatinine

Limits:

- We don't cover routine physical exams for a job, camp, or sports program.
- Some services require prior authorization or have benefit limits.

PODIATRY SERVICES (FOOT CARE)

We cover medically necessary:

- Treatment for health problems such as infections, inflammations, ulcers, and bursitis.

- Removal of nail matrix or root.
- Treatment of neuromas, hammertoe, hallux valgus, calcaneal spurs, or exostosis.
- Surgery for bunions or ingrown toenails.
- Care and treatment of fractures, dislocations, and sprains.
- Orthotic shoe inserts.
- Diabetic foot care (may include routine foot care).

Limits:
- Treatment of children is limited to acute conditions.
- We don't cover routine treatment for flat feet, nail trimming, and dislocated feet.

Some services require prior authorization or have benefit limits.

PRESCRIPTION PHARMACY BENEFITS

For Medicaid members, your prescription pharmacy benefits are covered under fee-for-service (traditional) Medicaid. DXC Technologies, Inc. manages these benefits. To learn more about your prescription pharmacy benefits, call the DXC Technologies, Inc. Help Desk at 888-483-0797.

For WVCHIP members, your prescription pharmacy benefits are covered under CVS Caremark. To learn more about your prescription pharmacy benefits, call CVS Customer Care at 800-241-3260 to locate a participating pharmacy or visit their website at caremark.com.

UniCare will still cover medically necessary:
- Medicine you get as part of a hospital stay
- Injectable medicine you get at the doctor's office

Some services require prior authorization or have benefit limits.

PREGNANCY AND MATERNITY CARE

We cover medically necessary:
- Provider visits and professional services for pregnancy, problems with a pregnancy, and after-delivery care when medically necessary.
- Services given by a licensed nurse-midwife (a pregnant member can choose a nurse-midwife as her PCP).
- Prenatal education classes.
- A nurse case manager or care coordinator to work with you throughout your pregnancy if it's high risk.
- Tests that are needed, like an ultrasound.
- HIV testing, treatment, and counseling.
- Vaginal childbirth and cesarean sections (C-sections).
- Newborn exams.

- A follow-up visit for the mother and the baby within two days of an early discharge when ordered by the treating provider:
  −An early discharge is a hospital stay of less than 48 hours for vaginal childbirth and less than 96 hours for a C-section
- A visit to your provider between 7-84 days after your delivery to make sure you are healing well

WVCHIP pregnant mothers are only eligible for up to 60 days postpartum. If a member is pregnant at the time of turning 19 and aging out of WVCHIP coverage, the member needs to contact DHHR to be evaluated for WVCHIP pregnancy coverage.

Taking Care of Baby and Me® is the UniCare program for all pregnant members. It is very important to see your primary care provider (PCP) or obstetrician or gynecologist (OB/GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you to have a healthy baby. Prenatal care is always important. With our program, members receive health information and rewards for getting prenatal and postpartum care.

Our program also helps pregnant members with complicated health care needs. Nurse care managers work closely with these members to provide:

- Education
- Emotional support
- Help in following their doctor's care plan
- Information on services and resources in your community, such as transportation, WIC, home-visitor programs, breastfeeding, and counseling

Our nurses also work with doctors and help with other services members may need. The goal is to promote better health for members and delivery of healthy babies.

Quality care for you and your baby

At UniCare, we want to give you the very best care during your pregnancy. That's why you will also be part of My Advocate®, which is part of our Taking Care of Baby and Me® program. My Advocate® gives you the information and support you need to stay healthy during your pregnancy.

Get to know My Advocate®

My Advocate® delivers maternal health education by phone, web, and smartphone app that is helpful and fun. You will get to know Mary Beth, My Advocate's automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use
- Communication with your care manager based on My Advocate® messaging should questions or issues arise
- An easy communication schedule
- No cost to you

With My Advocate®, your information is kept secure and private. Each time Mary Beth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

Helping you and your baby stay healthy

My Advocate® calls give you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn, and answer a question or two over the phone. If you tell us you have a problem, you'll get a call back from a care manager. My Advocate® topics include:

- Pregnancy and postpartum care
- Well-child care
- Dental care
- Immunizations
- Healthy living tips

When you become pregnant

If you think you are pregnant:

- Call your PCP or OB/GYN doctor right away. You do not need a referral from your PCP to see an OB/GYN doctor.
- Call the Customer Care Center if you need help finding an OB/GYN in the UniCare network.

When you find out you are pregnant, please also call the Customer Care Center. You may also visit unicare.com/wv, for information about having a healthy pregnancy and baby, plus your benefits. This includes information such as:

- Self-care information about your pregnancy
- Details on My Advocate® that tells you about the program and how to enroll and get health information to your phone by automated voice, web, or smartphone app
- Healthy Rewards program information on how to redeem your rewards for prenatal, postpartum, and well-baby care
- A section on having a healthy baby, postpartum depression, and caring for your newborn, with helpful resources

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants, and Children program (WIC). The Customer Care Center can give you the phone number for the WIC program close to you.

When you are pregnant, you must go to your PCP or OB/GYN at least:

- Every four weeks for the first six months
- Every two weeks for the seventh and eighth months
- Every week during the last month

Your PCP or OB/GYN may want you to visit more than this based on your health needs. You'll also have the opportunity to work with a nurse to help you with your pregnancy. Ask your provider or call us to learn more about childbirth classes.

When you have a new baby
When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery
- 72 hours after a Cesarean section (C-section)

You may stay in the hospital less time if your PCP or OB/GYN and the baby's provider see that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

For Medicaid members, after you have your baby:

- Call the Customer Care Center as soon as you can to let us know you had your baby.
- Call Mountain Health Trust at 800-449-8466 to apply for Medicaid for your baby.

For WVCHIP members, after you have your baby:

- Call the Department of Health & Human Resources Customer Service Center (DHHR CSC) at 877-716-1212. All claims related to the child will be put on hold by WVCHIP until a Social Security number has been reported for the child being born. Please remember to apply for the child's Social Security card right away and report the Social Security number immediately upon receiving.

If you were enrolled in My Advocate® and received educational calls during your pregnancy, you will get calls on postpartum and well child education up to 12 weeks after your delivery.

It's important to set up a visit with your PCP or OB/GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

- It's important to have a follow-up visit with your OB provider after you deliver. It would be best to see them within 1-3 weeks, but no later than 12 weeks after delivery. Your health is important to the whole family.
- Your doctor may want to see you sooner than three weeks if you had certain issues before or during delivery, such as high blood pressure or if you had a cesarean section (C-section).

HOSPICE SERVICES

If you are terminally ill, you or your PCP can ask for hospice services. Includes nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide and homemaker, counseling and bereavement services, and medications. Requires physician certification. For adults, rights are waived to

other Medicaid services related to the terminal illness. If you choose hospice, you can change your mind. We must be notified that you are receiving these services.

PRIVATE DUTY NURSING

This is for Medicaid members younger than age 21 who need more one-on-one, continuous care than they can get from a visiting nurse or at hospitals and skilled nursing facilities. We cover up to 24 hours of nursing care, if medically necessary. Private-duty nursing is meant as a short-term transition until the caregiver takes over the member's care.

Limits:

- These types of care need an OK from us ahead of time.
- These types of care are for children younger than age 21 only.

This is not a covered benefit for WVCHIP members.

SUBSTANCE USE DISORDER (SUD) SERVICES

You do not need a referral for Substance Use Disorder (SUD) services. Some services may require a prior authorization. Your PCP or the Customer Care Center can help you get these services from behavioral health providers. You can call the Customer Care Center at 800-782-0095 (TTY 711).

Benefits you can receive include:

- Targeted case management, including during pregnancy
- Behavioral health assessment
- Screening, brief intervention, and referral to treatment
- Behavior management
- Inpatient and outpatient services
- Partial hospitalization services
- Residential adult services
- Withdrawal management
- Naloxone administration services administered by Emergency Medical Services
- Non-methadone medication assisted treatment (MAT)
- Individual, family, and peer recovery support services

SUD Recovery Support Program

Eligible members can receive access to our mobile platform that provides daily motivation check-ins, peer support through discussion groups and peer-to-peer messaging, counselor messaging, care plan reminders, high-risk location alerts, and content to support ongoing recovery. For more information or to enroll in the program, please call the Customer Care Center at 800-782-0095 (TTY 711).

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

- 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
- Court-ordered services that are not covered benefits and not medically necessary
- Custodial care, intermediate care (such as residential treatment centers or Psychiatric Residential Treatment Facilities), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of Autism Spectrum Disorder by W.Va. Code §5-16-7(a)(8)
- 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
- Electroconvulsive therapy
- Electronically controlled thermal therapy
- 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
- Glucose monitoring devices, except Accu-Check models covered under the prescription drug benefit
- Hearing aids implanted; external hearing aids are covered when prior authorized as medically necessary
- Homeopathic medicine
- Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
- Hypnosis
- Routine childhood immunizations from non-VFC providers (members must get vaccine from VFC provider)
- Incidental surgery performed during medically necessary surgery
- Infertility services
- Maintenance outpatient therapy services as described above
- Medical equipment as described above
- Medical rehabilitation and any other services which are primarily educational

- Optical Services not listed as covered, including vision correction surgery
- Oral appliances, including but not limited to those treating sleep apnea
- Orientation therapy
- Orthotripsy
- Personal comfort and convenience items or services
- Physical conditioning: Expenses related to physical conditioning programs and safety devices used to effect performance, primarily in sports
- Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered by WVCHIP
- Provider charges for phone calls, prescription refills, form completion, or physician-to-patient phone consultations via the Telehealth Policy during the COVID-19 pandemic
- Screenings, except those specifically listed as covered benefits
- Service/therapy animals and the associated services and expenses, including training
- Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family, including spouse, brother, sister, parent, or child
- Services rendered outside the scope of a provider's license
- Gender affirming operations and associated services and expenses
- Sensory Stimulation (SS) therapy
- Take-home drugs provided at discharge from a hospital
- Treatment of temporomandibular joint (TMJ) disorder; intraoral prosthetic devices; onlays/inlays; gold restorations; precision attachments; replacement crowns only covered every five years; cosmetic dentistry; dental implants; experimental procedures; splinting
- Therapies rendered outside the United States that are not medically recognized within the United States
- Transportation that is not emergent or medically unnecessary facility to facility transports
- Weight loss, health services, and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, bariatric surgery, and services of a similar nature

This is not a complete list of the services that are not covered by UniCare, Medicaid, or WVCHIP. If a service is not covered, not authorized, or is provided by an out-of-network provider, you may have to pay. If you have a question about whether a service is covered, please call the Customer Care Center at 800-782-0095 (TTY 711). A full list of benefits can be found online. Go to dhhr.wv.gov/bms and select Members.

REFERRALS AND SPECIALTY CARE

Referrals are not needed when you go to see your primary care provider (PCP). For women, referrals are not needed for appointments with your obstetrician/gynecologist (OB/GYN). If you need health care that your PCP cannot give, your PCP must refer you to another provider who can. Usually, you will be referred to a specialist in our network. When your PCP refers you to an in-network provider, the care you get from a specialist will be covered. To see our list of specialists, please call us at 800-782-0095 (TTY 711) or visit unicare.com/wv. The Customer Care Center can also help you if you believe you are not getting the care you need.

Some types of care do not need an OK from your PCP:

- Family planning
- OB-GYN care from UniCare providers
- Emergency care
- Vision care
- Behavioral health services (WVCHIP members must have these services coordinated by their PCP)

UTILIZATION MANAGEMENT

Your PCP and other providers work with you to decide what care is best. We always want you to have the care you need. For some health care services, your provider may have to ask us for our OK. This is so that we will pay for the services. This process is called Utilization Management, or UM for short.

You should know:

- We make payment rulings based on the care and services you need and the benefits you have.
- We base our rulings on whether or not the care is right for your health issues and is medically necessary. See the *Definitions* section to learn more about whether or not a service is medically necessary.
- We don't reward providers or other UM decision-makers for denying requests.
- We don't offer money as a reward to UM decision-makers to push them to approve less care.

If you have questions about how medical decisions are made or would like a copy of our Utilization Management procedures, call our Utilization Management office at 866-655-7423. The office is open Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your provider must ask the Utilization Management department. If the care is a covered benefit and is medically necessary for you, then it will be covered. If we do not approve a prior authorization request, you can appeal the decision.

Getting an OK will take no longer than seven calendar days or two business days if requested electronically for non-urgent requests. If urgent, getting an OK will take no more than two business days OR three calendar days — whichever is shortest. Services that require an OK from us include, but are not limited to:

- Inpatient admissions
- Some surgeries
- CT, MRI, PET scan, special X-rays, and tests
- Certain behavioral health services (Residential Treatment, Partial Hospitalization Program, Intensive Outpatient Services, Psychological and Neuropsychological testing, Drug Screenings)
- Some durable medical equipment, like custom wheelchairs, breathing machines, hospital beds
- All out-of-network care

If your provider does not get an approval from us before the service happens, it will be denied.

OUT-OF-NETWORK SERVICES

If you need to see a provider who is not on our list and we are unable to provide those services in our network, you may see a provider who is not in our network. The cost will be no greater than it would be if you received the services within our network. Your PCP must ask UniCare for approval. It is important to remember that your PCP must ask us for approval before seeing an out-of-network provider. Your PCP can call the Utilization Management department at 866-655-7423. We will make a decision within seven days. If you are approved to see a provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization, you can appeal the decision.

COST SHARING FOR MEDICAID

Cost sharing, or a copayment, is the money you need to pay at the time of service. Whenever you see your PCP or a provider you were referred to in our network, you are not responsible for any costs except the copayment. The amount of the copayment will change depending on the service and the Federal Poverty Level. Please see the tables below for more details.

Copayments will be collected for:

- Inpatient and outpatient services

- Physician office visits, including nurse practitioner visits
- Non-emergency use of an emergency room
- Caretaker relatives age 21 and up
- Transitional Medicaid members age 21 and up
- Any other members that are not specifically exempt

Service	Up to 50.00% FPL	50.01 - 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	$0	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

Copayments will not be collected from Medicaid members for:

- Family planning services
- Emergency services
- Behavioral health services
- Members under age 21
- Pregnant women (including up to 60 days after pregnancy)
- American Indians and Alaska Natives
- Members getting hospice care
- Other members or services not under the State Plan authority
- Members who have met their household maximum limit for cost-sharing per calendar quarter
- Members with primary insurance other than Medicaid
- Approved home infusion supplies
- Vaccines administered by a pharmacist

You have to pay the copays listed above until you and all family members in your household enrolled in the plan get to the household copay maximum. Your household copay maximum is based on your household income. You're assigned to a tier based on your household size and income for the quarter.

Tier	Gross quarterly income range	Copay maximum
Tier 1	$0-$1,966	$8
Tier 2	$1,967-$3,932	$71
Tier 3	$3,933 and above	$143

You'll have no copays for the rest of the quarter once your household meets its copay maximum. You also may self-attest (report to us) that you have met the copay maximum. Call our Customer Care Center when you meet your copay maximum. Keep all your household copay receipts to show you've met the copay maximum.

You will start each quarter with $0 in copays and build toward your copay maximum. The table above shows the services you have to pay copays for and how much they are.

For more information on copayment amounts, please call the Customer Care Center at 800-782-0095 (TTY 711).

COST SHARING FOR WVCHIP

WVCHIP members participate in some level of cost sharing, except for those children registered under the federal exception for Native Americans or Alaskan Natives, and those enrolled in WVCHIP Pregnant Women's coverage. WVCHIP has enrollment groups and each one has copays. You can find your copay group at the bottom of your UniCare ID card.

Service	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
PCP/Medical Home Visits	$0	$0	$0
Other Office Visits (Physicians and Nurse Practitioners)	$5	$15	$25
Preventive Services and Immunizations	$0	$0	$0
Inpatient Hospital Admissions	$0	$25	$25
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	$0	$25	$25
Emergency Department (waived if admitted)	$0	$35	$35
Vision Services	$0	$0	$0
Dental Benefit	$0	$0	$25 for some non-

			preventive services

Note: Copays also apply to prescription drugs, which are still covered by WVCHIP, but not administered through UniCare or any Managed Care Organization.

Out of Pocket Maximums: The maximum copayment amounts applied during a calendar year are as follows:

# of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
2 Children Medical Maximum	$300	$300	$400
3 or more Children Medical Maximum	$450	$450	$600
Dental Services	Does not apply	Does not apply	$150 per family

Copayments will not be collected from WVCHIP members for:

- Native Americans or Alaskan Natives
- Maternity services or pregnant women over 19 years of age
- PCP/Medical Home visits
- Members who have met their household maximum limit for the calendar year

For more information on copayment amounts, please call the Customer Care Center at 800-782-0095 (TTY 711).

ACCESS AND AVAILABILITY GUIDE

UniCare offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a provider in different situations.

Type of Visit	When You Should be Seen
Routine Care	Within 21 Days
Urgent Care	Within 48 Hours
Specialty Referrals	Within three weeks for routine referrals; within 24 hours for urgent referrals
Non-urgent (sick) exams	Within 72 hours of request
Initial Prenatal Care	Within 14 Days of Known Pregnancy
Emergency Care	Immediately

The following table shows what your travel time should be for your appointments.

Traveling to Your	Should Take No Longer Than
PCP	30 Minutes
Specialist You See Often	30 Minutes
Federally qualified health centers and rural health clinics	30 Minutes
Hospital	45 Minutes
Tertiary Services	60 Minutes

RENEWING YOUR BENEFITS

For Medicaid members

You need to renew your benefits every year. If you don't, you may have a gap in your coverage. Be on the lookout for a letter close to your anniversary month saying it's time for you to renew. Then, you can renew online or in person. If you've moved, it's important to update your address with DHHR. Find the phone numbers and addresses at dhhr.wv.gov.bcf.

For WVCHIP members

WVCHIP members are required to re-determine eligibility every 12 months. After 10 months of coverage through WVCHIP, the child's parent or guardian will receive a letter from their local DHHR office to re-determine eligibility. Promptly returning the application helps assure that the child will not have a gap in coverage. Coverage for pregnant women ends 60 days after the birth occurs and is not renewable. You may also find applications to renew coverage on the chip.wv.gov website or they can be submitted electronically at wvpath.org.

LETTING US KNOW WHEN YOU'RE UNHAPPY

You may not always be happy with UniCare. We want to hear from you. UniCare has people who can help you. UniCare cannot take your Medicaid or WVCHIP benefits away because you make a grievance, appeal, or ask for a State Fair Hearing. You may continue receiving benefits during a grievance, appeal, or State Fair Hearing. Making a grievance, appeal, or State Fair Hearing will be administered at no cost to you.

There are two ways to tell UniCare about a problem:

Grievance or Appeal

A **Grievance** is a way for you to show dissatisfaction about things like:

- The quality of care or services you received;
- The way you were treated by a provider;
- A disagreement you may have with the health plan policy; or
- You do not agree to extend the time for a decision of a grievance or an appeal.

Contact us:

Customer Care Center:
800-782-0095
(TTY 711)
Monday through Friday
8 a.m. to 6 p.m. Eastern time

Mail:
Attn: Grievance & Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

An **Appeal** is a way for you to ask for a review when your UniCare health plan takes action to:

- Deny or give a limited approval of a requested service;
- Deny, reduce, suspend, or end a service already approved; or
- Deny payment for a service.

Or fails to:

- Act within required time frames for getting a service;
- Make a grievance decision within thirty (30) days of receipt of request;
- Make an expedited grievance decision within three (3) days of receipt of request;
- Make an appeal decision within thirty (30) days of receipt of request.
- Make an expedited appeal decision within seventy-two (72) hours of receipt of request.

UniCare must give you a written Notice of Action if any of these actions happen. The Notice of Action will tell you what we did and why and give you your rights to appeal or ask for a State Fair Hearing.

You have some special rights when making a grievance or appeal

1. A qualified clinical professional will look at medical grievances or appeals.
2. If you do not speak or understand English, call **800-782-0095 (TTY 711)** to get help from someone who speaks your language.
3. You or your representative may help you file a grievance or an appeal.
4. If your physical or behavioral health is in danger, a review will be done within three business days for a grievance or seventy-two (72) hours for an appeal or sooner. This is called an expedited review. Call UniCare and tell UniCare if you think you need an expedited review.

5. UniCare may take up to 14 days longer to decide if you request the change of time or if we think it is in your best interest. If UniCare changes the time, we must tell you in writing the reason for the delay.
6. If you have been getting medical care and your UniCare health plan reduces, suspends, or ends the service, you can appeal. In order for medical care not to stop while you appeal the decision, you must appeal within 13 days from the date the Notice of Action was mailed and tell us not to stop the service while you appeal. If you do not win your appeal, you may have to pay for the medical care you got during this time.
7. You may request enrollment in another Managed Care health plan if the issue cannot be resolved.

How to File a Grievance or Appeal

1. **Grievance**: You may file a grievance on the telephone, in person, fax to 844-882-3520, or in writing. Call UniCare at 800-782-0095 (TTY 711) to file a grievance.

- UniCare will write you within five calendar days and let you know we got your grievance.
- UniCare must give written notice of a decision within 30 days.

2. **Appeal**: You may file an appeal orally or in writing to UniCare. Unless you need an expedited review, you must complete a written request, even if you filed orally.

- You must appeal within 60 days from the date of our Notice of Action.
- For help on how to make an appeal, call UniCare at 800-782-0095 (TTY 711).
- Send your written appeal to:

  Attn: Grievance & Appeals Department
  P.O. Box 91
  Charleston, WV 25321

  - Or by fax at 844-882-3520.
  - Or the form can be found online at unicare.com/wv.
- UniCare must write you within five business days and let you know we got your appeal.
- UniCare must give written notice of a decision within 30 days for standard appeals an within 72 hours for an expedited appeal.

STATE FAIR HEARINGS

You have the right to ask for a State Fair Hearing when your Managed Care health plan takes an action or when your appeal is not decided in your favor. You may ask for a State Fair Hearing orally or in writing. Unless you need an expedited review, you must complete a written request, even if you asked orally.

- You must ask for a State Fair Hearing within 120 days from the date of the Managed Care health plan's written Notice of Appeal Resolution Letter.
- If you do not speak or understand English, or need American Sign Language, call **800-782-0095 (TTY 711)** to get help from someone who speaks your language at no cost to you. Members who use a Telecommunications Device for the Deaf (TDD) can call **711**. These services are available to you at no cost.
- You may ask anyone, such as a family member, your minister, a friend, or an attorney to help you with a State Fair Hearing.
- A decision will be made within 90 days from the date you asked for a hearing.
- If you have been getting medical care and your Managed Care health plan reduces, suspends, or ends the service, you can ask for a State Fair Hearing. In order for medical care not to stop, you must ask for a State Fair Hearing within 13 days of the date the written Notice of Appeal Resolution was mailed and tell us not to stop the service while you appeal. If you do not win, you may have to pay for the medical care you got during this time.

Medicaid members, send your request for an appeal to:

WV Bureau for Medical Services
Attn: Office of Medicaid Managed Care
350 Capitol St., Room 251
Charleston, WV 25301-3708

WVCHIP members, send your request for an appeal to:

WV Bureau for Medical Services
Attn: WV Children's Health Insurance Program
350 Capitol St., Room 251
Charleston, WV 25301-3708

Keeping Your Grievance and Appeals

UniCare will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

COMPLAINTS

At any time, you can file a complaint. You may fax it to UniCare at 844-882-3520 or mail it to:

Attn: Grievance & Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

You will need to send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing a complaint and what you want UniCare to do

Your doctor or authorized representative can also file a complaint or grievance for you.

REPORTING FRAUD

If you suspect fraud, waste, or abuse by a UniCare member or provider, please report it to our special investigative unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call 800-782-0095 (TTY 711). You may also complete the Fraud, Waste, and Abuse Reporting form on our website at unicare.com/wv or by mailing it to:

Attn: Program Integrity Unit
UniCare Health Plan of West Virginia, Inc.
200 Association Drive, Ste. 200
Charleston, WV 25311

When reporting a provider, let us know:

- Their name, address, and phone number
- The name and address of the facility (hospital, nursing home, home health agency, etc.)
- The Medicaid number of the provider and facility, if available
- The type of provider (provider, physical therapist, pharmacist, etc.)
- The names and the phone numbers of other witnesses who can help in the investigation
- The dates of events
- Summary of what happened

When reporting a member, let us know:

- The person's name
- The person's date of birth and Social Security number, if available
- The city where the person lives
- Specific details about the waste, abuse, or fraud

MEET WITH UNICARE

You have the right to meet with UniCare during the grievance process. We can help you set up a meeting. Call us at 800-782-0095 (TTY 711).

OUR POLICIES

ADVANCE DIRECTIVES

Under Federal and State law, you have the right to make decisions about your medical care, including an advance directive. An advance directive is a legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advance directive allows you to plan in advance and participate in decision-making around your health. It is a way to let your providers know what kind of

treatment you do or do not want. You can also allow someone you trust to make treatment decisions for you. This would allow that person to make choices about your care and treatment. Many people choose a relative or someone they know well.

You should speak with your provider about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. It will become a part of your medical records. Remember, you can change your advance directive at any time.

Your provider and the Customer Care Center can help you to fill out or answer questions about advance directives.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of UniCare, you have the right to disenroll at any time. You may re-enroll in another health plan if you choose. The enrollment broker can help you. Just call 800-449-8466 (TTY 304-344-0015).

Sometimes members are disenrolled from the health plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid or WVCHIP managed care
- You move outside of our service area
- You have had or need an organ or tissue transplant (MHT members only)
- You are placed in a nursing facility, State institution, or intermediate care facility for individuals with intellectual disabilities for more than 30 calendar days
- You were incorrectly enrolled in UniCare

If this happens, your services may stop suddenly. The enrollment broker and the Customer Care Center can answer any questions you may have about disenrollment. If you move out of the country or out of state, call the West Virginia Bureau for Medical Services at 304-558-1700.

APPROPRIATE TREATMENT OF MINORS

Minors are treated as adults when it comes to birth control, pregnancy, or family planning (except for sexual sterilization). Our members who are 13 years of age or older may refer themselves to any plan or out-of-plan OB/GYN for yearly exams and regular health care services (including cervical cancer screenings) at no cost to you. They don't need an OK ahead of time from their PCP.

Family planning records are kept private. PCPs and other health care providers should keep all family planning records private, even if the patient is a minor, unless the law says it is OK to share your information with others. Your provider is allowed to share your medical information with other providers who take care of you, public health officials, or government agencies.

UniCare is not responsible for the privacy of medical records held by providers who aren't part of your health plan.

All information, records, and data collected and maintained by UniCare or its subcontractors that relate to enrolled children is protected from unauthorized disclosure. UniCare restricts the release of information on minors to authorized persons, and associates follow a rigorous verification and authentication process prior to the release of information on minors. UniCare's policy limits the disclosure of information concerning enrolled children to purposes directly related to the administration of the Medicaid program in accordance with 42 C.F.R. §431.302.

Oral interpreters for minors are available in the case of an emergency.

THIRD PARTY INSURANCE

We can, and should, know about everyone giving you care. We need to know this to pay for your health care. We won't share this information with anyone except your health care provider and others as the law allows.

If you have insurance other than Medicaid or WVCHIP, please call the Enrollment Broker at 800-449-8466 (TTY 304-344-0015). Please call the Customer Care Center and let us know if another insurance company has been involved with your:

- Workers' compensation claim
- Personal injury
- Medical malpractice law suit
- Car accident

You must use any other health insurance you have first before using Medicaid. If you have other health insurance coverage, you are not eligible for WVCHIP.

What to do if you get a bill
In most cases, you shouldn't get a bill from our provider. You may have to pay for charges if:

- You agree to pay for service ahead of time that we don't cover or approve.
- You agree ahead of time to pay for care from a provider who doesn't work with us, and you did not get our OK ahead of time.

Call us if you get a bill and don't think you should have to pay for the charges. Please tell us the date of service, the amount being charged, and why you were billed. Have the bill with you when you call us. Sometimes a provider may send you a *statement* that is not a *bill*.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

UniCare has a Community Advisory Committee (CAC) to give members a say about our policies and services. CAC members inform, direct, and suggest ideas about issues involving our services. Call our Customer Care Center if you would like to join the CAC.

The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices in this member handbook describes the UniCare privacy policies and procedures.

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

NEW MEDICAL TREATMENTS

We want you to benefit from new medical treatments, so we review them on a routine basis. A group of PCPs, specialists, and medical directors decide if the treatment:

- Is approved by the government.
- Has shown, in a reliable study, how it affects patients.
- Will help patients as much as, or more than, treatments we use now.
- Will improve the patient's health.

The review group looks at all of the information. The group then decides if the treatment is medically necessary. They will let your provider know if the treatment is medically necessary and if we approve it.

QUALITY IMPROVEMENT

At UniCare, we want to make your health plan better. To do this, we have a Quality Improvement (QI) program. Through this program, we:

- Evaluate our health plan in order to improve it.
- Track how happy you are with your PCP.
- Track how happy you are with us.
- Use the information we get to make a plan to improve our services.
- Carry out our plan to help make your health care better.

You may ask us to send you information about our QI program. This will include a description of the program and a report on our progress in meeting our improvement goals. Call our Customer Care Center.

ACCREDITATION REPORT

UniCare is accredited by the National Committee for Quality Assurance (NCQA). You can request a summary of our accreditation report by calling our Customer Care Center. You can also find it on our website at unicare.com/wv.

IMPORTANT CONTACT INFORMATION

Entity	Phone Number	Street Address
UniCare Customer Care Center Call this number if you have questions about your benefits or if you would like to learn more about case management.	800-782-0095 (TTY 711)	
UniCare Local Office Call this number for help with local resources.	888-611-9958	200 Association Drive Ste. 200 Charleston, WV 25311
24-hour nurse help line	888-850-1108 (TTY 711)	
Behavioral Health Crisis Line	833-434-1261 (TTY 711)	
Emergency	Dial 911	
West Virginia Department of Health and Human Resources (DHHR) Call this number if you move, change your phone number, or become pregnant.	304-558-0684 877-716-1212	One Davis Square Ste. 100 East Charleston, WV 25301
West Virginia Bureau for Medical Services (BMS)	304-558-1700	350 Capitol St. Room 251 Charleston, WV 25301
WVCHIP Help Line Call this number if you need more information about benefit eligibility, application status, renewals, and general information.	877-982-2447	
Enrollment Broker Call this number to join a new health plan, report other health insurance, or disenroll from your current plan.	800-449-8466 (TTY 304-344-0015)	
SKYGEN USA Call this number for help finding a dentist or to learn	877-408-0917 (TTY 800-508-6975)	

Entity	Phone Number	Street Address
more about your dental benefits.		
Vision Service Plan (VSP) Call this number for help finding an eye doctor or to learn more about your vision benefits.	844-526-0198 (TTY 800-428-4833)	
Behavioral Health Utilization Review/Prior Authorization Your provider can fax this number for help with behavioral health services that need an OK from UniCare before you get them.	Inpatient Fax: 855-325-5556 Outpatient Fax: 855-325-5557	
Disease Management Call to enroll in the DM program or leave a private message for your case manager 24 hours a day.	888-830-4300 (TTY 711)	
Grievances, Appeals, and State Fair Hearings	800-782-0095 (TTY 711) Fax: 844-882-3520	P.O. Box 91 Charleston, WV 25321-0091
Non-emergency Medical Transportation (LogistiCare) Call this number to make a ride request for a provider visit. (Medicaid members only)	844-549-8353 (TTY 866-288-3133)	
Fraud, Waste, and Abuse	855-782-0095 (TTY 711)	200 Association Drive Ste. 200 Charleston, WV 25311
National Poison Control Center	800-222-1222	
Medicaid Pharmacy (DXC Technologies, Inc.) Use this number to find out more information about Medicaid Pharmacy benefits or	888-483-0797	

Entity	Phone Number	Street Address
to get help related to Pharmacy services, including diabetes supplies.		
WVCHIP Pharmacy (CVS Caremark) Use this number to find out more information about WVCHIP Pharmacy benefits.	800-241-3260	
Medical injectable prior authorization Your provider can call this number for help with medications given by your provider (covered under your medical benefit) that need an OK from UniCare before you get them.	877-375-6185 Fax: 844-487-9290	
Utilization Management/ Prior Authorization (except medical injectables) Your provider can call this number for help with medical services that need an OK from UniCare before you get them.	866-655-7423 Fax: 855-402-6983	
West Virginia Relay Service This number lets people who have a hearing or speech loss communicate with a trained person who can help them speak with someone who uses a regular telephone.	800-982-8772 (TTY 711)	P.O. Box 29230 Shawnee Mission, KS 66201-9230

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't

want this, please visit **unicare.com/health-insurance/about-us/privacy** for more information.

- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
  - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.

- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call our Customer Care Center at **800-782-0095**. If you're deaf or hard of hearing, call **711**.

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call our Customer Care Center or contact the Department of Health and Human Resources (DHHR) at **877-716-1212**. Nothing bad will happen to you if you complain.

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at **unicare.com/health-insurance/about-us/privacy**.

Race, ethnicity and language

We receive race, ethnicity and language information about you from the state agency. We protect this information as described in this notice.
We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do **not** use this information to:
- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

Your personal information
We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.
- We may use your PI to make decisions about your:
  – Health
  – Habits
  – Hobbies
- We may get PI about you from other people or groups like:
  – Doctors
  – Hospitals
  – Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 800-782-0095 (TTY 711).

Revised November 4, 2020

UniCare Health Plan of West Virginia, Inc.

PRIMARY CARE PROVIDER (PCP) SELECTION FORM

If your UniCare member ID card does not show the primary care provider (PCP) of your choice, or if you wish to change your PCP for any reason, you can:

- Call the UniCare Customer Care Center at 1-800-782-0095 to speak with someone who can help you.
- Complete this form and return it to us within 30 days.

  OR

- Request a new PCP by signing on to our member website.

You may choose one PCP for your whole family, or each family member may choose a different PCP. You must list each family member on the form even if you select the same PCP. We will send you new ID cards within five days after we receive your completed form. Or you can go to the member website to print your ID cards. Always carry your ID card with you.

☐ Please check this box if you are pregnant.

When you are done filling out this form, just mail it back in the envelope we provided. No stamp is needed.

Choose the PCP who's right for you. Send this form back today!
Look in our provider directory and give us your first and second choices for a PCP.

Please print your information below.

Your Name (please print): ______________________________

City: ______________________ State: ________ ZIP code: ______________

☐ Please check this box if you have moved in the last year. If you move, please remember to call our Customer Care Center at 1-800-782-0095.

Your Daytime Telephone Number: ______________________

Your Signature: ______________________

Choose a new PCP
Member Name (First and Last): ______________________________

Member ID Number: ______________________

First Choice — PCP Name (First and Last): ______________________
Second Choice — PCP Name (First and Last): ______________________

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.

WV MHB ENG 11.20

Provider Procedural Manual

Corporate Office

1110 Main Street
Wheeling, WV 26003

P: 1.800.624.6961
F: 1.740.699.6169
TTY: 711

healthplan.org

Exhibit
PL0004
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This manual is intended for the sole use of the physicians of The Health Plan. Any reproduction or distribution of any part of this manual without written consent from The Health Plan is prohibited.

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Section

1

Welcome

Introduction

Respect for our members, respect for our providers, and respect for our clients.

At The Health Plan, our strong relationships with the communities we serve are driven by respect for the people who reside in our service areas.

Paramount in our core values is our commitment to advancing the quality of care delivered by our providers and received by our members using the best available practices.

As a provider, there are TWO important concepts to understand about The Health Plan:

The **first** concept is that of the personal physician. Members enrolled in our HMO and POS products are required to select a primary care physician (PCP), who act as the coordinator of care for the patient. Members must contact their PCP prior to making appointments with specialty providers. Upon assessment of the patient needs, the PCP may find it appropriate to refer the patient to other participating specialty providers.

The **second** concept pertains to that of an established network. The Health Plan contracts with providers in order to obtain quality care at an affordable price. This enables us to contain premium increases to our membership. All services that can be properly performed by plan providers must be referred in-plan. Services which are not available through this in-plan network require preauthorization via an out-of-plan referral.

In an effort to provide better access to services, The Health Plan has established contracts with out-of-plan providers. This is known as the tertiary network. Should a member of The Health Plan require specialty of care or services not available through the in-plan network of providers, then his/her physician will refer him/her to one of the participating tertiary providers. These are still considered out-of-plan referrals requiring preauthorization. *These are discussed in greater detail in the pertinent section of the manual.*

The purpose of this manual is to give you an overview of The Health Plan and its structure so that you can function more effectively as a provider.

In addition to this manual and the training that accompanies it, The Health Plan customer service representatives are always available to assist in any way possible by calling 1.800.624.6961.

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About Us

The Health Plan was established in 1979 through provisions under the federal HMO Act. As a federally qualified and state-certified, 501(c)(4) not-for-profit HMO, our goal is to provide high quality, comprehensive and cost-effective health care. The Health Plan is West Virginia's first and largest HMO, with a service area encompassing all 55 counties in West Virginia and 36 counties in Ohio.

We have a strong, regional plan with a distinct, local market focus.

At The Health Plan, we take pride in the communities we serve and our not-for-profit status. For over 40 years, we have been able to develop new lines of business and expand our markets.

This strategy has led to consistent, steady growth for The Health Plan, with over 200,000 members enrolled across our diverse product lines. Many THP members are enrolled through their employers, state Medicaid and Medicare Advantage plans.

Being one of the most financially stable managed care organizations in the region has been a key to The Health Plan's success. Our financial strength allows us to put customer care over corporate profits by using over 90 cents of every health care premium dollar to pay claims for our insured members. The remainder is used to cover administrative overhead and any surplus at the end of the year is invested as equity and reserved for the protection of our members.

The Health Plan offers a complete line of managed care products and services designed to provide clients with innovative health care benefits at a reasonable cost. These include:

- Fully-Insured Health Maintenance Organization (HMO)
- Fully-Insured Preferred Provider Organization (PPO)
- Fully-Insured Point-of-Service (POS)
- Self-Funded Health Plans (HMO, MEWA, POS, PPO)
- Consumer Driven Services, including HRA, HSA and FSA Administration and COBRA Administration
- Competitive Stop Loss Coverage
- Benefits Administration
- Short-Term Disability Administration
- Pharmacy Benefit Management
- Vision and Dental Programs
- West Virginia Medicaid
- SecureCare (HMO) and SecureChoice (PPO) Medicare Advantage Plans
- SecureCare Dual-Eligible Special Needs Plan (D-SNP)
- Medicare Supplement

Mission Statement

"Established as a community health organization, The Health Plan delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across our community."

In keeping with our mission, we have identified members' rights along with their responsibilities, which are clearly indicated in the member's handbook.

As a participating provider with The Health Plan, it is imperative that you be aware of these rights and responsibilities. You are expected to assist our members by making them aware of their rights and by supporting these within your practice.

Network Services Contacts

When calling for assistance, please reference the contacts below.

Our hours of operation are 8:00 am to 5:00 pm EST Monday through Friday.

Please submit all claims and correspondence to: **1110 Main Street, Wheeling WV 26003-2704**

Provider Delivery Services

Antoinette Geyer– Senior Vice President, Provider Delivery Services
Email: ageyer@healthplan.org

Provider Contracting

Responsibilities - New contracts, amendments, contract changes (i.e. ownership, name or TIN change.)

Deloris Barrett–Director, Contracting
1.304.220.6387 or 1.800.624.6961, ext. 6387
Email: dbarrett@healthplan.org

Kim Rogers, MBA, RN – Director, Contracting
1.304.285.6512 or 1.800.624.6961, ext. 6512
Email: krogers@healthplan.org

Tiwatha Murdock– Network Development Manager
1.330.834.2271 or 1.877.236.2289, ext. 2271
Email: tmurdock@healthplan.org

Hallie Hendricks–Contract Specialist
1.330.834.2330 or 1.877.236.2289, ext. 2330
Email: hhendricks@healthplan.org

Provider Credentialing

Responsibilities - Credentialing/recredentialing all providers. Update expired credentials such as DEA, license, liability insurance, certifications. Assist with the addition of new providers to current group contract. Entry of new providers into the system.

Danielle Kaluger–Manager, Credentialing
1.740.699.6129 or 1.800.624.6961, ext. 6129
Email: dkaluger@healthplan.org

Tiffany Gerig–Ancillary Credentialing Representative
1.330.834.2204 or 1.877.236.2289, ext. 2204
Email: tgerig@healthplan.org

Tina Luff–Physician Initial Credentialing Representative
1.740.699.6279 or 1.800.624.6961, ext. 6279
Email: tluff@healthplan.org

Provider Support Services

Responsibilities - Entry of new provider information. Update provider changes to current groups. Assist providers with issues which cannot be resolved through THP's Customer Service Department.

Cayla Delman, Provider Relations Representative (internal)
1.740.699.6996 or 1.800.624.6961, ext. 6996
Email: cdelman@healthplan.org

Ashley Gummer–Provider Relations Representative (internal)
1.740.699.6248 or 1.800.624.6961, ext. 6248
Email: agummer@healthplan.org

EDI Support Center

Responsibilities – Set up and maintain EDI and direct deposit information. Assist with provider website questions and access. Troubleshoot and advise on issues between clearinghouse, provider and THP.

Ashley Gummer–Provider Relations Representative /EDI Support
1.740.699.6248 or 1.800.624.6961, ext. 6248
Email: hpecs@healthplan.org

Provider Engagement
Responsibilities - Perform educational and site visits and assist providers with issues which cannot be resolved through THP's Customer Service Department.

Wheeling Office:

Kayla Shreve–Wheeling Regional Manager Provider Engagement
1.740.699.6102 or 1.800.624.6961, ext. 6102
Email: kshreve@healthplan.org

Natalie Stewart–Provider Engagement Representative
1.330.834.2265 or 1.877.236.2289, ext. 2265
Email: nstewart@healthplan.org

Bethani Zelewicz–Provider Engagement Representative
1.740.699.6959 or 1.800.624.6961, ext. 6959
Email: bzelewicz@healthplan.org

Charleston Office

Barbara Good–Charleston Regional Manager Provider Engagement
1.304.720.4947 or 1.800.624.6961, ext. 4947
Email: bgood@healthplan.org

Garrett Coleman–Provider Engagement Representative
1.304.220.639 or 1.800.624.6961, ext. 6394
Email: gcoleman@healthplan.org

Jenny Pauley–Provider Engagement Representative
1.304.220.6356 or 1.800.624.6961, ext. 6356
Email: jpauley@healthplan.org

Nicole Rendinell–Provider Engagement Representative
1.304.220.6392 or 1.800.624.6961, ext. 6392
Email: nrendinell@healthplan.org

Seth Shockey–Behavioral Health Provider Engagement Representative
1.304.720.4957 or 1.800.624.6961, ext. 4957
Email: sshockey@healthplan.org

Morgantown Office

Rachel Waybright Tignor–Regional Manager Provider Engagement
1.304.285.6510 or 1.800.624.6961, ext. 6510
Email: rtignor@healthplan.org

Marjorie Burdick–Provider Engagement Representative
1.304.285.6507 or 1.800.624.6961, ext. 6507
Email: mburdick@healthplan.org

Jessica Legg–Provider Engagement Representative
1.304.285.6509 or 1.800.624.6961, ext. 6509
Email: jlegg@healthplan.org

Grace Matthews–Provider Engagement Representative
1.304.887.0400
Email: gmatthews@healthplan.org

Provider Quick Reference Guide

Our dedicated and friendly staff at The Health Plan are here to assist you when issues, questions or concerns arise. We've compiled a quick reference guide that lists important contacts that are most relevant for our providers.

Customer Services – Assistance with Eligibility, Pre-Authorization and Claims	
Customer Service – **Fully Funded** (including Commercial)	1.888.847.7902
Customer Service – **Self-Funded**	1.888.816.3096
Customer Service - **Medicare**	1.877.847.7907
Customer Service - **Medicaid**	1.888.613.8385
Behavioral Health (24/7)	1.877.221.9295
Paper Claims Submission	The Health Plan 1110 Main Street Wheeling, WV 26003
Coordination of Benefits (COB)	740.695.7903
Electronic Data Interchange (EDI) Support	740.699.6248
eviCore healthcare	1.877.791.4101
NantHealth | NaviNet Support	1.888.482.8057
Palladian Health	1.877.244.8514
Physician Access Line (24/7)	1.866.687.7347
Provider Information	Go to healthplan.org, "For Providers"
Urgent or Emergent Admissions (24/7)	1.800.304.9101
Fax Numbers	
Behavioral Health	1.866.616.6255
Medical Records	740.699.6163
Palladian Health	1.844.681.1205
Provider Relations	740.699.6169
Submit Clinical Information for Review	1.888.329.8471

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Email Contacts	
Behavioral Health	Behavioralhealthdocuments@healthplan.org
Contracting	dbarrett@healthplan.org or krogers@healthplan.org
Credentialing	dkaluger@healthplan.org
EDI	Hpecs@healthplan.org
eviCore healthcare	clientservices@evicore.com
Helpful Links	
eviCore healthcare	evicore.com
NaviNet	navinet.navimedix.com
Palladian Health	portal.palladianhealth.com
THP Corporate Website	healthplan.org
THP Provider Secure Website	myplan.healthplan.org
Provider Search	findadoc.healthplan.org/

Section 2

Physician Availability

Physician Availability

In an effort to control the high cost of emergency room (ER) utilization and to reduce the unnecessary denial of ER claims, we would like to offer the following information as a reminder of the physician's role as governed by his/her physician agreement. Physicians need to provide or arrange for service 24 hours a day, seven days per week. The physician should list one to two participating THP physicians as backups. The physician or designated backup(s) are to be available by phone or answering service. Answering machines should contain an appropriate message.

In cases of emergency (except for life endangering situations), The Health Plan members are instructed to call their primary care physician (PCP). If unable to reach their PCP, they are instructed to call The Health Plan 24-hour emergency number at **1.800.624.6961** for their physician's backups or for further assistance.

Please review access standards. They are also contained in The Health Plan Practice Guidelines and Standards.

Primary Care Physician Responsibilities:

- Maintain continuity of enrollee's health care by serving as the primary care provider
- Provide access twenty-four (24) hours a day, seven (7) days a week
- Make referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with THP's utilization management policies
- Maintain a current medical record for the enrollee, including documentation of all services provided by the PCP, as well as specialty or referral services
- Adhere to EPSDT Periodicity Schedule for enrollees under age twenty-one (21)
- Follow THP's established procedures for coordination of in-network and out-of-network services for Medicaid enrollees

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Primary Care Physician Guidelines

1. You will be listed on The Health Plan's provider directory under primary care physicians (PCP). (MEMBERS MUST SELECT A PCP.)
2. If you have a medical subspecialty, you may also be listed under a second category for your specialty.
3. If you wish to change to a different category on the provider lists, you must make a request in writing to Provider Relations at providersupport@healthplan.org or by mail to Attention: Provider Relations, 1110 Main Street, Wheeling, WV 26003
4. If you wish to be listed as NOT ACCEPTING NEW PATIENTS on the provider lists, you must meet the required minimum and make a written request to Provider Relations.
5. PATIENT ROSTER:

- The PCP patient roster can be obtained through our provider secure portal that enables your office to generate a member roster at any time. The member information is updated every 24 hours, seven days a week. To access The Health Plan's provider portal, simply click on myplan.healthplan.org. Be sure to cross-reference the member ID number, date of birth, and name that appears on your roster with the information in your member's chart to ensure that they are the same people. Please refer to the "Roster" folder on the left-hand side of your screen after logging onto the provider secure portal to obtain your member roster.
- You will only have access to patients who have you listed as their PCP. It is important to review your roster. If you have patients who have been attributed to your practice, you should contact them to request that they become established with your practice. If they were assigned in error report this to Provider Relations and we will have Customer Service contact the member to be reassigned.
- Once you have obtained your roster, it should be checked for patients who:
  - May be listed but have never been seen, AND
  - Patients who are seen regularly but do not appear on the roster.
- The roster should also be checked before patient appointments.
- If you wish for the member to choose you as their PCP, have the member call The Health Plan from your office. Members may change their PCP once per month by calling The Health Plan Customer Service Department at **1.800.624.6961**
- If you want a patient to be removed from your roster, you must submit a request to Provider Relations stating the reason for the request. You may make such a request in the following situations:
  - Noncompliance concerning the physician's orders
  - When a member has been seeing another PCP on a regular basis
  - When a member has been referred by another PCP on a regular basis
  - When a distinct personality clash exists

You will receive a response from Provider Relations, or the member will receive a letter from The Health Plan requesting that they choose another PCP.

PCPs Encouraged to Screen for Behavioral Health Needs

The primary care setting is potentially one of the key points of access to screening, assessment, early intervention, referral, and treatment of behavioral health needs. The primary care provider is often the first to encounter a patient with a mental health or substance abuse need and is in the unique position to assess the patient, utilize brief screening tools and to treat or refer members as needed.

The Health Plan encourages primary care providers to use appropriate screening tools to assess members for behavioral health needs. Screenings should be provided to people of all ages, even the young and the elderly. Screening tools for mental health and substance use disorders can be found at integration.samhsa.gov/clinical-practice/screening-tools. If you need assistance with referral to a behavioral health specialist contact The Health Plan's Clinical Services Department at **1.800.624.6961** extension 7644 for assistance.

The Health Plan also encourages the sharing of information between primary care and behavioral health providers. For your convenience, the "Authorization to Disclose Health Information to Primary Care Physician and Continuity of Care" form is available on the website at myplan.healthplan.org, "Forms," "Behavioral Health Forms."

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Substance use disorder (SUD) is a widespread problem. Many times, the primary care physician (PCP) is the first professional to encounter a patient with alcohol or other substance use disorder issues.

The Health Plan suggests a few points for practitioners/providers to consider when encountering patients who may be experiencing problems with substance use disorders.

What PCPs Can Do:

- Carefully ask about SUDs and screen for problem use.
- Make sure the diagnosis is listed in the patient chart and on your claims.
- Follow-up with the patient. Schedule a follow-up appointment or schedule an appointment with a qualified behavioral health clinician. Make sure that a substance use disorder diagnosis is included on each follow-up visit. Patients may want to minimize their use of a substance, so persistence is required in raising the topic and keeping it at the forefront of a patient's care.
- Encourage the patient to follow through. Express interest in his/her progress.
- Make a clear statement about needing to cut down if use is problematic. Give advice.
- Consult The Health Plan guidelines for the treatment of patients with substance use disorders which includes various screening tools.

Practitioners/providers need to be mindful that substance use disorders can co-occur with other behavioral health problems such as major depression or anxiety disorder, which can make treating substance use disorders or diagnosing a behavioral health disorder more difficult. In instances like this, a referral to a behavioral health provider is prudent. Practitioners/providers wishing to refer a patient for behavioral health services or to facilitate coordination of services may call Clinical Services at **1.800.624.6961**, ext. 7644 for assistance. Additional resources on substance use disorders can be found at nida.nih.gov.

Secondary Care Physician Guidelines

Members may select a secondary care physician (SCP).

1. The following provider specialties can be selected as a secondary care provider (SCP):
   - OB/GYN
   - Endocrinologist
   - Oncologist
   - Nephrologist

   A SCP will be listed on The Health Plan's provider list with two categories: SCP and specialist.

     - Specialist listed as a primary or secondary care physician may require a referral if the specialist is not listed as the member's PCP or SCP.

2. If the member has you selected as a SCP, they pay the PCP copay in most cases, depending on the plan's summary plan description (SPD)

3. If you wish to change to a different category on the provider list, you must make a request in writing to Provider Relations at providersupport@healthplan.org or by mail to Attention: Provider Relations, 1110 Main Street, Wheeling, WV 26003.

4. If you wish to be listed as NOT ACCEPTING NEW PATIENTS on the provider list, you must meet the minimum requirements and submit a written request to Provider Relations.

5. PATIENT ROSTER:

   - SCP patient rosters can be obtained through our secure provider portal that enables your office to generate a member roster at any time. The member information is updated every 24 hours. To access The Health Plan's provider website, visit myplan.healthplan.org. Be sure to cross-reference the member ID number, date of birth, and name that appears on your roster with the information in your member's chart to ensure that they are the same people.

     Please refer to the "Roster" folder on the left-hand side of your screen after logging onto the provider secure portal for obtaining your member roster.
   - You will only have access to patients who have listed you as their SCP.
   - Once you have obtained your roster, it should be checked for patients who may be listed; but have never been seen, and patients who are seen regularly; but do not appear on the roster.
   - The roster should also be checked before patient appointments.
   - If you wish for the member to choose you as their SCP, you may have the member call The Health Plan from your office. Members may change their SCP once per month by calling The Health Plan Customer Service Department at **1.800.624.6961**.
   - If you want a patient to be removed from your roster, you must submit a request to Provider Relations stating the reason for the request. You may make such a request in the following situations:
     1. Noncompliance concerning the physician's orders.
     2. When a distinct personality clash exists.

You will receive a response from Provider Relations, or the member will receive a letter from The Health Plan requesting that they choose another SCP. In that case, you will receive a copy of The Health Plan letter to the member.

SCP may provide referrals ***only in cases*** where the referral is related to care pertaining to his/her specialty. If you are not listed as the member's SCP, you are considered a specialist and a referral from the PCP is required.

Specialist Guidelines

1. You will be listed in The Health Plan provider directory under SPECIALISTS THAT MAY R EQUIRE REFERRALS. Although The Health Plan has eliminated the call-in referral to The Health Plan Medical Department, the PCP is still the coordinator of all medical care for the member, and still needs to coordinate referrals to specialists. Members who are a part of the ASO line of business may still require phone-in referrals to a specialist.

2. If you wish to change to a different category on the provider directory, you must make a request in writing to Provider Relations at providersupport@healthplan.org or by mail to Attention: Provider Relations, 1110 Main Street, Wheeling, WV 26003. Your request will be reviewed in accordance with The Health Plan's credentialing guidelines to assure you meet qualifications required for a specific category.

3. Except in cases of emergency treatment, specialists shall only treat members upon referral from a PCP or a SCP.

4. Except in cases requiring emergency treatment, *specialists must submit a report to the appropriate PCP or SCP* concerning the proposed plan of specialty treatment, including possible hospitalization or surgery, as soon as possible after examination of a member.

5. Specialists should contact the PCP to arrange referrals to another physician. *Specialist-to-specialist referrals are not generally permitted.* In emergency situations, a specialist to whom a patient has been referred may refer that patient to another specialist only in cases where the referral is related to care pertaining to his/her specialty, i.e., specialized surgery and/or care requiring tertiary services. The plan recommends, however, that the specialist communicate with the PCP regarding the need for the referral in such instances. This may be done after the fact in instances where the emergency may require immediate action.

6. Specialists will send a copy of the member's treatment record to the appropriate PCP or SCP.

Physician Care of Self or Family

Based on recommendations from the American Medical Association (AMA), The Health Plan upholds that practitioners should not treat themselves or their immediate family members, or members of their household. Accordingly, The Health Plan benefit plans DO NOT permit payment to a provider for treating their family members.

The following degrees for relationship are included within the definition of immediate relative.

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

EMERGENCIES: In the case of medical emergencies, a THP practitioner can provide care until a qualified practitioner is available.

ORDERS (written or verbal): The Health Plan practitioners shall not write orders or dictate verbal orders for themselves or a member of their immediate family.

PRESCRIPTIONS: The Health Plan practitioners shall not write prescriptions for themselves or members of their immediate family.

PCP ASSIGNMENT: The Health Plan practitioners shall not be permitted to act as primary care physician for themselves or members of their immediate family.

Section 3

Member Benefits

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Member Benefits

The Health Plan member handbook is the primary source of information regarding The Health Plan member benefits. **The Health Plan member handbook is available upon request.**

Office Copayment

Member handbooks are subject to the copayment of the benefit plan ch osen.

Vision Benefits

The Health Plan offers benefit riders for vision benefits administered through Vision Service Plan (VSP) for commercial members and Superior Vision for Medicaid and Medicare members. Providers must be a participating provider with the appropriate vision provider to be eligible to offer covered vision services. You will need to verify vision coverage through the appropriate vision carrier.

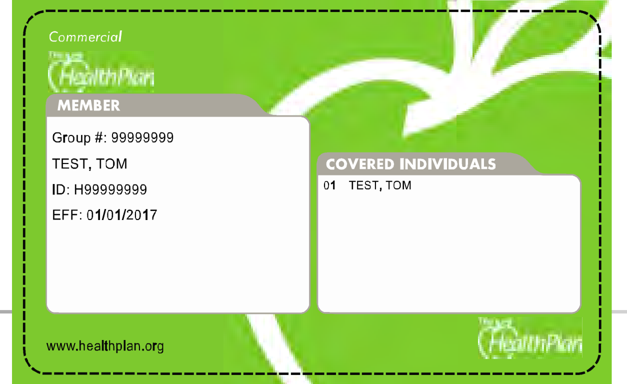
Please note: Members are entitled to vision benefits only under this separate vision service program.

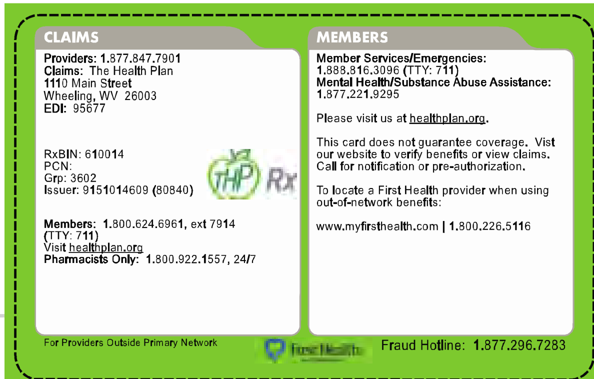
Members may require ophthalmologic medical services in conjunction with a medical condition. These medical services must be offered through a contracted ophthalmologi st or optometrist with The Health Plan. A referral from the primary care physician (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Product Matrix

The product matrix lists all the products offered by The Health Plan. This matrix identifies the basic plan design of each product and includes a sample ID card.

PRODUCT MATRIX





SAMPLE ID CARD FRONT/BACK

	Member selects Primary Care Physician (PCP)	Referrals required for Specialty Care	Member has OB/GYN Open Access	Member has Mental Health Open Access	Member has Out-of-Network Benefits
COMMERCIAL					
Fully Funded HMO	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Referrals must be submitted to The Health Plan for any tertiary or out-of-network care.	YES, through OB/GYN secondary physician when selected.	YES. Refer to Directory for appropriate providers.	NO
Fully Insured POS	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Referrals must be submitted to The Health Plan for any tertiary or out-of-network care.	YES for all in-network OB/GYN services.	YES. Refer to Directory for appropriate providers.	YES
Fully Insured PPO	NO	NO. Member may self-refer to any network specialist to receive in-network benefits.	YES for all in-network OB/GYN services.	YES. Refer to Directory for appropriate providers.	YES
SELF-FUNDED					
Self-Funded HMO, EPO, PPO, POS	PPO: NO HMO, EPO, POS: YES	PPO: NO. HMO, EPO, POS: YES. Services requiring referral/precert may differ by plan sponsor. Contact The Health Plan to confirm benefits.	Determined by specific employer benefits.	Determined by specific employer benefits.	Determined by specific employer benefits.
MEDICAID					
MHT/WVHB/SSI	YES	YES	YES for all in-network OB/GYN services.	YES. Refer to Directory for appropriate providers.	NO
MEDICARE					
SecureCare HMO*	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Referrals must be submitted to The Health Plan for any tertiary or out-of-network care.	YES, through OB/GYN secondary physician when selected.	YES. Refer to Directory for appropriate providers.	NO
SecureCare SNP	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Referrals must be submitted to The Health Plan for any tertiary or out-of-network care.	YES, through OB/GYN secondary physician when selected.	YES. Refer to Directory for appropriate providers.	NO
SecureChoice PPO	NO	NO	YES	YES. Refer to Directory for appropriate providers.	YES
Medicare Supplement	NO	NO. Member may self-refer to any specialist who accepts Medicare.	YES	YES	YES. Any provider who accepts Medicare.

For verification of eligibility or benefit information specific to a particular member, go to myplan.healthplan.org. If you require assistance with registering for access to this secure website, please call 1.800.624.6961, ext. 6248.

* Includes WVU Medicine – The Health Plan SecureCare (HMO)

Rev. 12/19

Commercial HMO Plans

Commercial health maintenance organization (HMO) plans are plans that are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees. The Health Plan assumes the responsibility for providing the benefit package, administering all aspects of the plan and the risk for paying for all covered services. These plans require a member to choose a primary care physician (PCP), and although The Health Plan has eliminated the need for the PCP to call in a referral for specialty physician services, the member must be referred by their PCP and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless authorized by the plan.

HMO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- Prescription drugs

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and X-rays, not associated with preventive services, depending on the plan.

Commercial Point-of-Service (POS) Plans

Commercial point-of-service (POS) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups, with a minimum size of two employees, contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees.

POS plans are designed to allow members the freedom to choose between having their health care managed or arranged by their primary care physician (PCP) as an in-plan option or the member has the option to manage and arrange their care as an out-of-plan option. The plan provides the benefit package giving the employer the option to choose from a variety of deductibles and copay plans. These plans require a member to choose a PCP, obtain a referral for specialty physician services, and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions.

Members have out-of-plan option benefits and may choose to access services outside The Health Plan network at an increase in their out-of-pocket expense for deductibles, copays, and co-insurance amounts.

POS benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care

- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their plan benefit.

Commercial Preferred Provider Organization (PPO) Plans

Commercial preferred provider organization (PPO) plans are fully insured by a Health Insuring Corporation (HIC). Employers contract with The Health Plan to provide a health insurance benefit plan and pre-pay a monthly premium to cover eligible employees. Members who are covered under the PPO plan generally are not required to select a primary care physician (PCP) or obtain a referral for specialty physician services. All prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admission apply. By utilizing The Health Plan in-plan or tertiary network, members receive a higher level of benefits. Members who utilize out-of-network providers or fail to preauthorize a service will have increased out-of-pocket expenses for deductibles, copays, and co-insurance amounts.

PPO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.

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Sample Commercial ID Cards

This card is issued to members enrolled in a Commercial HMO or PPO plan. This includes WV State employees who are covered by the Public Employees Insurance Agency (PEIA).

FRONT

BACK

SecureCare HMO Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our Plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and X-rays, not associated with preventive services.

SecureChoice PPO Medicare Advantage Plan

SecureChoice PPO is The Health Plan's Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. The Health Plan prior authorization requirements apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from The Health Plan's extensive network of participating providers.

The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits in addition to enhanced benefits that are offered by The Health Plan.

PPO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.

D-SNP Program (Medicare Advantage Special Needs Plan)

Effective January 1, 2014, The Health Plan began a Medicare Special Needs Plan (SNP) for those members who have a chronic condition. The special needs population are those recipients who qualify for both Medicare and Medicaid. These "dual-eligibles" are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

SNP members will select a primary care physician (PCP) and a THP case manager will be assigned to the member.

Provider Reimbursement and Billing

The provider will bill The Health Plan for medically appropriate covered services provided to the D-SNP member. The Health Plan will reimburse the provider for services rendered according to the member's benefit plan, less any copays, co-insurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to West Virginia or Ohio Medicaid program.

To obtain referrals or eligibility information please call our Customer Service Department at 1.877.847.7907.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at ssa.gov/OP_Home/ssact/title19/1902.htm.

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

If a provider is referred to us who is balance billing or refusing to take D-SNP patients, Medicare MLN Matters documents will be sent to the provider and document the training. This policy is included in Section 4 of the Provider Procedural Manual and published periodically in our quarterly ProviderFocus newsletter.

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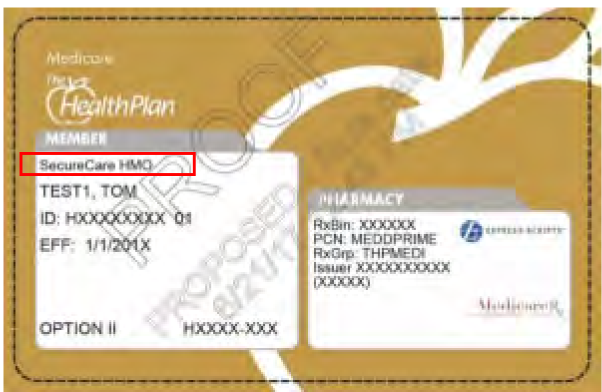
Sample Medicare ID Cards

This card is issued to Medicare members who are enrolled in our HMO, PPO, or SNP plans. The specific plan will be indicated on the front of their ID card (as shown in the red box below).

FRONT



BACK

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Mountain Health Trust and West Virginia Health Bridge (WV Medicaid Program)

Mountain Health Trust (MHT) and WV Health Bridge (WVHB) are fully insured managed care plans offered to Medicaid-eligible residents of West Virginia. The plan requires a member to select a primary care physician (PCP), obtain a referral for specialty physician services, and follow prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless prior authorization is given by the plan.

Under the Medicaid programs, the state of West Virginia determines eligibility and enrollment through a broker hired by the state of West Virginia for enrollment services. Once the member selects The Health Plan, we are notified electronically of enrollment. At that time, a packet of information is sent to the member, along with an ID card from The Health Plan. The MHT and WVHB member will have two cards. The Health Plan ID card, as well as the West Virginia Medicaid card, issued annually, showing eligibility. The Health Plan will not reissue their ID card each month with the exception of a replacement ID card for a lost or misplaced ID card or a change in PCP.

The date appearing on The Health Plan ID card is the actual date the card printed and not the effective date of coverage. The effective date of coverage is always the first of the month, except for a newborn.

You may contact The Health Plan Customer Service Department at **1.888.613.8385** to check eligibility or if you have any question regarding MHT and WVHB programs. Eligibility, benefits, and claims status are available through our secure provider portal.

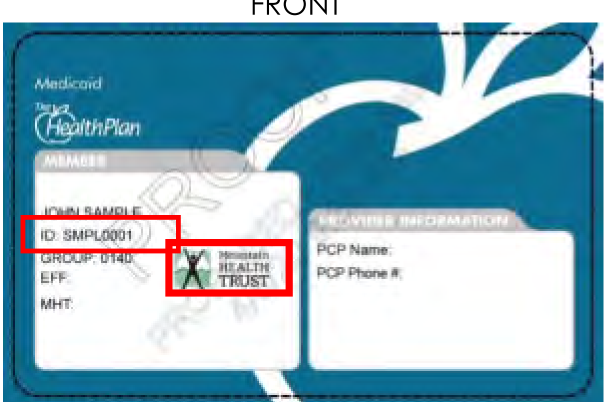
Sample Medicaid ID Cards

This card is issued to Medicaid members who are enrolled in our Mountain Health Trust () or WV Health Bridge plans (). The specific plan and group number that a member is enrolled in will be indicated on the front of their ID card (as seen in the red boxes below).

Take note of the member's group number:

- Mountain Health Trust plan (): 0140, or 0142 for SSI members
- WV Health Bridge plan (): 0141

FRONT



BACK

Administrative Services Only (ASO) Self-Funded Employer Groups

Many employers choose to pay claims as they are incurred, rather than pay a prepaid monthly premium for their employee's medical benefits. The Health Plan offers administrative services only (ASO) plans to assist these employers with administering their benefit plan. The plan offers them a contracted network of providers, utilization management services, medical management, prescription plans, customer service and claims processing. These plans are most often designed by the employer group and administered by The Health Plan. ASO plan benefits, copays, deductibles, and ID cards may vary from the standard insured plans offered by The Health Plan.

Sample Self-Funded ID Cards

This card is issued to members who are enrolled in a Self-Funded plan. The company name will differ on these cards (as shown in the red box below).

Note: Services requiring referral/ prior authorization may differ by plan. Contact The Health Plan to confirm benefits.

FRONT

BACK

Vision Service Benefit

Members enrolled through The Health Plan Commercial and Medicare programs may also have vision benefits. Benefits are administered through Vision Service Plan (VSP) for Commercial members. Superior Vision administers vision benefits for THP Medicare members. Please refer to resources available through VSP and Superior Vision for information on benefits and coverage under these vision plans.

Vision Service Plan (vsp.com)

Monday - Friday 8 AM to 11 PM
Saturday 10 AM to 11 PM
Sunday 10 AM to 10 PM
Closed Thanksgiving Day and Christmas Day

1.800.877.7195

For assistance with translation, hearing impaired callers may call 1.800.428.4833.

Superior Vision (superiorvision.com)

Monday – Friday 8 AM – 9 PM EST

1.844.353.2900

Members enrolled through The Health Plan WV Medicaid programs may have vision benefits. Those benefits are administered through Superior Vision. Refer to **Section 5** for additional information on Medicaid vision benefits.

Billing for Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered under a medical benefit plan but is often covered by a vision benefit plan. When there is the need to provide a vision screening as part of a medical exam, the following billing guidelines will assist you in obtaining appropriate reimbursement for the vision screening if there is a benefit that is available through The Health Plan's vision benefit vendors, provided you are a participating provider.

Billing Procedures

The visit is billed to The Health Plan on the appropriate CMS 1500 form with the following codes:

92002, 92004, 92012, or 92014		Eye exam, new or established patient
92015	vs	Determination of refractive state

After The Health Plan has made payment for the exam and denied the refraction as non-covered, you can then submit the visit code and the 92015 – Determination of Refractive State – to The Health Plan's vision provider (as long as you are a contracted provider) for payment of the refraction.

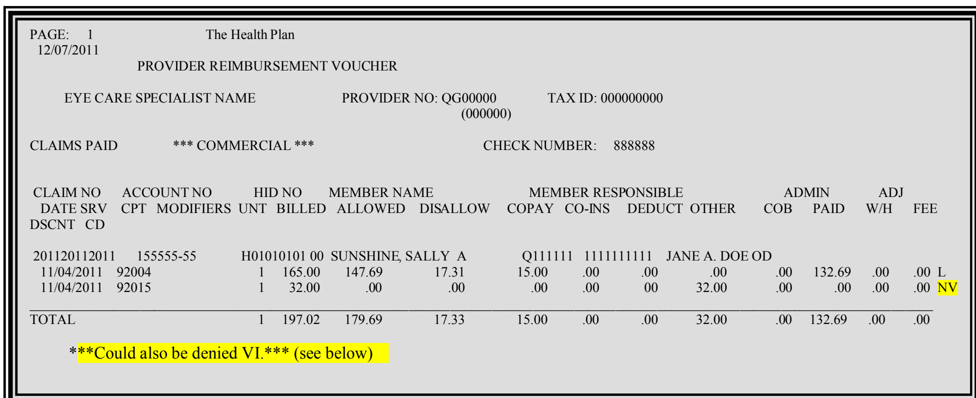
You must include our payment voucher (with the page that shows the explanation of the denial codes) when submitting to VSP for the remaining portion.

Vision provider will coordinate benefits with The Health Plan and pay only the refraction which is still due when a benefit is available to cover the refraction. If the member has a vision benefit through some other plan that is not associated with The Health Plan, you may also submit a claim for the refraction to that plan in the same manner and they will adjudicate the claim according to their plan guidelines.

The Health Plan encourages our **diabetic members** to see an in-plan **ophthalmologist** or **optometrist** for an annual dilated retinal exam (excludes self-funded ASO participants.) If a **92015-Determination of Refractive State** is also done during the visit, the following billing procedures apply.

- *Without a referral and with a waiver of the associated office copayment.*

Once The Health Plan has made payment, you can then submit the visit code and the 92015-Determination of Refractive State to the appropriate vision plan, for payment of the refraction. You must include our payment voucher when submitting to VSP for the remaining portion. VSP will coordinate benefits with The Health Plan and pay only the refraction which is still due.



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PROVIDER REIMBURSEMENT VOUCHER

EYE CARE SPECIALIST NAME PROVIDER NO: QG00000 (000000) TAX ID: 000000000

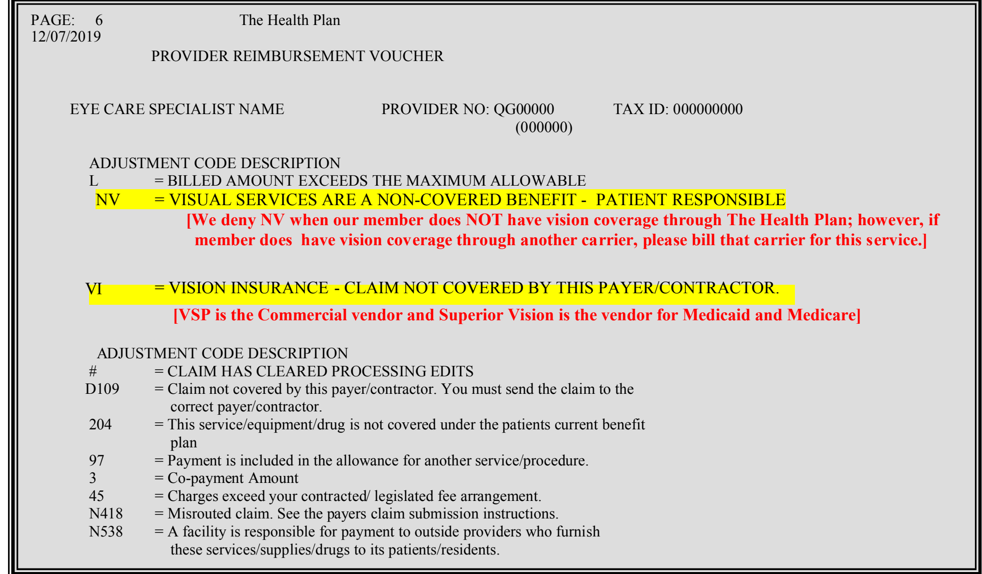
CLAIMS PAID *** COMMERCIAL *** CHECK NUMBER: 888888

CLAIM NO	ACCOUNT NO	HID NO	MEMBER NAME	MEMBER RESPONSIBLE		ADMIN	ADJ
201120112011	155555-55	H01010101 00	SUNSHINE, SALLY A	Q111111	1111111111	JANE A. DOE OD	

DATE SRV	CPT	MODIFIERS	UNT	BILLED	ALLOWED	DISALLOW	COPAY	CO-INS	DEDUCT	OTHER	COB	PAID	W/H	FEE DSCNT	CD
11/04/2011	92004		1	165.00	147.69	17.31	15.00	.00	.00	.00	.00	132.69	.00	.00	L
11/04/2011	92015		1	32.00	.00	.00	.00	.00	00	32.00	.00	.00	.00	.00	NV
TOTAL			1	197.02	179.69	17.33	15.00	.00	.00	32.00	.00	132.69	.00	.00	

Could also be denied VI. (see below)

Include the page of the voucher that has explanation of the denial codes when submitting to VSP or Superior Vision.



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12/07/2019
PROVIDER REIMBURSEMENT VOUCHER

EYE CARE SPECIALIST NAME PROVIDER NO: QG00000 (000000) TAX ID: 000000000

ADJUSTMENT CODE DESCRIPTION
L = BILLED AMOUNT EXCEEDS THE MAXIMUM ALLOWABLE
NV = VISUAL SERVICES ARE A NON-COVERED BENEFIT - PATIENT RESPONSIBLE
[We deny NV when our member does NOT have vision coverage through The Health Plan; however, if member does have vision coverage through another carrier, please bill that carrier for this service.]

VI = VISION INSURANCE - CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR.
[VSP is the Commercial vendor and Superior Vision is the vendor for Medicaid and Medicare]

ADJUSTMENT CODE DESCRIPTION
# = CLAIM HAS CLEARED PROCESSING EDITS
D109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
204 = This service/equipment/drug is not covered under the patients current benefit plan
97 = Payment is included in the allowance for another service/procedure.
3 = Co-payment Amount
45 = Charges exceed your contracted/ legislated fee arrangement.
N418 = Misrouted claim. See the payers claim submission instructions.
N538 = A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.

The Health Plan's Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Members have the right to receive information regarding the plan. Information such as a summary of the plan's accreditation report and the plan's: services, policies, benefits, limitations, practitioners and providers. Members have the right to information on member's rights and responsibilities and any charges they may be responsible for. Members have the right to obtain evidence of medical credentials of a plan provider, (i.e. diplomas and board certifications). If a member needs assistance with any of the above, they may contact The Health Plan's Customer Service Department at **1.888.847.7902**.
- Members can expect to receive courteous and personal attention and to be treated with dignity. Plan employees, providers and their staff will respect members' privacy.
- All information concerning The Health Plan member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by The Health Plan except when the release is required by law. The Health Plan assures that all patient information is held in the strictest confidence. All staff must adhere to The Health Plan confidentiality policy revised and adopted in November 1993. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so.
- The member's personal choice of a primary care physician (PCP) enables the member to participate in the management of his/her total health care needs, including the right to refuse care from a specific practitioner. Members of The Health Plan are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of The Health Plan may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).
- The Health Plan members have the right to express their comments, opinions or complaints about The Health Plan or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from The Health Plan. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with The Health Plan review procedures. Both informal and formal steps are available to members to resolve all complaints/grievances.
- The Health Plan members may participate in decision-making about their health care when possible and within the plan guidelines. Members have a right to discuss with providers, without limitations or restrictions being placed upon the providers, appropriate or medically necessary treatment options for their condition(s) regardless of cost or benefit coverage. However, this does not expand coverage by the plan. Members also have the right to formulate advance directives.
- The Health Plan members have the right to have a meaningful voice in the organization by expressing their suggestions and comments regarding their health plan coverage, policies, members' rights and responsibilities, and operations. Member's comments and opinions are received by The Health Plan through yearly member satisfaction surveys, telephone calls from our members, by email to: information@healthplan.org or through our corporate website. Member's comments/opinions are also received through various The Health Plan departments.

- Members have the right to full disclosure, from their health care provider, of any information relating to their medical condition or treatment plan. Members have the right to examine and offer corrections to their own medical records, in accordance with a pplicable federal and state laws. The plan will not release personal health information to an employer, or its designee, without a signed plan authorization form by the member. For information on obtaining medical records, contact The Health Plan Customer Service Department at **1.888.847.7902**.

Statement of Members' Responsibilities

- A member must choose a PCP for each person listed on The Health Plan ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coo rdinator for all his/her health care needs.
- A member must identify him/herself as a member of The Health Plan to avoid unnecessary errors; always carry their ID cards; and never permit anyone else to use their ID card.
- A member is asked, through outreach calls to new members, to read their member handbook and understand the benefits and procedures for receiving health care services. To assure maximum coverage, the member has a responsibility to follow the rules and to contact The Health Plan for assistance, if necessary.
- A member is required to notify The Health Plan of any changes in the following:
  1. Name, address, telephone number
  2. Number of dependents (marriage, divorce, newborns, etc.)
  3. Loss of an identification card
  4. Selection of a primary care physician
- Members are asked to be on time for appointments and to call the physician's office promptly if an appointment can't be kept.
- Members must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.
- Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible, and follow those instructions and guidelines given by those providers who deliver health care services.
- If members receive emergency care outside The Health Plan's service area, they are required to contact The Health Plan as soon as possible within 48 hours.
- Members must contact their PCP, secondary care physician or OB/GYN **before** seeking any specialty physician/service.
- Members must provide The Health Plan with all relevant, correct information and pay The Health Plan any money owed according to coordination of benefits or subrogation policies.
- Members must make required copayments under the schedule of benefits.
- Members are asked to be courteous and respectful of The Health Plan employees, providers, and their staff.

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877- 847-7907（TTY：711）

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza lingüística gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877- 847-7907 （TTY：711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร

1-877-847-7907 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-877- 847-7907 (टिटिवाइ: 711).।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877- 847-7907 (TTY: 711) تماس بگیرید.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877- 847-7907 (TTY: 711).

Revised 5/2020

Section

4

Medicare

SecureCare HMO Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

In keeping with our mission, we have identified members' rights, along with their responsibilities, that are clearly indicated in the member's handbook.

The benefits for SecureCare HMO members are identical to traditional Medicare benefits, in addition to enhanced benefits that are offered by The Health Plan.

It is imperative that you are aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards you are required to meet when caring for Medicare Advantage enrollees. The following Member Services Department is available to assist with any member issues that may arise at 1.877.847.7907.

SecureChoice PPO Medicare Advantage Plan

SecureChoice PPO is The Health Plan's Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. The Health Plan preauthorization requirements apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from The Health Plan's extensive network of participating providers.

The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

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It is imperative that you are aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards you are required to meet when caring for Medicare Advantage enrollees. The following Member Services Department is available to assist with any member issues that may arise at 1.877.847.7907.

D-SNP Medicare Advantage Special Needs Plan

Effective January 1, 2014, The Health Plan began a Medicare Special Needs Plan (SNP) for those members who have a chronic condition. The special needs population are those recipients who qualify for both Medicare and Medicaid. These "dual-eligibles" are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

The Health Plan received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan that offers a SNP program by completing a Model of Care (MOC) for Centers for Medicare and Medicaid Services (CMS). This approval applies to the Dual-Eligible Special Needs Plan (D-SNP).

The Health Plan has developed the MOC to provide comprehensive care management to members enrolled in the D-SNP. The Health Plan's MOC is a written document describing measurable goals of the program. The Health Plan staff structure, care management roles and interdisciplinary care team (ICT) use clinical practice guidelines and protocols to provide yearly training for personnel and our providers. The care management team uses a health risk assessment tool to collect information about our members to develop an individualized plan of care.

Measurable goals

- Improve access to essential services including medical, behavioral health, and social services by providing a comprehensive network. Every SNP member will be assigned a case manager with licensed social workers readily available.
- SNP members will select a primary care physician (PCP) and a THP case manager will be assigned to the member.
- Streamline the process of transition of care across health care settings, providers, and health services coordinated by the physician/provider and the care manager.
- Improve access to preventive care.
- Improve member health outcomes through participating in annual Healthcare Effectiveness Data and Information Set (HEDIS®) data collection, as well as member surveys.

The above list is just a brief description of some of our measurable goals.

Provider reimbursement and billing

The provider will bill The Health Plan for medically appropriate covered services provided to the D-SNP member. The Health Plan will reimburse the provider for services rendered according to the member's benefit plan, less any copays, coinsurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, coinsurance, and deductible directly to the West Virginia or Ohio Medicaid program.

Provider education

Provider education will be conducted by several approaches: face-to-face, web-based training, seminars and ProviderFocus newsletter articles.

To access our MOC and the D-SNP MOC Annual Training presentations are on the secure provider portal under "Resource Library," "Training and Education."

To obtain referrals or eligibility information please call our Customer Service Department at 1.877.847.7907.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at ssa.gov/OP_Home/ssact/title19/1902.htm

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

If a provider is referred to us who is balance billing or refusing to take D-SNP patients, Medicare MLN Matters documents will be sent to the provider and document the training. This policy is included in this section of the Provider Procedural Manual and also published periodically in our quarterly ProviderFocus newsletter.

Coordination of Benefits
Medicare Advantage Secondary Payer

Medicare Advantage is not always the primary payer for health insurance claims. The Health Plan will comply with the Centers for Medicare and Medicaid Services' (CMS) requirement to provide information pertaining to claims in which Medicare Advantage is secondary. Medicare Advantage is the secondary payer when the beneficiary is entitled to veteran's benefits, workers' compensation, black lung benefits, or employer group coverage based on the Medicare secondary payer guidelines.

THP Insurance Company Medicare Supplemental Plans

Medicare beneficiaries who have Medicare as their primary insurance pay a monthly premium to The Health Plan to cover their Medicare deductibles and coinsurance. The Plan provides benefit packages that are designed by Medicare and administer all aspects of the plan in accordance with Medicare guidelines. These plans DO NOT require a member to choose a primary care physician (PCP) or obtain a referral for specialty physician services.

Medicare Noncovered Service Guidelines

The Health Plan Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require The Health Plan to provide appropriate notice of non-coverage/coverage to the members and educate providers on 1) coverage and exclusions of medical services; 2) limits of plan coverage; and 3) how to correctly advise members prior to providing services of such limitations or service exclusion under Medicare. To ensure that you understand what your role and responsibility is concerning covered and non-covered medical services we are providing this provider manual as a guide.

Providing Notice of Non-Coverage

The first method The Health Plan utilizes to educate members of non-covered services is provided upon enrollment through the Evidence of Coverage (EOC) booklet Chapter 4, Section 3: "What services are not covered by the plan?" The second method is provided through the "Notice of Denial (or partial denial) of Medical Coverage" issued through the pre-service determination (also known as "prior authorization", coverage determination or organization determination) process. Lastly, for every service that is billed to The Health Plan for payment, the member receives Explanation of Benefits (EOB) that provides an explanation of the charges and what, if any, the member is financially responsible for paying to the provider.

Unsure if Covered

For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member financial liability. In such instances, the appropriate process is for the member, or the provider acting on behalf of the member, to request a pre-service determination.

Never Covered

However, if a service is **never** covered by the plan (statutorily excluded from coverage per Medicare rules) and the plan's Evidence of Coverage (EOC) provided to the member is clear that the service or item is never covered, The Health Plan is not required to hold the member harmless from the full cost of the service or item.

Appeal Rights

For any payment or coverage request for service that The Health Plan receives that is denied, a standardized denial notice, as stated above, is provided with appeal rights. The member, or you as their treating provider, has the right to appeal any denial of a service or item.

Member Liability

When the provider, or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that:

a) The item or service is not covered by the plan; or

b) That coverage is available only if the member is referred for the service by a contracted provider

And nonetheless, the member receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require that plans hold the member harmless from the full cost of the service or item charged by the provider.

Medicare Advantage Billing Rules are Different

This page explains how and when to bill a member for non-covered services.

As a contracted provider with The Health Plan you must always submit a claim for payment of services to The Health Plan prior to billing our members, even if you have received a pre-service determination denial.

Billing for Non-covered Services

GY - No pre-service determination was made

Use this modifier to tell us that you informed/explained to the member that in his/her Health Plan EOC there was a "clear" exclusion and the service was not covered.

GA - Pre-service notice of non-coverage was provided by the plan

Use this modifier to tell us that:

- A pre-service determination was requested and the "Notice of Denial (or partial denial) of Medical Coverage" was issued; or
- The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service.

Note: When using this modifier please also provide the pre-service determination number in field #23 of the CMS1500 form.

When claims are billed with these modifiers, they are processed with the appropriate codes for member financial liability and you may bill the member.

However, if you bill us for **non-covered** services **without** using the GA or GY modifier, The Health Plan will deny your claim as provider responsibility. If you bill us for **covered** services **with** the GY or GA modifier, The Health Plan will deny your claim for incorrect use of modifier.

Part of your responsibility as a contracted provider is to inform your patients when a service is not covered (or statutorily excluded) by The Health Plan. In order for The Health Plan Medicare department to know if you have given proper notice of non-coverage to our members, you must follow the billing rules and use the modifiers as stated above. Following the billing rule s and appropriate use of the modifiers ensures that you understand when to provide proper notice of non-coverage of medical services to our Medicare Advantage plan members in advance and limits the confusion of coverage and financial responsibility between the members and The Health Plan.

IMPORTANT REMINDER: Improper Use of Advance Notices of Non-Coverage (ABN)

On May 5, 2014 CMS released a memo titled "Improper Use of Advance Notices of Non-coverage", directing all Medicare Advantage organizations (MAO) and their contracted providers to cease with using ABN notices and ABN-like notices as they are not compliant with the Medicare Advantage organization determination requirements. Per CMS, an ABN does not apply in or under the Medicare Advantage context because a MAO member has the right under these statutes and regulations to a pre-service determination prior to receiving services.

For information on this topic, see the Claims Processing Manual Chapter 1 and MLN Booklet:
Medicare Advance Written Notices of Noncoverage ICN 006266

CMS Quality Measures/Standards

Quality healthcare is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). CMS implements quality initiatives to assure quality health care for Medicare beneficiaries through accountability and public disclosure. CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting.

What are Quality Measures?

Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.

Download the following Medicare Learning Network Booklets:

- CMS Initial Preventive Physical Examination
- CMS Annual Wellness Visit
- CMS Preventive Services

Appointment of Representative Statement for a Medicare Member

To appoint a representative, a Medicare member or their representative should complete the form entitled: Appointment of Representative -CMS-1696 - PDF.

If you do not use form CMS-1696, your appointment must:

- Be in writing and signed and dated by you and your representative;
- Provide a statement appointing the representative to act on your behalf;
- Authorize the release of your personal health information to your representative;
- Include a written explanation of the purpose and scope of the representation;
- List your name and your representative's names, phone numbers, and addresses;
- Include your Medicare Number (Health Insurance Claim Number or Medicare Beneficiary Identifier) or National Provider Identifier (NPI);
- Indicate your representative's professional status, if any, or relationship to you; and
- Be filed with the entity processing your appeal.

Unless revoked, an appointment is considered valid for one year from the date the form is signed. Once the form is filed, it is valid for the duration of the appeal. Therefore, a signed form can be used for more than one appeal as long as the appeal is filed within one year of the date on the form.

In addition, there are certain individuals who can bring an appeal on the member's behalf, pursuant to State or other applicable laws. Such an individual, known as an "authorized representative," may be a court-appointed guardian, an individual who has durable power of attorney, a health care proxy, or a person designated under a State's health care consent statute.

Appointment of Representative Forms are available English, Spanish & Large Print.

Notice of Medicare Noncoverage (NOMNC)

When to Deliver the NOMNC

A Medicare provider, or The Health Plan, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Instructions and CMS Form 10055 are available on the CMS website.

Medicare Outpatient Observation Notice (MOON)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the individual is receiving observation services and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The **Medicare Outpatient Observation Notice (MOON)** was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice **no later than thirty-six (36) hours** after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS approved standardized MOON form (CMS -10611) and accompanying instructions are available on the CMS website.

The Health Plan will monitor hospitals and critical care hospitals for compliance to valid delivery of the MOON on a yearly basis.

Medicare Appeals Overview

When an enrollee requests coverage for a particular service, the decision on whether to provide such coverage is considered an "Organization Determination." Enrollees have the right within 60 days of a denial to request either a standard pre-service (30-day) or post service claim (60-day) or expedited (72 hours) reconsideration whenever a Medicare Advantage organization has denied an enrollee's request for services, Part B drugs will have a standard turn-around time of 7 days effective January 1, 2020

Where the Medicare Advantage organizatio n affirms its advice "Organization Determination" in whole or in part, the Medicare Advantage organization must automatically forward the case file to CMS's independent review entity so that it may make a final reconsidered determination. CMS contracts with MAXIMUS Federal Service, Inc.

The parties to an organization determination *for purposes of an appeal* include:

- The enrollee (including his or her representative);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the Medicare health plan) determined to hav e an appealable interest in the proceeding.

Who may request reconsideration (Chapter 13 Medicare Managed Care Manual – 70.1)

An enrollee, an enrollee's representative or a non-contract physician or provider to the Medicare health plan may request that the determination be reconsidered. However, contract providers do not have appeal rights. An enrollee, an enrollee's representative, or physician (regardless of whether the physician is affiliated with the Medicare health plan) are the only parties who may re quest that a Medicare health plan expedite a reconsideration.

For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a representative form.

If the reconsideration request comes from the enrollee's primary care physician in The Health Plan's contract network, no enrollee notice verification is required.

If the request comes from either an in-network (contract) physician or a non-contract physician, and the patient's record indicates he or she visited this physician at least once before, a Medicare health plan may assume the physician has informed the enrollee about the request and no further verification is needed.

If this appears to be the first contact between the physician requesting the reconsideration and the enrollee, a Medicare health plan is to undertake reasonable efforts to confirm the physician has given the enrollee appropriate notice. For example:

- If the physician makes the request by phone, during the call a health plan may confirm the physician gave the enrollee notice that he or she is acting on the enrollee's behalf.
- The physician makes the request by a fax, letter, or email, and the enrollee is copied on the correspondence, and/or the writing includes a statement affirming that the enrollee knows that the physician is acting on the enrollee's behalf with the enrollee's knowledge and approval.
- The Medicare health plan may call the enrollee and ask if he or she knows that this physician making the request is acting on his or her behalf with his or her knowledge and approval. Notice of Medicare Hospital Discharge Appeals Notices

Notice of Medicare Hospital Discharge Appeals Notices

An Important Message from Medicare about Your Rights (Form CMS-R-193)

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A detailed notice of discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge.

Forms and instruction can be found on the CMS website.

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or The Health Plan that inpatient care is no longer medically necessary must request an immediate review by the peer review organization (PRO) of the determination. The member must request the immediate PRO review by noon of the first working day after receipt of the notice. The member will not be financially responsible for the hospital care until the PRO makes its decision. If the admission was not authorized by The Health Plan or the admission did not constitute emergency or urgently needed care and the PRO upholds The Health Plan's determination, the member is financially responsible for the hospital costs.

A member who fails to request an immediate PRO review may request expedited reconsideration by The Health Plan through the appeal process. Form CMS 10066

Forms and instruction can be found on the CMS website.

Low Income Medicare Beneficiaries

The qualified Medicare beneficiary (QMB) program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments and deductibles from those enrolled in the QMB program, including those enrolled in Medicare Advantage and other Part C Plans.

For changes from July 1, 2018, refer to the CMS MedLearn Matters article for further guidance:

The patient should make the provider aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. A patient should not get a bill for medical care that Medicare covers. Patients cannot be charged for Medicare deductibles, coinsurance and copayments.

1.800.MEDICARE (1.800.633.4227).

Medicare Provider Rights and Responsibilities

It is imperative that you be aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards that you are required to meet when caring for Medicare Advantage enrollees. Customer Service is available to assist with any member issues that may arise by calling **1.877.847.7907** or visiting medicare2020.healthplan.org

Overview of Physician Responsibilities

Primary Care Physicians (PCPs):

- Act as a health care manager for members to arrange and coordinate their medical care, including but not limited to, routine care, and follow-up care after the receipt of emergency services.

Specialists:

- Provide continuity and coordination of care by sending a written report to PCPs regarding any treatment or consultation provided to members, regardless of whether the service was a result of a PCP referral or the member making his/her own arrangements.

All Contracted Physicians:

- Arrange for the provision of medical services to The Health Plan's members by a participating practitioner after hours, on weekends, vacations, and holidays. Services from non-participating covering practitioners may not be covered, unless otherwise approved by The Health Plan.
- All physician offices must have 24-hour on-call capability, either directly or through an answering service, not an answering machine.
- Help members obtain their benefit coverage by getting written prior authorization for services that require it and prior to referring for out-of-plan services, as appropriate.
- Facilitate candid discussion with members regarding appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Such discussion should include complete and current information concerning a diagnosis, treatment, and prognosis, in terms that the member (or designee) can be expected to understand.
- Provide to members the information necessary to give informed consent prior to the start of any procedure or treatment.
- Maintain appropriate medical records regarding members and their treatment, recognizing that said records are confidential and ensuring that they are maintained in accordance with legal and ethical requirements concerning confidentiality and security.
- Cooperate with The Health Plan, or its designee, in the resolution of members' complaints, expedited appeals, appeals and/or grievances.
- Comply with other administrative requirements as specified in the applicable contract or stipulated in this Provider Manual or its updates.
- Promote the efficient delivery of medical services to maximize health care resources and the member's premium dollar and improve quality of care provided.

- Refrain from providing treatment to the physician's own family members.
- Provide medical information in a culturally-competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

NCQA Requirements:

- Comply with The Health Plan medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.

CMS Marketing Guidelines:

- Comply with CMS Marketing Guidelines for provider-based activities. The guidelines, available below, govern how providers can and cannot inform or educate patients about enrollment and plan information.

SecureCare/SecureChoice Rights and Responsibilities

An excerpt from THP's Medicare Member Handbook

Our plan must honor your rights as a member of the plan.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services. at 1.877.847.7907.

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1.877.847.7907 or contact our Director of Medicare.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with The Health Plan Appeals Coordinator at 1.877.847.7907 (TTY: 711). You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227) or directly with the Office for Civil rights. Contact information is included in the Evidence of Coverage or you may contact Member Services for additional information.

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1.800.368.1019 (TTY: 1.800.537.7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services at 1.877.847.7907. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients at 1.877.847.7907. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services at 1.877.847.7907.

We must give you information about the plan, its network of providers, and your covered services

As a member of SecureCare (HMO) or SecureChoice (PPO), you have the right to get several kinds of information from us. (As explained above, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services at 1.877.847.7907:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the Plan Provider Directory.
  - For a list of the pharmacies in the plan's network, see the Plan Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services at 1.877.847.7907 or visit our website at medicare2020.healthplan.org.
- Information about your coverage and the rules you must follow when using your coverage.
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services at 1.877.847.7907.
- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision, we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

   - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

- Utilization Review. The Health Plan has a Utilization Management Program in place that monitors the use of, or evaluates the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or care settings. Areas of utilization management include:
   - Prior authorization of health care services, for example elective admissions, home health services, durable medical equipment or imaging studies. Prior authorizations may be for non-urgent services, urgent services or post services. The decisions for prior authorizations are made within strict time frames to minimize any disruption in the provision of health care. Non-authorization decisions are communicated to members and providers within strict time frames with sufficient information to understand the reason for the non-authorization and to decide whether to appeal the non-authorization. Only medical directors who are physicians may not authorize services for medical necessity.
   - Hospital inpatient review– Clinical information is received from hospitals which enable registered nurses at The Health Plan to assist with post-hospital care needs and arranging services to ensure care across the continuum.
   - Care/case management is a personalized process to assess treatment options and opportunities to coordinate care, design care plans to improve quality and efficacy of care, manage cost and benefits patient care to ensure optimal outcomes for members with catastrophic illness or those needing episodic management of health care needs. Registered nurses perform the functions of utilization management.
- New Technology
   - The Health Plan tries to keep pace with change and ensure members have access to safe and effective care. The Health Plan continually reviews new trends in medical technology, procedures, pharmacological treatments and drugs. Scientific evidence, medical effectiveness and determinations from regulatory bodies are all components of the review of new technology. The Health Plan reviews this information to form the basis for coverage decisions in the future.

We must support your right to make decisions about your care.

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms at 1.877.847.7907.
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Probate Court in the county in which you reside.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services at 1.877.847.7907.

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1.800.368.1019 or TTY 1.800.537.7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having :

- You can call Member Services at 1.877.847.7907.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
  - Visit the Medicare website to read or download "Your Medicare Rights & Protections"
  - Call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY:1.877.486.2048)

You have some responsibilities as a member of the plan.

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services at 1.877.847.7907. We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know at 1.877.847.7907.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.

- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- Tell us if you move. If you are going to move, it's important to tell us right away. Call Member Services at 1.877.847.7907.
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Call Member Services at 877.847.7907.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.
- Contacting Utilization Review Staff
  - During business hours 8:00 AM – 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961, ext. 7644.
  - After 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961.

Section
5

Medicaid

Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB)

West Virginia Medicaid Programs

The Health Plan began administering health care benefits to Mountain Health Trust (MHT) members on September 1, 1996. THP currently serves all 55 counties in West Virginia.

Mountain Health Trust (MHT)/WV Health Bridge (WVHB) ID Cards and Eligibility

The MHT or WVHB member will have two ID cards: The Health Plan ID card and the WV medical card, which is sent annually from the West Virginia Department of Health and Human Resources (DHHR).

The Health Plan no longer uses the member's social security number (SSN) as the ID number; instead a random HID is used. The member should always present both ID cards since The Health Plan does not determine eligibility. Each eligible individual family member will have a separate ID card with his/her own plan ID number. The Health Plan ID card has the MHT or WVHB logo and important lines of information:

- Member's plan ID # including – 01 suffix (important for billing correctly)
- Medicaid number
- Member's name
- Member's PCP name
- PCP phone number

The Health Plan ID card is sent to the member once, unless they change PCP or lose the card and request another one.

All members, except newborns, become effective on the first of each month and could term on the last day of the month. If you have any eligibility questions, please call the Customer Service Department at 1.888.613.8385 to verify coverage or visit the secure provider portal. If you do not have access to this site, please contact:

Provider Relations – EDI Support
Phone: 1.800.624.6961, ext. 6248
Email: hpecs@healthplan.org
Fax: 740.695.7883

When medically necessary, The Health Plan makes services available 24 hours a day, seven days a week. Physicians must comply with the access standards set forth in **Section 2** of the provider manual.

THP must cover out-of-network services that are otherwise covered under the Medicaid Contract for the enrollee if THP's network is unable to provide such services. THP must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as THP is unable to provide them. To the extent possible, THP must encourage out-of-network providers to coordinate with THP with respect to payment.

THP regularly measures the extent to which providers in the network comply with these requirements and take remedial action if necessary. THP must ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the ho meless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. THP also ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

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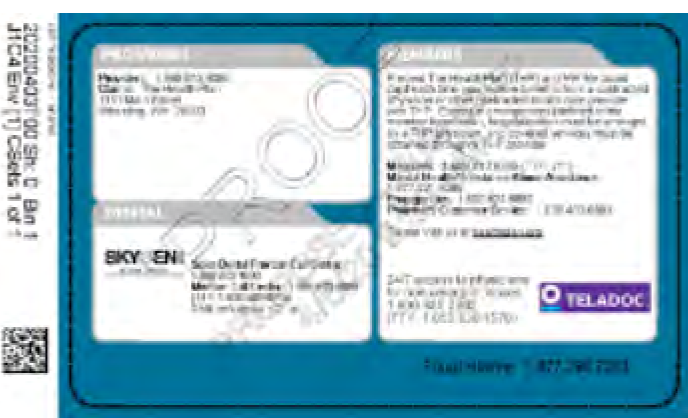
Mountain Health Trust ID Cards

TANF and SSI ID Card

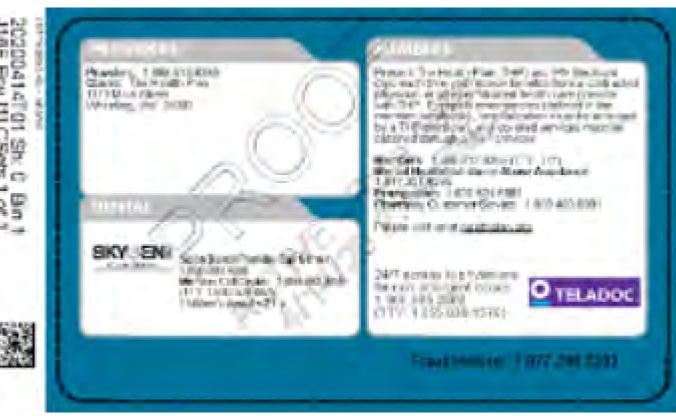
Group number: 0140 and 0142

The THP Medicaid ID cards are color-coded blue for ease in identifying the Medicaid population. All pertinent billing information is on the card, including the members' THP ID number and Medicaid ID number. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

TANF ID Card
Group number: 0140



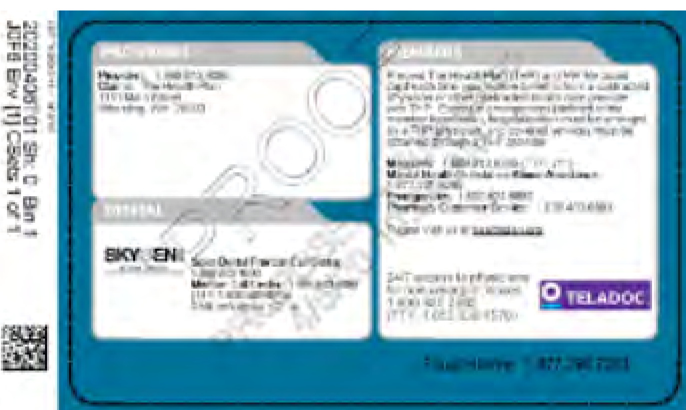
SSI ID Card
Group number: 0142



WV Health Bridge ID Cards

The THP Medicaid ID cards are color-coded blue for ease in identifying the Medicaid population. All pertinent billing information is on the card, including the members' THP ID number and Medicaid ID number. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

WV Health Bridge Card
Group number: 0141



Medicaid Benefits and Exclusions at a Glance

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Medical

- **Primary Care/Specialist Office Visits/FQHC/RHC–** Includes physician, physician assistant, nurse practitioner and nurse midwife services.
- **Physician Services–** Certain services may require prior authorization or have service limits. May be delivered through telehealth.
- **Laboratory and X-ray Services–** Includes lab services related to substance abuse treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires prior authorization.
- **Clinics–** Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.
- **Private Duty Nursing–** For children ages 0-21. Requires prior authorization. Limits apply.

Hospital

- **Inpatient**– Includes all inpatient services (including including long-term acute care (LTAC), bariatric and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Requires prior authorization.
- **Organ and Tissue Transplants–** Corneal transplants only.
- **Outpatient–** Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.

Ambulatory Surgical Care

- Includes services and equipment for surgical procedures.

Emergency

- **Post-stabilization–** Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- **Emergency Transportation–** Includes ambulance and air ambulance. Out-of-state requires prior authorization.

Rehabilitation

- **Pulmonary Rehabilitation–** Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Maximum of 12 weeks or 36 visits per calendar year.
- **Cardiac Rehabilitation–** Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery.
- **Inpatient Rehabilitation–** Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility; limited to 60 days per calendar year). Not covered for adults over the age of 21. Requires prior authorization.

Specialty

- **Podiatry—** Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Surgical procedures other than in-office require prior authorization.
- **Physical and Occupational Therapy—**Combined 20 visits per year for habilitative and rehabilitative services. Prior Authorization required on the 21st visit.
- **Speech Therapy—For children (ages 0-21**): Prior authorization required. The benefit limit is 20 visits per calendar year. For adults (21 and older): Limited to specific medical/surgical conditions and prior authorization is required.
- **Chiropractor—**Limited to manual manipulation of the spine and X-ray exam related to service. Prior authorization required on the 21st visit per calendar year.
- **Handicapped Children's Services/Children with Special Health Care Needs Services—** Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist—**Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires prior authorization.

Preventive Care and Disease Management

- **EPSDT**— (ages 0-21) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require prior authorization.
- **Tobacco Cessation—**Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children.
- **Sexually Transmitted Disease Services—**Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- **Preventive Screenings**
  - Annual pap smear for cervical cancer screening beginning at age 18, earlier if medically necessary.
  - Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year.
  - Prostate cancer screening: Beginning at age 50.
  - Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Maternity

- **Right From The Start—**Includes prenatal care and care coordination. Services covered through 60-day post-partum and infants less than one year old.
- **Family Planning—**Services to aid recipients of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered. Tubal ligations are the responsibility of fee for service.
- **Maternity Care—**Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics

- Requires prior authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

- Requires prior authorization for all visits. If you revoke three times, you are no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

- Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Prior authorization required prior to 2nd certification period.

Dental

- **For children (ages 0-21)**
  - Must use participating practitioners (see provider directory or call Skygen Dental).
  - Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization.
- **For adults (21 and older)**
  - Adults covered only for accident or injury, tumor removal, or emergency extraction.
  - TMJ is not covered for adults.

Vision

- **For children (ages 0–21)**
  - Must use participating vision services practitioners. See provider directory or call Superior Vision.
  - Vision screening and therapy.
  - One eye exam covered once every 12 months.
  - Limited one frame per year.
  - Contact lenses covered for certain diagnoses.
  - Repairs.
- **For adults (21 and older)**
  - Adults limited to medical treatment only.
  - Medical contact lenses for adults and children covered for certain diagnoses.
  - One pair of glasses up to 60 days after cataract surgery.

Diabetes Management

- Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination. If annual exam reveals abnormal conditions, any follow-up appointment with a specialist will require prior authorization from the member's PCP.

Hearing

- **For children (ages 0–21)**
  - Requires prior authorization.
  - Audiology screening (only if referred by a PCP or ENT practitioner).
  - One hearing aid every five years.
  - Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under 21 years of age and require prior approval.
- **For adults (21 and older)**
  - Requires prior authorization.
  - Covered for specific medical conditions.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (up to age 21) with mental illness and substance use disorder. Limited frequency and amount of services. Certain services require prior authorization. Children's residential treatment is not covered
- **Inpatient Psychiatric Services under age 21** – Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization. Children's residential treatment is not covered
- **Inpatient Psychiatric Services for ages 21-64** – Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization.
- **Outpatient** – Includes services for individuals with mental illness and substance use disorder. Providers of ACT and IOP must be certified by the BMS. Certain services require prior authorization. Most services may be provided by telehealth.
- **Psychological**–Testing. Some evaluation and testing procedures have frequency restrictions. Certain services require prior authorization.
- **Drug Screening** – Laboratory services to screen for presence of one or more drugs of use. Limits apply and prior authorization is required for some testing.
- **Substance Use Disorder (SUD) Services** – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance use disorder. Prior authorization is required for some services.

*There are additional services to those included on this list. If you have questions on whether a service is covered, look at the section of the handbook that explains what Medicaid covers or give us a call.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.
Early Intervention Services for Children Three and Under
Tubal ligations- includes doctor and hospital charges
Nursing Facility Services – Includes nursing, social services, and therapy.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on per unit per month basis. Requires physician ord er and nursing plan of care.
ICF/MR Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires physician or psychiatrist certification.
Prescription Drugs – Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor, Hepatitis-C, weight gain, cosmetic, hair growth, fertility, less than effective, and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investi gational/ research nature or for end-stage diseases. Must be used to manage disease.
School-based Services – Service limitations are listed in the fee for service Medicaid provider manual.
Transportation – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: 1.844.549.8353.

Exclusions

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.
- Organ transplants, except in some instances.
- 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.

Exclusions, continued

- 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.

  REMEMBER – no other dental problems will be covered for adults such as plates, crowns, bridges, etc. (even TMJ when caused by an accident/injury). Practitioner services for non-covered dental problems will be covered when it is medically necessary and appropriate for you to go to the practitioner to get the services. Bills for the oral surgeon or dentist will not be covered for adults.
- 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.
- Services based on religious beliefs are not paid for by The Health Plan.
- 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 of 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 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.

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.

Exclusions, continued

- Services not provided, arranged, or authorized by your practitioner, except in an emergency or when allowed in this policy. Elective pre-surgery testing on an inpatient basis without the authorization of The Health Plan's medical director.
- Sports-related devices will not be paid for by The Health Plan.
- Acupuncture will not be paid for by The Health Plan, unless it is for anesthesia used with a covered procedure.
- Services by a practitioner with the same legal address or who is a member of the covered person's family will not be paid for by The Health Plan. This includes spouse, brothers, sisters, parents or children.
- Unlicensed services by a practitioner will not be paid for by The Health Plan.
- War-related injuries or treatment in a state or federal provider for military or service-related injuries or disabilities will not be paid for by The Health Plan.
- Non-medical services related to the treatment of temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD) will not be paid for by The Health Plan. WV Medicaid covers TMJ for children up to age 21.
- If a member decides to get hospice services instead of medical treatment, he/she gives up the right to other Mountain Health Trust or West Virginia Health Bridge services for the terminal illness. Coverage continues for other medical conditions not related to the terminal illness.
- Sterilization of a mentally incompetent or institutionalized person will not be paid for by The Health Plan.
- Inpatient tests not ordered by the attending practitioner or other licensed practitioner will not be paid for by The Health Plan, except in cases of emergency.
- Therapy and related services for a patient showing no progress will not be paid for by The Health Plan. Speech therapy for members ages 0-21 must meet criteria and be pre-authorized. Speech therapy for adults is not a covered benefit except when medically needed as a result of specific medical/surgical conditions such as ALS, cerebral palsy, stroke, or physical trauma.
- Non-emergency transportation is not covered by The Health Plan but is covered by FFS Medicaid. Use your medical card to get this service.
- Services that, in the judgment of your practitioner, are not medically appropriate or not required by accepted standards of medical practice or the plan rules governing services.
- Megavitamin therapy and nutrition-based therapy will not be paid for by The Health Plan.
- Services performed after your physician has advised the member that further services are not medically appropriate or not covered services will not be paid for by The Health Plan.
- Homeopathic treatments will not be paid for by The Health Plan.
- Treatment for flat foot and subluxation of the foot are not covered.
- Services related to moral or religious objections are not covered.

This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at 1.888.613.8385.

Additional Resources for Medicaid Members

Program	Description	Contact Information
Tobacco Cessation	▢ The Health Plan's nationally certified ALA (American Lung Association) tobacco cessation facilitator engages and educates the member to assist in developing a member specific tobacco quit plan. The program addresses: o Developing a plan to quit o Getting support and encouragement o Learning new skills and behaviors o Getting medication, if necessary, to assist with quitting and how to take it correctly o Preparing for relapse and difficult situations	1.888.613.8385
Free Cell Phones for Medicaid Members	▢ THP has partnered with SafeLink to offer the LifeLine program to our members at no cost. Members receive: o A smartphone with 1GB data and 1,000 monthly minutes o Unlimited text o Free calls to The Health Plan	1.877.631.2550 www.safelink.com Promo code: THPWV
Non-Emergent Transportation	▢ Members with Medicaid may be eligible for transportation services ▢ Members can contact NEMT broker to schedule a reservation	1.844.549.8353
Right From The Start Program (RFTS)	▢ Statewide program that helps WV mothers and their babies lead healthier lives by offering home visitation services with a designated coordinator (RN or LSW)	www.wvdhhr.org/rfts
West Virginia Birth to Three Program	▢ WV Birth to Three services are administered by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child and Family Health in cooperation with the Early Intervention Interagency Coordinating Council (ICC)	1.304.558.5388
Children's with Special Healthcare Needs (CSHCN)	▢ CSHCHN Program was created to assist families who have children with conditions that need special care	1.304.558.5388
Teladoc	▢ 24/7/365 access to providers for non-emergent issues	1.800.TELADOC (835-2362)

Hours of Operation

Providers must ensure that the hours of operation for members are convenient, do not discriminate against enrollees, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee for service. The provider must ensure that waiting times at sites of care are kept to a minimum and ensure that the waiting time standard for Medicaid enrollees is the same standard used for commercial enrollees. Providers cannot discriminate against Medicaid enrollees in the order that patients are seen or in the order that appointments are given (providers are not permitted to schedule Medicaid-only days).

Cultural Competence

Providers are required to perform healthcare services in a culturally competent manner to all members. This includes members with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physic al and mental disabilities, regardless of gender, sexual orientation, or gender identity.

To ensure that providers provide services in a culturally competent manner, THP has developed training materials related to cultural competence and social determinants of health. The Cultural Competency/Social Determinants of Health Training for Providers PowerPoint presentation and attestation form may be accessed on THP's provider portal under "Resource Library," "Training and Education." Cultural competency training is noted by THP's provider engagement representatives during provider on-site surveys. Provider engagement representatives will conduct provider training upon request.

EPSDT

Early and periodic screening, diagnosis, and treatment (EPSDT): Medically necessary services, including interperiodic and periodic screenings, listed in section 1905(a) of the Social Security Act. EPSDT entitles Medicaid-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in section 1905(a) of the Social Security Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions

EPSDT services should be provided to all children and young adults up to age 21. The provider should do the screening (periodic, comprehensive child health assessments) to all eligible enrollees.

These should be regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

At a minimum, these screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);
2. An unclothed physical exam;
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);

4. Vision testing;
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the advisory committee on immunization practices;
6. Hearing testing;
7. Dental services (furnished by direct referral to a dentist for children beginning six months after the first tooth erupts or by 12 months of age);
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

It is important that the provider documents all of the above on the member's chart as well as referrals. The provider should submit a 1500 claim form with the appropriate codes/modifiers for services rendered to The Health Plan for reimbursement. EPSDT claims are paid without any coordination of benefits. Further information regarding EPSDT, current EPSDT forms and periodicity guidelines can be found on the following websites:

- dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx
- dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx

The Health Plan sends a monthly notice to the PCP with the list of his/her patients(s) that are expected to have a well-child exam during that month. If the member is not a patient of that PCP, the sheet should be returned to The Health Plan and marked accordingly in order to correct the records.

REMEMBER, THESE DATES ARE FOR WELL-CHILD EXAMS. If the provider does a well-child exam at the same time as a sick visit, please use the appropriate codes.

The Health Plan also sends a reminder notice to appropriate members each month that a well-child exam is due.

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Copays

Medicaid members have copays for some services. The following copays apply:

Service	Tier 1 Up to 50% FPL	Tier 2 50.01 to 100% FPL	Tier 3 100.01% of FPL
Inpatient hospital (acute care 11x)	$0	$35	$75
Office visit (physicians and nurse practitioners) (99201-99205, 99212-99215 only for office visits for new and established patients based on level of care)	$0	$2	$4
Non-emergency use of emergency department hospital only (Lowest level, 99282, of emergency room visits in hospitals. The definition of this visit is an emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making)	$8	$8	$8
Any outpatient surgical services rendered in a physician's office, ASC or outpatient hospital, excluding emergency rooms	$0	$2	$4

Member and providers can access copay and member eligibility information through the WV Medicaid Fiscal Agents AVRS system by calling 1.888.483.0793.

Maximum Out-of-Pocket (OOP):

Each calendar year quarter, members will have a maximum out-of-pocket (OOP) payment. The OOP is the most the member will ever be required to pay in any given quarter regardless of the number of health care services received. The following table shows the OOP for each tier level.

Tier Level	Out-of-Pocket Maximum
1 (Up to 50% FPL)	$8
2 (50.01 - 100% FPL)	$71
3 (100.01% FPL and above)	$143

Calendar quarters are as follows:

January 1 – March 31
April 1 – June 30
July 1 – September 30
October 1 – December 31

Exemptions:

The following populations and services are exempt from copays:

- Pregnant women, including pregnancy-related services up to 60 days postpartum;
- Native American and Alaska natives;
- Intermediate care facility or MR services;
- Provider-preventable services;
- Individuals in nursing homes;
- Receiving hospice services;
- Medicaid waiver services, or covered through the breast and cervical cancer treatment program;
- Family planning services and emergency services.

Medicaid Out-of-Network Non-Patient Facing Provider Reimbursement

Effective August 1, 2019, services rendered by out-of-network non-patient facing providers will only be reimbursed if an authorization is obtained prior to the service being conducted.

Reimbursement for services prior authorized to out-of-network non-patient facing providers will be at 80% of the current WV Medicaid fee schedule.

Failure to obtain prior authorization for any service performed by an out-of-network non-patient facing provider will result in claim denial.

Under federal law, the Medicaid program prohibits balance billing by all practitioners, regardless of location. All out-of-network practitioners' claims for providing non-emergency medical services will be denied unless the services have been prior authorized.

Emergency out-of-network Medicaid-covered services are eligible for reimbursement. The documentation provided with the claim must clearly indicate an emergency situation existed.

The Health Plan may pay for covered services due to out-of-network hospital transfers if:

- Medically necessary services are not available in plan.
- WV Medicaid members are traveling outside the state and need emergency medical treatment.
- Services have been pre-approved by The Health Plan.

For documented emergencies, the member may be admitted without prior approval in-network or out-of-network, but the request for authorization and documentation must be submitted within 24 hours of admission.

Prescription Benefit

Pharmacy services for WV Medicaid managed care organization (MCO) members are administered by the traditional fee-for-service pharmacy program. All prescriptions should be billed with the information below:

- BIN 610164
- PCN DRWVPROD

Questions regarding claims processing should be directed to the Medicaid Fiscal Agent's POS Pharmacy Help Desk at 1.888.483.0801. Vendor specification document can be found on the West Virginia Medicaid Management Information System website for further information regarding claims processing.

Family Planning

Family planning services may be obtained by a Medicaid member without a referral or prior authorization through any Medicaid family planning provider, regardless if they are in The Health Plan network or not. Family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

These services include:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- History and physical exam
- Pap smear and lab tests if medically indicated as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STD) if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up and care for complications associated with contraceptive methods issued by the family planning provider
- Provisions for contraceptive pills, devices, and supplies (Depo-Provera injections are permissible, prescriptions are to be issued for contraceptive pills)
- Tubal ligation and vasectomies (consent forms required)
- Pregnancy testing and counseling
- Family planning provided at postpartum visits and/or discharge post-delivery (postpartum care should be provided within eight weeks of delivery)

Local Health Departments

The Health Plan contracts with local West Virginia Health Departments to provide certain services for the Medicaid programs without a referral. These services include:

- All sexually transmitted disease (STD) services including screening, diagnosis, and treatment
- HIV services including screening and diagnostic studies
- Tuberculosis services including screening, diagnosis, and treatment
- Childhood immunizations
- Family planning
- HealthCheck

The Health Department should forward all records to the member's PCP and/or OB/GYN provider.

Environmental lead assessments for THP children with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. THP is responsible for the blood lead screenings.

Staffing

Staffing for the Medicaid program consists of senior management, vice president of Medicaid, Medicaid operations director, Medicaid managers and supervisors, an appeals coordinator, customer service representatives and claims analysts. The vice president is responsible for coordinating programs between The Health Plan and WV Medicaid to assure compliance with the program, as well as ongoing education to MHT and WVHB members.

There are outreach representatives who are under the direct supervision of the director. The outreach representatives are responsible for ongoing education of MHT and WVHB members.

The Health Plan will ensure that follow-up and outreach contacts are initiated for missed appointments and failure to follow medical treatment plans.

A provider should notify The Health Plan that a member is not keeping scheduled appointments, not following the medical treatment plan, the member's behavior in the waiting room was inappropriate, or any other reason in which the member could benefit from redirection of behavior. The provider should document his/her chart accordingly. This documentation should be provided to The Health Plan after a member misses a second appointment.

Outreach representatives will then contact the member to discuss the situation, suggest alternate methods, and otherwise educate, especially to follow the provider's treatment plan. If transportation is the problem, members should be referred to the state's transportation vendor for non-emergency transportation assistance. The member needs to understand that the provider can ask for his/her removal from his/her roster if this noncompliance persists. Please call the Medicaid Unit at 1.855.577.7124 for an outreach representative to educate the member about these issues.

MHT and WVHB members are continually educated about appropriate use of the emergency room. If members present to the ER for non-emergency cases, they may be responsible for the cost of the ER visit ora copay. The PCP should be contacted first for instructions, day or night. If it is a life-threatening situation, the member can call 911 or go to the closest ER but still call the PCP and The Health Plan within 48 hours after going to the ER. Follow-up care and treatment, including the removal of stitches, casts, and dressings must be given or arranged by the PCP.

Surgical Consent Forms

The Health Plan, in accordance with the WV Medicaid guidelines, will continue to require the completion of the state surgical consent forms for the following procedures:

- Hysterectomy
- Voluntary sterilizations (male or female)
- Pregnancy termination

The surgical consent forms for voluntary sterilizations must be completed and signed by the Medicaid member 30 days prior to the surgery. The consent form is valid for 180 days. Please note that none of the consent forms need to be submitted to The Health Plan but should remain with the member's medical records.

Pregnancy and Newborn Enrollment

In accordance with the state of West Virginia requirements to effectively monitor and/or provide appropriate intervention during the member's antepartum, delivery, and postpartum period, The Health Plan has elected to adopt the state's guidelines. The Health Plan will continue to require all providers rendering services for antepartum care to submit the appropriate code for each encounter during the antepartum period that will be separately reimbursed. The Health Plan will also require separate billing for the delivery and postpartum services by submitting the appropriate CPT code(s).

The Health Plan requires the completion of the prenatal risk screening instrument (PRSI) upon the initial encounter when the EDC date is determined for all MHT and WVHB members receiving maternity services. Physicians are asked to complete the prenatal risk screening form and fax it to The Health Plan at 740.695.5297 or complete the prenatal risk screen form located on the Provider website.

The most recent version of the PRSI is available here and can be found on the WV DHHR's Office of Maternal, Child and Family Health website.

Based on this screening tool, members are contacted to begin tracking their pregnancy. An initial prenatal care visit must be scheduled within 14 days of the date on which a Medicaid woman is found to be pregnant. Any member who has a high-risk pregnancy will be referred to the prenatal care coordinators who are nurses with obstetrics experience. If the member smokes, she is also referred to the tobacco cessation program. Outreach representatives monitor the low-risk pregnancies on a trimester basis. Members are encouraged to participate with the Women, Infant, and Children's (WIC) program.

When The Health Plan MHT or WVHB member gives birth, her newborn(s) is automatically covered from date of birth. The enrollment specialist calls new mothers in the hospital to enroll the newborn(s) into The Health Plan. The new mother is reminded to apply for a SSN for the newborn and to select a PCP for the baby. The importance of well-child visits and immunizations are stressed. The new mother will receive a newborn packet from The Health Plan along with the baby's ID card.

Members are encouraged to sign the baby up for the WIC program. The Health Plan ID card with the PCP listed is sent to the newborn. There is a process in place to get the newborn a Medicaid number within 30 days. If you need a newborn's ID number please call 1.855.577.7124, but please allow 10 business days from the baby's birth.

The new mother is also reminded of the importance of her own postpartum checkup that should occur within eight weeks of delivery. The outreach representative makes a postnatal follow-up call. She also does an initial newborn follow-up at that time. During the postnatal contact, the Edinburgh postnatal depression scale (EPDS) is reviewed for postpartum depression. If the member has a high score, she is referred to The Health Plan prenatal care coordinators who notify the member's OB provider.

Members can qualify for THP's postnatal incentive plan by going to their postnatal appointment within 7-84 days after delivery.

Women's Access to Health Care

In accordance with the Women's Health and Cancer Rights Act of 1998, The Health Plan covers reconstructive surgery after a mastectomy under the same terms and conditions as other regular inpatient services under the Plan, and will include:

- Coverage for reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymph edema.

This is all handled in a manner determined in consultation with the attending physician and the patient and approved by The Health Plan as medically necessary and appropriate.

The Health Plan allows women to have direct access to a range of women's health care providers, including obstetricians/gynecologists, advanced nurse practitioners, certified nurse midwives, and physician assistants. *This information is disclosed to members in the Member Handbook.*

An annual pap test and physical breast exam is encouraged for each member and may be done by the PCP and/or OB/GYN.

Tobacco Cessation

Members are encouraged to participate in The Health Plan's sponsored tobacco cessation classes **free of charge**. A friendly staff member will provide the member with one-on-one personal support that can help him/her quit.

Diabetes

Insulin pumps are covered in specific medical cases. Diet management and education are covered as part of the diabetes disease management program. Blood glucose monitors are covered for members who are diabetic when a participating provider writes the order and the monitor is obtained from a participating provider.

Members with diabetes should have an annual health assessment, dilated eye exam, kidney testing, and fasting lipid profile. Quarterly visits are encouraged for foot exams, HbA1c, blood pressure, and diabetes education. The Health Plan sends members with diabetes a yearly coupon as a reminder to have the dilated eye exam.

Medicaid Behavioral Health Services

THP is required to provide behavioral health services as outlined in the Bureau for Medical Services (BMS) provider manual to WV Medicaid members enrolled with THP. BMS' provider manual may be accessed on the WV DHHR website.

The following chapters of the manual provide detailed information regarding services typically provided by behavioral health providers:

- Chapter 503: Licensed Behavioral Health Centers
- Chapter 504 Substance Use Disorders Services
- Chapter 510 Hospital Services
- Chapter 519: Practitioner Services
- Chapter 521: Behavioral Health Outpatient Services
- Chapter 522: Federally Qualified Health Centers and Rural Health Centers Services
- Chapter 523: Targeted Case Management and
- Chapter 531: Psychiatric Residential Treatment Facilities for Children Under 21

Note that while THP will cover behavioral health services as required by BMS, THP and BMS may have differing prior authorization requirements. Please refer to the following list of behavioral health services that are reimbursable by THP. The chart explains the unit of service, if it is available via telehealth, if prior authorization is required, and any qualifying conditions that must be met.

Contact THP's Clinical Services Department at 1.877.221.9295 with questions or to obtain prior authorization for services.

Applied Behavior Analysis

Code	Descriptor	Units of service	Available by telehealth?	Provider Type	Authorization required?	Criteria	Notes
H0031	Initial functional assessment	Event	No	BCBA, BCBA-D, BCaBA	Yes	BMS	F to F, 1:1, Max one per year, may be billed in conjunction with other ABA codes
H0032	Development of ABA plan	15 min	No	BCBA, BCBA-D, BCaBA	Yes	BMS	F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period
H2012	Behavioral Health Day Tx	60 min	No	BCBA or BCBA-D	Yes	BMS	F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period
H2019	Therapeutic Behavioral Services	15 min	No	BCaBA	Yes	BMS	F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period
H2014	Group Skills Training and Dev.	15 min	No	BCBA, BCBA-D, BCaBA	Yes	BMS	F to F, 1:2 to 3, Can be billed in conjunction with others up to 40 hours per week, and/or 8 hours within a 24-hour period
H2014U4	Individual Skills Training and Dev.	15 min	No	RBT under supervision, BCBA, BCBA-D, BCaBA	Yes	BMS	F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period
H2014U5	Individual Skills Training and Dev	15 min	No	RBT under supervision, BCBA, BCBA-D, BCaBA	Yes	BMS	F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period

All ABA services must comply with the BMS provider manual chapter 519.23
*** Non par providers must submit authorization request for all services.

ECT and TMS

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria
90870	Electroconvulsive therapy	Episode	No	Yes	Interqual
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Episode	No	Yes	Interqual
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management	Episode	No	Yes	Interqual
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; Subsequent motor threshold re-determination with delivery and management	Episode	No	Yes	Interqual

FQHC-RHC

Code	Descriptor	Units of service	Available by telehealth?	Authorizations required?	Provider type	Notes
T1015 HE	Behavioral Health Encounter	Per encounter	Yes (see BMS manual)	No	Limit one BH encounter per day. Physician, physician extender, licensed psychologist, LICSW, LCSW, LGSW and LPC	Encounter code must be accompanied by procedure code representing activity conducted, may not be used for group therapy
90853	Group Psychother apy	Per group	Yes (see BMS manual)	No	Physician, licensed psychologist, LICSW, LCSW, LGSW and LPC	Maximum 12 per group, must be billed outside encounter code, cannot be billed in combination with another BH service provided on same day under encounter code.

*** Non par providers must submit authorization request for all services.

Inpatient and PRTF

Code	Descriptor	Units of service	Available by telehealth?	Provider type	Authorization required?	Criteria	Notes
	Acute Inpatient Care (Mental Health or SUD diagnoses)	Per diem	No	Hospital or IMD	Yes	Interqual	Must be authorized within one working day of admission, contracted rate
	Psychiatric Residential Treatment for individuals under 21	Per diem	No	Approved unit	Yes	BMS	Must be authorized within one working day of admission, contracted rate, facility must comply with BMS requirements at Chapter 531

***** The following are not billable services for WV Medicaid:

Observation for behavioral health diagnosis

Residential services (group home, etc.)

Bundled Medication Assisted Treatment

Subacute level of psychiatric hospitalization

*** Non par providers must submit authorization request for all services.

Partial Hospitalization

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
H0015*	Treatment session	Hour	Yes	Yes after 30 sessions	Interqual	Maximum 3 hours, may not be billed with 90853 or H0035
H0035*	Per diem treatment	Session	Yes	Yes after 30 sessions	Interqual	Minimum four hours, may not be billed with 90853 or H0015
90853*	Intensive group therapy	Two hours	Yes	Yes after 30 sessions	Interqual	Two-hour sessions, may not be billed with H0015 or H0035

* Must be billed on UB

** PHP must be certified by BMS

***Medical services may not be billed outside the PHP bundle

Refer to BMS' provider manual chapter 510.5

Urine Screens

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
80305-80307	Presumptive drug screens	Event	No	Yes after 24 per calendar year	BMS	Review BMS policy at Chapter 529.2, one permitted per date of service
G0431, G0434	Definitive drug screens	Event	No	Yes after 12 per calendar year	BMS	Review BMS policy at Chapter 529.2, one permitted per date of service

*** Non par providers must submit authorization request for all services
****Breathalyzer may not be billed in combination with any urine drug code other than 80305

Psychological Testing

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
96112	Developmental test administration by qualified professional with interpretation and report	First hour	No	No	Interqual	May only be billed one per event, may only be performed once per year per provider
96113	Developmental test administration by qualified professional with interpretation and report	Each additional 30 minutes	No	Yes after 6 Units	Interqual	Billed in conjunction with 96112, may not be billed in conjunction with any other psychological testing code other than 96130 and 96131, once per year per provider
96130	Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers	First hour	No	No	Interqual	May be billed in conjunction with other psychological testing codes, maximum one unit, may only be billed once per year per provider

Psychological Testing, continued

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
96131	Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers	Each subsequent hour	No	Yes, after one unit	Interqual	May be billed in conjunction with other psychological testing codes, may only be billed once per year per provider
96132	Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers	First hour	No	Yes	Interqual	May be billed in conjunction with 96136 and 96137 once per year per provider, maximum one event
96133	Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers	Each additional hour	No	Yes	Interqual	May be billed in conjunction with 96132, 96136, 96137 once per year per provider
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method	First 30 minutes	No	No	Interqual	May be billed only once per event, may not be used for administration of screening tools, may be billed in conjunction with any other testing code other than 96112 and 96113 once per year per provider, maximum one event

Psychological Testing, continued

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method	Each additional 30 minutes	No	Yes, after 6 units	Interqual	Billed in conjunction with 96136, may be billed in conjunction with any other psychological testing code except 96112 and 96113, may not be used for administration of screening tools, once per year per provider
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only	Event	No	No	Interqual	May be billed in conjunction with other psychological testing codes
96116	Neurobehavioral status exam, administration, face to face time with patient and time interpreting test results and preparing report	Event	No	No	Interqual	One per six months per provider, must be performed by qualified professional

*** Grid is THP policy until development of BMS manual and standards. Non par providers must obtain prior authorization for all events.
*** Non par providers must submit authorization request for all services

LBHC

Code	Descriptor	Units of service	Available by Telehealth (must use POS 02)	Requires Prior Authorization	Criteria	Notes
H0031	Mental Health Assessment by Non-Physician	Event	Yes	No	BMS	
90791	Psychiatric Diagnostic Evaluation	Event	Yes	No	BMS	
90792	Psychiatric Diagnostic Evaluation w/ med serv	Event	Yes	No	BMS	
T1023 HE	Screening by Licensed Psychologist	Event	Yes	No	BMS	
H0032	Mental Health Service Plan Development	15 min	Yes	No	BMS	
H0032 AH	Mental Health Service Plan Development by Psychologist	15 min	Yes	No	BMS	
G9008	Physician Coordinated Care Oversight Services	15 min	Yes	No	BMS	
90887	Case Consultation	Event	Yes	No	BMS	One unit per 90 days
H0004 HO	BH Counseling, Professional, Individual	15 min	Yes	No	BMS	
H0004 HO HQ	BH Counseling, Professional, Grp	15 min	Yes	No	BMS	
H0004	BH Counseling, Supportive, Ind.	15 min	Yes	No	BMS	
H0004 HQ	BH Counseling, Supportive, Grp.	15 min	Yes	No	BMS	
H0038	Peer recovery support	15 min	Yes	Yes after 400 units	BMS	Peer must be certified by BMS, max case load of 20
T1017	Targeted Case Management	15 min	Yes, excluding required F to F monthly contact	No	BMS	Service must conform to requirements in BMS manual

LBHC, continued

Code	Descriptor	Units of service	Available by Telehealth (must use POS 02)	Requires Prior Authorization	Criteria	Notes
90846	Family Psychotherapy w/o Patient present	Event	Yes	No	BMS	
90847	Family Psychotherapy w Patient present	Event	Yes	No	BMS	
90853	Group Psychotherapy	Per hour		No	BMS	
90832	Psychotherapy 30 min		Yes	No	BMS	
90834	Psychotherapy 45 min		Yes	No	BMS	
90837	Psychotherapy 60 min		Yes	No	BMS	
90839	Psychotherapy for Crisis 60 min		Yes	No	BMS	
90840	Psychotherapy for Crisis each additional 30 min	30 min	Yes	No	BMS	
IOP Services (Programs must be approved by BMS in advance and providers must bill with IS modifier unless daily rate)						
H0004 HO IS	BH Counseling, Professional, Ind, Intensive Service	15 min	Yes	Yes after 30 total IOP dates of service	BMS	Program must be certified by BMS
H0004 HO HQ IS	BH Counseling, Professional, Grp, Intensive Service	15 min	Yes	Yes after 30 total IOP dates of service	BMS	Program must be certified by BMS
H0004 IS	BH Counseling, Supportive, Ind., Intensive	15 min	Yes	Yes after 30 total IOP dates of service	BMS	Program must be certified by BMS
H0004 HQ IS	BH Counseling, Supportive, Grp., Intensive	15 min	Yes	Yes after 30 total IOP dates of service	BMS	Program must be certified by BMS
H0015	Bundled daily rate for IOP	Daily	Yes	Yes after 30 sessions/ dates of service	BMS	Program must be certified by BMS

LBHC, continued

Code	Descriptor	Units of service	Available by Telehealth (must use POS 02)	Requires Prior Authorization	Criteria	Notes
Skills Training and Development						
H2014 U4	Skills Training 1:1 Paraprofessional	15 min	No	No	BMS	
H2014 U1	Skills Training 1:2 to 4, Paraprofessional	15 min	No	No	BMS	
H2014 HN U4	Skills Training 1:1 by Professional	15 min	No	No	BMS	
H2014 HN U1	Skills Training 1:2 to 4, Professional	15 min	No	No	BMS	
Medication Services						
H2010	Comprehensive Medication Services (clozaril, etc.) MH	15 min	Yes	No	BMS	Cannot be used for MAT
Comprehensive Services						
H2012	Day Treatment	60 min	No	No	BMS	Program must be certified by BMS
H2015U1	Comprehensive Community Support Services (1:12 ratio)	15 min	No	No	BMS	Program must be certified by BMS, may be bundled to daily rate with permission
H2015U2	Comprehensive Community Support Services (1:8 ratio)	15 min	No	No	BMS	Program must be certified by BMS, may be bundled to daily rate with permission
H2011	Crisis Intervention	15 min	No	No	BMS	maximum allowable 16 units per 30 days
H0036	Community Psychiatric Supportive Treatment (CSU)	15 min	No	Yes after 144 units	BMS	CSU must be certified by BMS, maximum 48 units per day, max total 288 units per six months per BMS manual, telephone IDT may be required after extended stay

LBHC, continued

Code	Descriptor	Units of service	Available by Telehealth (must use POS 02)	Requires Prior Authorization	Criteria	Notes
Comprehensive Services, Cont.						
H0040	Assertive Community Treatment (ACT)	Daily rate	Yes partial	Yes	BMS	Team must be certified in advance by BMS and comply with BMS manual requirements in Chapter 503
Behavior Management Services						
H2019 HO	Therapeutic Behavioral Services, Development		No	No	BMS	Not to be used for autism, see ABA section
H2019	Therapeutic Behavioral Services, Implementation		No	No	BMS	Not to be used for autism, see ABA section
Transportation						
A0120 DD HE	Transportation by Minibus	Max 6 trips daily	No	No	BMS	Transportation must meet BMS stipulations for programming and mileage limitations, only paid in ACT and CCSS programs
A0160 DD HE	Transportation by mile	One mile	No	No	BMS	Transportation must meet BMS stipulations for programming and mileage limitations, only paid in ACT and CCSS programs
Telehealth						
Q3014GT	Telehealth origination fee	Event		No	BMS	

LBHC, continued

Code	Descriptor	Units of service	Available by Telehealth (must use POS 02)	Requires Prior Authorization	Criteria	Notes
SUD Residential Services, refer to BMS manual for claims restrictions						
H2036U1 HF	Residential Recovery Services ASAM Level 3.1	Daily rate	No	Yes after 3 days	BMS	Program must be certified by BMS
H2036U3 HF	Residential Recovery Services ASAM Level 3.3	Daily rate	No	Yes after 3 days	BMS	Program must be certified by BMS
H2036U5 HF	Residential Recovery Services ASAM Level 3.5	Daily rate	No	Yes after 3 days	BMS	Program must be certified by BMS
H2036U7 HF	Residential Recovery Services ASAM Level 3.7	Daily rate	No	Yes after 3 days	BMS	Program must be certified by BMS, may be hospital based
E/M Services						
99205	New Patient	Event	Yes	No		
99211	Est. Patient Simple	Event	Yes	No		
99212	Est. Patient Problem Focused	Event	Yes	No		
99213	Est. Patient Expanded	Event	Yes	No		
99214	Est. Patient Moderate	Event	Yes	No		
99215	Est. Patient High Complexity	Event	Yes	No		
96372	Injection	Event	No	No		
90833	Therapy add on 30 minutes	Event	Yes	No		
90836	Therapy add on 45 minutes	Event	Yes	No		

*** All telehealth services require POS 02
*** Non par providers must submit authorization request for all services.
**** In Home services are permitted for many codes with a POS 12. Please see BMS manual chapter 503 for further clarification.

Professional Services

Chapter 521, Behavioral Health Outpatient Services (group or individual):

- Physician
- Physician Extender
- Licensed Psychologist (LP)
- Supervised Psychologist (SP)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW); and
- Licensed Graduate Social Worker (LGSW)."

Code	Descriptor	Units of service	Available by Telehealth? ***	Requires Prior Authorization	Criteria	Notes***
90791	Psychiatric Diagnostic Evaluation	Event	Yes	No	BMS	Max. two Events per year by same provider/entity, must be performed by physician, physician extender, Lic Psychologist, Supervised Psychologist, LICSW or LPC
90792	Psychiatric Diagnostic Evaluation w/ med serv	Event	Yes	No	BMS	Max two Events per year by same provider/entity, must be performed by physician or physician extender
H0031 AJ	Mental Health Assessment by Non-Physician	Event	Yes	No	BMS	Max two per year, provided by licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LCSW, LGSW, or LPC
90832	Individual Psychotherapy	16 to 37 min.	Yes	No	BMS	Physician, physician extender, and independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW
90832 AJ	Individual Psychotherapy	16 to 37 min.	Yes	No	BMS	Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW
90833	Individual Psychotherapy as add on to E/M codes	16 to 37 min.	Yes	No	BMS	May be performed by physician or physician extender only
90834	Individual Psychotherapy	38 to 52 min.	Yes	No	BMS	Physician, physician extender, and independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW

Professional Services, continued

Code	Descriptor	Units of service	Available by Telehealth? ***	Requires Prior Authorization	Criteria	Notes***
90834 AJ	Individual Psychotherapy	38 to 52 min.	Yes	No	BMS	Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW
90836	Individual Psychotherapy as add on to E/M codes	38 to 52 min.	Yes	No	BMS	May be performed by physician or physician extender only
90837	Individual Psychotherapy	53 plus min.	Yes	No	BMS	Physician, physician extender, and independently enrolled Lic. Psychologist, Supv. Psychologist, LICSW, LPC
90837 AJ	Individual Psychotherapy	53 plus min.	Yes	No	BMS	Non independently enrolled Lic. Psychologist, Supv. Psychologist, LICSW and LPC
90875	Individual Psychotherapy with Biofeedback	30 min.	No	No	BMS	Physician or Physician extender only
90876	Individual Psychotherapy with Biofeedback	45 min.	No	No	BMS	Physician or Physician extender only
90853	Group Psychotherapy	Event	Yes	No	BMS	Physician, physician extender, and independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW. Max 12 per group
90853 AJ	Group Psychotherapy	Event	Yes	No	BMS	Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW. Max 12 per group
90839	Psychotherapy for Crisis	60 min.	No	No	BMS	Physician, physician extender, Lic. Psychologist, Supv. Psychologist, LICSW, LPC only
90840	Psychotherapy for Crisis each additional 30 minutes	30 min.	No	No	BMS	Physician, physician extender, Lic. Psychologist, Supv. Psychologist, LICSW, LPC only
90846	Family Psychotherapy without Patient	45 to 50 min.	Yes	No	BMS	Physician, physician extender, Lic. Psychologist, Supv. Psychologist, LICSW, LPC only

Professional Services, continued

Code	Descriptor	Units of service	Available by Telehealth? ***	Requires Prior Authorization	Criteria	Notes***
90847	Family Psychotherapy with Patient	45 to 50 min.	Yes	No	BMS	Physician, physician extender, and independently enrolled Lic. Psychologist, Supv. Psychologist, LICSW, LPC only
90847 AJ	Family Psychotherapy with Patient	45 to 50 min.	Yes	No	BMS	Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW
Q3014 GT	Telehealth origination fee	Event		No	BMS	Only one entity may bill in an encounter
Evaluation And Management Codes						
99205	New Patient	Event	Yes	No		Physician, physician extender
99211	Est. Patient Simple	Event	Yes	No		Physician, physician extender
99212	Est. Patient Problem Focused	Event	Yes	No		Physician, physician extender
99213	Est. Patient Expanded	Event	Yes	No		Physician, physician extender
99214	Est. Patient Moderate	Event	Yes	No		Physician, physician extender
99215	Est. Patient High Complexity	Event	Yes	No		Physician, physician extender
96372	Injection	Event	No	No		Physician, physician extender
90833	Therapy add on 30 minutes	Event	Yes	No		Physician, physician extender
90836	Therapy add on 45 minutes	Event	Yes	No		Physician, physician extender

*** All telehealth services require POS 02
*** All clinicians billing in a group or physician practice must be credentialed by THP and must utilize the correct billing modifiers. Please review THP policy regarding ability to bill under physician NPI
*** Non par providers must submit authorization request for all services.
*** Please refer to BMS manual and THP policy for credentialing exceptions made in OBMAT programs

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Medicaid Behavioral Health Credentialing and Billing Guidelines

The Health Plan requires credentialing of all licensed behavioral health practitioners opera ting within a physician's practice.

Unlicensed personnel may not bill for behavioral health services within a physician's practice with the exception of supervised psychologists officially approved by the WV Board of Examiners of Psychology. THP will only reimburse supervised psychologists when providing services to our Medicaid members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV found **here**.

Please note that this guideline does not apply to physician's offices within Licensed Behavioral Health Centers. Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

Also note that The Health Plan, in conformity with Mental Health Parity rules, does not require pre-authorization for clinic-based behavioral health outpatient services. Our authorization list is available on our corporate website in the "For Providers" section.

The Health Plan defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP's Customer Service Department at 1.800.624.6961.

Medicaid

Chapter 519.2 and Chapter 521 of the Bureau for Medical Services (BMS) provider manuals clearly describe the circumstances under which a licensed behavioral health practitioner may provide services under the auspices of a physician's practice (again, these rules do not apply to physicians or practitioners employed by a licensed behavioral health center or an FQHC/RHC). The chapters are available on the WV DHHR's website. **For the purpose of this section only, physician is understood to include physician extenders such as APRN and PA.**

Note that there is an exception, described below, for Office Based Medication Assisted Treatment programs properly certified/registered with the Office of Health Facility Licensure and Certification. This exception will be detailed below and applies only to members with Medicaid coverage/benefits.

Physicians may have appropriately licensed behavioral health staff working under them to provide behavioral health services which include the following: Licensed Professional Counselor (LPC), Licensed Independent Clinical Social Worker (LICSW), Licensed Certified Social Worker (LCSW), Licensed Graduate Social Worker (LGSW), Supervised Psychologist and Licensed Psychologist (LP).

The BMS does not specify that a licensed behavioral health practitioner must practice under the supervision of a psychiatrist, nor does it make any statement about the scope of practice of the supervising physician.

The following staff may bill for behavioral health services in a medical clinic setting:

- Licensed Psychologist
- Advanced Practice Registered Nurse
- Physician Extender
- Supervised Psychologist officially approved by the WVBOP
- LICSW
- LCSW
- LGSW
- Licensed Professional Counselor

The BMS requires that all staff with the exception of the LCSW and the LGSW bill under their own rendering NPI, using the appropriate CPT code without a modifier.

Please note OBMAT exception below. Therefore, all staff other than the LCSW and the LGSW must be credentialed with THP before they can bill for services. The LCSW and LGSW may bill under the physician's NPI with an AJ modifier on the CPT code and do not need to be credentialed by THP. Currently, the reimbursement level for modified and non-modified CPT codes is almost identical in most cases.

Office Based Medication Assisted Treatment (OBMAT) programs (applies to WV Medicaid only): In those OBMAT programs that are properly certified/registered with the Office of Health Facility Licensure and Certification (OHFLAC) the following staffing requirements/permissions will apply. **These individuals may bill under the physician's NPI using the AJ modifier so long as the appropriate supervision requirements are met**:

Staff Credentials: The following are the minimum supervision requirements per degree/credential type:

- Bachelor's Degree in Human Services without Alcohol and Drug Counselor Credential*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.
- Master's Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.
- Doctoral Level, Non-Licensed*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

The following providers do not require supervision but will require credentialing with THP and therefore must bill as rendering provider. They may not bill under the physician's NPI:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Supervised Psychologist listed as such on the Board of Examiner's website;
- Licensed Professional Counselor
- National Certified Addiction Counselor II as defined by NAADAC
- Master Addiction Counselor as defined by NAADAC
- Bachelor's Degree in Human Services with Alcohol and Drug Counselor Credential

The WV Medicaid manual cites the following behavioral health codes as available with an AJ modifier: 90832, 90834, 90837, 90853, H0031 and 90847.

The Health Plan payment, authorization and approval methodologies conform to BMS requirements as stated in the manuals.

The Health Plan utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on CAQH or WV Department of Insurance.

Be aware that this will require that the rendering provider have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the NPPES website.

Should you have any questions regarding these instructions please feel free to contact our behavioral health provider engagement representative, Seth Shockey at sshockey@healthplan.org or clinical psychologist Sheila Kelly at skelly@healthplan.org.

Providers should be aware that commercial and self-insured policies may vary. Please call our customer services line at 1.877.221.9295 should there be questions regarding these types of policy coverages.

The Health Plan will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan's Special Investigations Unit for fraud, waste and abuse. New network providers may be requested to submit planned procedures for prepayment review. All out of network providers are required to submit all procedures for prior authorization.

Adult Dental

Dental Services: Adults age 21 and over

Contractual Definition: Adult coverage is limited to the treatment of fractures of mandible and maxilla, biopsy, removal of tumors, and emergency extractions. TMJ surgery and treatment are not covered for adults.

A referral from the PCP is not required for the initial evaluation by the dental provider. **If extracting more than three teeth on the same date of service, the dental provider will be required to submit documentation related to the emergency extraction along with the claim.**

The above requirement applies to all teeth except wisdom teeth (see exclusions).

Examples of urgent/emergent dental services are:

- Incision and drainage (I&D) of abscess
- Repair of acute wounds
- Tooth broken off to the gum line
- Non–restorable tooth
- Removal of an abscess tooth
- Removal of a tumor or treatment of a fracture; and
- Treatment of infection

Exclusions

Dental services not covered by THP include, but are not limited to, the following:

- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Dental services for which the prior authorization has been denied or not obtained
- Dental services for the convenience of the member, the member's caretaker, or provider of service
- Procedure for cosmetic purposes
- Temporomandibular joint (TMJ) for adults
- Anesthesia services when solely for the convenience of the members, member's caretaker or the provider of service
- Local anesthesia or oral sedation are considered part of the treatment procedure and may not be billed separately
- Dental services for residents of intermediate care and nursing facilities (nursing homes, ICF/MR and PRTF)
- Use of unlisted codes when a national CDT is available
- Unbundled CDT codes
- Removal of implants
- **Extraction of wisdom teeth are excluded unless they meet the emergent/urgent definition.**
  - **Documentation is required to be submitted with the claim for all wisdom teeth extractions.**

Oral surgery including dental accidents

Oral surgery is covered only for the cases below and **require prior authorization**.

- Oral surgery is covered for non-dental surgical and hospital procedures for birth defects (like cleft lip and cleft palate)
- Medical or surgical procedures within or next to the oral cavity or sinuses that are medically needed
- Dental services medically needed because of an accidental injury are covered when your doctor submits a plan of treatment to THP. The medical service must be performed within six months of the injury
- Medically needed medical or surgical procedures within or next to the oral cavity or sinuses resulting from the removal of tumors and cyst

Not covered oral services:

- Cosmetic services or repairs that THP decides are not needed for daily living
- Other procedures involving the teeth or areas around the teeth including, but not limited to:
  - Shortening of the mandible or maxilla for cosmetic purposes
  - Correction of malocclusion or mandibular retrognathia
  - Treatment of natural teeth due to diseases
  - Repair, removal or replacement of sound natural teeth
  - Diagnosis and treatment of temporomandibular joint (TMJ) pain dysfunction syndrome

Procedure code 41899

For members age 21 or older, prior authorization is required for this procedure. Please contact Customer Service. Adult dental benefits are limited to emergency extractions only.

Dental services in a hospital setting

All procedures provided by a dentist or oral surgeon in a hospital setting requires a prior authorization. Refer to the BMS website for covered codes for adult dental over the age of 21.

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Children's Dental

Children's dental services (up to age 21) are covered by the managed care organization. Skygen USA is The Health Plan's administrator and providers must contract with them to provide services to our members. Providers should call 1.888.983.4690. If you would like a copy of Skygen USA's Provider Manual, please visit skygenusa.com.

Unlisted Procedure Code 41899

For members under the age of 21 that require dental services to be rendered in a hospital setting, the dental provider is required to obtain a prior authorization from Skygen USA for the procedure. Once the provider obtains the prior authorization from Skygen USA, the hospital services are required to be authorized through The Health Plan. Providers will need to contact THP's Customer Service Department at 1.888.613.8385 to obtain the prior authorization. The authorization number from Skygen USA will be required when requesting the authorization from THP.

Oral Health Fluoride Varnish Program

Primary care providers may receive a reimbursement for fluoride varnish application.

- Fluoride varnish is reimbursable to both ***medical and dental*** providers:
  - May be billed two times/year for each type of provider = four fluoride varnish treatments/year
  - Patient must be under 21 years old
  - Code may only be billed once within a six-month period per each type of provider
- **Medical Providers**
  - Bill procedure code 99188
  - Apply during time of well-child visit or health screening
  - Oral health risk assessment should be conducted prior to application
- **Dental Providers**
  - Bill procedure code D1206
  - Provide service at a dental visit
- **Topical application of fluoride** (excluding fluoride varnish)
  - Bill procedure code D1208
  - **CANNOT** bill D1206 with D1208

Additional information regarding this program is on the BMS website.

Immunization Registry

There is a West Virginia statewide immunization information system (WVSIIS) for all children, adolescents, and adults. WVSIIS is a confidential, computerized information system that keeps complete and up-to-date shot records. Children often receive shots from several providers that can make the immunization record fragmented, causing missed doses or over immunization. The benefits of this registry are access to a current immunization record, better patient care, and higher immunization rates and less disease.

Childhood and adolescent immunization reviews should be done at well-child visits as well as during urgent problem-oriented visits.

For more information about this registry please call 1.877.408.8930 or visit the website at: wvimm.org/wvsiis

Appeals and Grievances

This section outlines the information provided to Medicaid members regarding the right to file a complaint, grievance or appeal.

Complaints and Grievances

- You can file a complaint, also called a grievance, at any time.
- If you are unhappy with something that happened to you when you received health care services, you can file a complaint or grievance. Examples of why you might file a complaint or grievance include:
  - You feel you were not treated with respect
  - You are not satisfied with the health care you got
  - It took too long to get an appointment
  - You do not agree with a decision that we made
- To file a complaint or grievance you should call The Health Plan at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, you may fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003
- You will need to send us a letter that has:
  - Your name
  - Your mailing address
  - The reason why you are filing the complaint and what you want The Health Plan to do
  - Your doctor or authorized representative can also file a complaint or grievance for you

We will let you know when we receive your complaint or grievance. You can file a complaint or grievance at any time after the event about which you are unhappy. The Health Plan will conduct a full investigation after we receive your complaint or grievance. We will usually give you a decision within 30 calendar days and no later than 90 calendar days but may ask for extra time to give an answer.

The Health Plan will provide translation services, as needed, at no cost to you.

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Appeals

If you believe your benefits were unfairly denied, reduced, delayed or stopped, you have the right to file an appeal with The Health Plan. You also have the right to appeal any adverse decision.

- To file an appeal, you can call The Health Plan at 1.888.613.8385.
- To file an appeal in writing, you will need to fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street Wheeling, WV 26003.
- You will need to send us a letter that has:
  - Your name
  - Your provider's name
  - The date of service
  - Your mailing address
  - The reason why we should change our decision
  - A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal
  - Your doctor or authorized representative can also file an appeal for you

If you call and give your appeal over the phone, The Health Plan will acknowledge your appeal in a letter and send you the letter to sign. Be sure to read the letter carefully. You must sign the letter and return it to The Health Plan to have an appeal.

You must file an appeal within sixty (60) calendar days from the date on the notice of action from The Health Plan.

We will let you know when we have received your appeal and you can get copies of documents, records, and information about the appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits. A Committee will look at your appeal. None of the people on the Appeal Committee wi ll have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. We have provided the titles and qualifications of individuals who may participate in your appeal decision review.

- Medical Director – board-certified practitioners (radiology, behavioral health, obstetrics/gynecology, general surgeon with current state licensures)
- Nurse Navigators – registered nurses with current state licensures.

The Health Plan must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If The Health Plan needs more information for the appeal, or if you want to provide more information, you or The Health Plan can ask for fourteen (14) more calendar days to finish the appeal. If The Health Plan decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Fast Appeals

If your appeal is about our decision to not approve or pay for some or all of your health care services, and you need an appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal appeal decision, like the one described above, you can ask for a fast appeal by calling The Health Plan at 1.888.613.8385. A fast appeal must be written within (60) calendar days. If we allow a fast appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your appeal. We will call you twenty-four (24) hours after we get your appeal to let you know the date, time, and place of the meeting. We will make a decision on your appeal no later than seventy-two (72) hours after we get your appeal. If The Health Plan determines that an appeal is not a fast appeal, The Health Plan will provide your fast appeal request to the State so that they can determine a timeframe for resolution. You will get a written notice explaining the next steps in the process.

To file a fast appeal, you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone Number: 1.888.613.8385
Fax: 1.888.450.6025

If we decide your appeal is not a fast appeal, we will handle your appeal like the normal appeals described in the section above. You have the right to file a grievance if you are unhappy with the decision to deny the fast appeal.

State Fair Hearing Process

If you are not happy with The Health Plan's appeal decision, and your appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within thirteen (13) calendar days before any action is taken. You must request a State Fair Hearing within 120 calendar days from the notice of appeal resolution from The Health Plan. You may also request a State Fair Hearing if The Health Plan does not meet the timeframe for making a decision on your appeal.

Send your request for State Fair Hearing to:

Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The Bureau for Medical Services decision will be sent to you in writing. If you are not happy with th e Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:

The West Virginia Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

The Health Plan will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired and;
- You request an extension of benefits within thirteen (13) days of The Health Plan determination.

To request an extension of benefits, call member service at 1.888.613.8385. The Health Plan will pay for the services in question when the result of the appeal is to overturn the original decision. The Health Plan will pay for some or all the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, The Health Plan may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

Keeping Your Grievance and Appeals

The Health Plan will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

Provider Reconsideration (Appeal)

If a provider does not agree with the decision made by The Health Plan, they have the right to file a reconsideration. Providers are limited to one level of reconsideration/appeal. A provider has the greater of 180 days from The Health Plan's denial or 180 days from the date of service to request a reconsideration.

MHT/WVHB Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Receive information about The Health Plan, its services, practitioners, and your rights and responsibilities according to contract standards. We will provide this information upon enrollment, annually, and at least 30 days prior to any change. The Health Plan will provide all information according to the requirements of state law and the contract. Please see the benefit grid for covered services according to the contract.
- Be able to request and receive your medical records, and to request they be amended or corrected and receive prompt action in a timely manner of no later than 30 days from receipt of the request for records and no later than 60 days from the receipt of a request for amendments.
- Know you have the right to privacy and confidentiality with regard to your personal information. Information about your medical history and enrollment file is private. You have the right to approve or refuse the release of personal information by The Health Plan, unless the law or this agreement requires it.
- Be able to discuss appropriate or medically necessary treatment options for your condition(s) with your practitioner, even if they are not covered by The Health Plan. However, if you or your practitioners prefer a certain treatment and it is not covered by The Health Plan, you could be responsible for the cost. This information will be presented in a manner appropriate to the enrollee's condition and ability to understand. Your appropriate behavior, such as keeping appointments, helps in this decision-making. However, this does not expand coverage by The Health Plan.
- Receive medical advice or options communicated to you without any limitations or restrictions being placed upon the practitioner or PCP by The Health Plan.
- Be treated with respect, dignity, and privacy by The Health Plan employees, practitioners, and their staff. If you feel that your treatment has not been respectful, please call The Health Plan Customer Service Department at 1.888.613.8385.
- Get prompt resolution of issues raised, including complaints or grievances and issues relating to authorization, coverage, or payment of service(s). There are informal and formal steps available to you to resolve all complaints/grievances without reprisal from The Health Plan.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- Change your PCP at any time by calling or writing The Health Plan. The new PCP has to be available.
- Choose a participating PCP and OB/GYN and, with proper referrals, see a participating specialist.
- Be able to refuse care from the designated practitioner and select a different affiliated practitioner.
- Know how to obtain out-of-area services.

- Help make decisions about your health care when possible and within The Health Plan guidelines as outlined in this agreement, including the right to refuse treatment.
- Make an advance directive.
- Tell us your comments, opinions or complaints about The Health Plan or your medical care.
- Have coverage denials involving medical necessity or experimental treatment reviewed, after exhaustion of The Health Plan's internal grievance procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care service, as part of an external review.
- Know how you can get a list of The Health Plan's practitioner network, including the names and credentials of all participating practitioners. You should know how to choose practitioners within the Health Plan. If you have any questions regarding the qualifications of any plan physician, please contact The Health Plan's Customer Service Department at 1.888.613.8385.
- Know you are free to exercise your rights. Exercising these rights does not adversely affect our treatment of you.
- Know how to obtain access to a summary of the Health Plan's accreditation report.
- Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the enrollee needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.
- Know that you will not be discriminated against in the delivery of health care services consistent with the benefits covered in your policy, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, being homeless, sexual orientation, genetic information, or source of payment.
- Know you have full disclosure from your health care practitioner of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.
- Access emergency health care services, consistent with your determination of the need for such services as a prudent layperson, and post-stabilization services. No referral is needed.
- Know you can file a grievance for an administrative or medical complaint. You will continue to get good care and be treated with respect, even if you file a complaint.
- Receive continuation of benefits while your appeal is pending; however, you may have to pay for the cost of continuation of benefits if the appeal is upheld.
- Be able to have a practitioner or medical professional review any coverage denials according to The Health Plan review procedures.
- Get a second opinion from a qualified health care professional within or outside the network, at no cost to you. This second opinion could be in addition to that of a specialist referred by the PCP.
- Have all coverage denials reviewed by appropriate medical professionals consistent with The Health Plan's review procedures.

- Be informed of plan policies and any charges for which you may be responsible.
- A woman has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without a referral from her PCP, and no woman shall be required to obtain a referral from her PCP as a condition to coverage of prenatal or obstetrical care.
- A woman whose plan provides coverage for surgical services in an inpatient or outpa tient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.
- A woman whose plan provides coverage for laboratory or X-ray services has a right to the following when performed for cancer screening or diagnostic purposes: (1) a baseline mammogram for women age 35 to 39, inclusive; (2) a mammogram for women age 40 to 49, inclusive, at least every two years; (3) a mammogram every year for women age 50 and over; (4) a pap smear at least annually for women age 18 and over.
- A non-symptomatic person over 50 years of age and a symptomatic person under 50 years of age have the right to colorectal cancer examinations and laboratory tests for colorectal cancer.
- Be able to have rehabilitation services.
- Receive child immunization services, which shall not be subject to payment of any deductible, per-visit charge and/or copayment.

A member with diabetes whose health benefits policy includes eye care benefits has the right to direct access to an optometrist or ophthalmologist of their choice from the panel without referral from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access to future examinations shall be subject to prior authorization from a PCP.

Statement of Members' Responsibilities

For The Health Plan to provide appropriate and medically necessary health care services and to allow you to get the most from your plan membership, we want to work together with you and your family. Please share in responsibilities by doing the following:

- Pick a PCP. You should keep a relationship with a PCP. The PCP will be the manager and medical home for your health care needs.
- Identify yourself as a THP member to avoid mistakes when you go to the practitioner or see another practitioner.
- ***Always*** carry The Health Plan ID and Medicaid medical cards. ***Never*** let anyone else use them.
- Read this handbook. You should follow the guidelines and contact The Health Plan for help, if needed.

- Let The Health Plan know any changes in the following:
  - Name, address, telephone number.
  - Number of dependents (marriage, divorce, new baby, child leaves home, etc.).
  - Loss of ID card.
  - Change of PCP.
- Be on time for appointments. If you cannot keep an appointment, call and cancel.
- Give details about your health to the physicians. This information is needed for the diagnosis and treatment of medical problems.
- Follow directions given by your practitioners, such as what medicines to take or what foods you should eat.
- If you get emergency care outside The Health Plan service area, call The Health Plan within 48 hours.
- You must talk with your PCP or OB/GYN before receiving specialty care or services.
- You must give The Health Plan information on other insurance you have or if you have worker's compensation or if you're in an accident. You may have to pay The Health Plan money owed under Coordination of Benefits or Subrogation policies.
- Please be friendly to The Health Plan's employees, practitioners and their staff.

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Medicaid Members' Rights and Responsibilities

Your Rights

As a member of The Health Plan, you have rights around your health care and to receive information according to contract standards. Each year, The Health Plan submits its annual report to the Bureau for Medical Services (BMS) by April 1st. This report includes a description of the services, personnel and the financial standing of THP.

The annual report is available to members by request only. To get a copy of the report, you can call Member Services at 1.888.613.8385. You can also get a copy of the report from BMS.

You have the right to:

- Ask for and obtain all included information
- Be told about your rights and responsibilities
- Get information about The Health Plan, our services, our providers, and your rights
- Be treated with respect and dignity
- Not be discriminated against by The Health Plan
- Access all services that The Health Plan must provide
- Choose a provider in our network
- Take part in decisions about your health care
- Refuse treatment and choose a different provider
- Get information on treatment options and different courses of care according to the member's ability to understand
- Have your privacy respected
- Ask for and to get your medical records within 30 days of request
- Ask that your medical records be changed or corrected if needed within 60 days of request
- Be sure your medical records will be kept private
- Recommend changes in policies and procedures
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are homeless
- Refer yourself to in-network and out-of-network family planning providers
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services

- Get emergency post-stabilization services
- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have your parent or a representative make treatment decisions when you can't
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook annually after initial enrollment
- Dis-enroll from your health plan
- To exercise your rights. Exercising these rights does not adversely affect our treatment of you.
- Ask us about our Quality Improvement program and tell us how you would like to see changes made.
- Ask us about our utilization review process and give us ideas on how to change it.
- Know the date you joined our health plan
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends
- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your permission

Your Responsibilities

As a member of The Health Plan, you also have some responsibilities:

- Read through and follow the instructions in your member handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care
- Give information about your health to The Health Plan and your PCP
- Always remember to carry your member ID card

- Only use the emergency room for real emergencies
- Keep your appointments
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know
- Follow your PCPs recommendations about appointments and medicine
- Go back to your PCP or ask for a second opinion if you do not get better
- Call Member Services at 1.888.613.8385 whenever anything is unclear to you or you have questions
- Treat health care staff and others with respect
- Tell us right away if you get a bill that you should not have g otten or if you have a complaint.
- Tell us and your DHHR caseworker right away if you have had a transplant or if you are told you need a transplant.
- Tell us and DHHR when you change your address, family status or other health care coverage.
- Know that we do not take the place of workers' compensation insurance

Provider Reporting Requirements

Reporting of Required Reportable Diseases

Health care providers are required to report certain diseases by state law. This is to allow for both disease surveillance and appropriate case investigation/public follow-up. THP may be responsible for (1) further screening, diagnosis and treatment of identified cases enrolled in THP as necessary to protect the public's health, or (2) screening, diagnosis and treatment of case contacts who are enrolled with THP. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health within the Department of Health and Human Resources. The three primary types of diseases that must be reported are:

1. Division of Surveillance and Disease Control, Sexually Transmitted Disease Program. According to WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, sexually transmitted diseases (STDs) are required to be reported for disease surveillance purposes and for appropriate case investigation and follow-up. For contact notification, THP must refer case information to the Division of Surveillance and Disease Control. The Division has an established program for notifying partners of persons with infectious conditions. This includes follow-up of contacts to individuals with HIV and AIDS. Once notified, contacts who are enrollees with THP may be referred back to for appropriate screening and treatment, if necessary.
2. Division of Surveillance and Disease Control, Tuberculosis Program. As per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, individuals with diseases caused by M. tuberculosis must be reported to the WV Bureau for Public Health, DSDC, TB Program for appropriate identification, screening, treatment and treatment monitoring of their contacts.
3. Division of Surveillance and Disease Control, Communicable Disease Program. As per WV Legislative Rules Title 6-4, Series 7, cases of communicable disease noted as reportable in West Virginia must be reported to the local health departments in the appropriate time frame and method outlined in legislative rules. This both provides for disease surveillance and allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc. (Note: Per legislative rule, reports of category IV diseases [including HIV and AIDS] are submitted directly to the state health department, not to local jurisdictions.)

Federal Reporting Requirements

The Health Plan must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to BMS. (See Medicaid Physician Provider Manual for state requirements and procedures):

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F –Sterilizations. This includes completion of the consent form.
- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

Provider Responsibilities and Reimbursement

Providers must inform enrollees of the costs for non-covered services prior to rendering such services. Providers are prohibited from collecting copays for missed appointments. Please remember that enrollees are held harmless for the costs of all Medicaid-covered services provided, except for any cost-sharing obligations.

You are required to treat all information that is obtained through the performance of the services in your contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations.

If you have any questions regarding a Medicaid member's eligibility, please call our Customer Service at 1.888.613.8385, Monday – Friday, 8:00 a.m. to 5:00 p.m. Please remember that WV Medicaid determines eligibility for an enrollee to be in managed care.

The Health Plan encourages provider training to promote sensitivity to the special needs of this population.

The Health Plan does not discriminate against providers acting within the scope of their license. Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the enrollee needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.

The Health Plan may not make specific payments, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

We will provide information to members regarding their rights and responsibilities and any changes upon enrollment, annually, and at least 30 days prior to any change in their benefits.

Provider Overpayments

The Health Plan is responsible for the recovery of all overpayments, including those due to fraud, waste, and abuse. In addition to internal processes to identify any overpayments, THP has a process in place for network providers to report receipt of an overpayment. The provider is required to notify THP in writing of the reason for the overpayment and return the full amount of the overpayment to THP within 60 calendar days after the date on which the overpayment was identified. In the event that THP makes an overpayment to a provider, THP must recover the full amount of the overpayment from the provider. This recovery will be administered through the claims system by offsetting the overpayment against future claims payments.

Provider Reimbursement

If a provider's reimbursement is tied to a WV Medicaid fee schedule, THP is required to implement any rate changes adopted by BMS within 30 calendar days of notification of the rate change. THP must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The Health Plan must reprocess any claims paid between the notification date and the system load date to the updated rate. This provision does not apply to payments made to CAH under Article III, §2.7.6 or payments made to FQHCs/RHCs per Article III, §2.4.9.

Changes to Provider Fee Schedules

If a provider is reimbursed based upon the WV Medicaid fee schedule the following processes will be followed when updated rates are received from BMS.

FQHC/RHC

Upon BMS notification to The Health Plan of any changes to the FQHC/RHC reimbursement rates, The Health Plan must update payment rates to FQHC/RHCs to the effective date in the notification by BMS. The Health Plan must pay the new rate for any claims not yet paid with a date of service on or after the effective date of change. If payment has already been made for a claim within the current state fiscal year with a date of service on or after the effective date of the rate change, The Health Plan must reprocess the claim to reimburse at the new rate. The new payment rate must be loaded into the The Health Plan's claims payment system within thirty (30) calendar days of notification of the payment rate change.

Critical Access Hospitals

Upon BMS notification to The Health Plan of any changes to the CAH reimbursement rates, The Health Plan must update payment rates to CAH effective from the designated CMS effective date. The Health Plan must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The new payment rate must be loaded into The Health Plan's claims payment system within thirty (30) days of notification of the payment rate change.

Other BMS Fee Schedules

(RBRVS, CLFS, Imaging, etc.)

In the case of provider reimbursement that is tied to the Medicaid fee-for-service rate schedule, The Health Plan is required to implement any rate changes adopted by the Department within thirty (30) calendar days of notification of the rate change. The Health Plan must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The Health Plan must reprocess any claims paid between the notification date and the system load date to the updated rate.

Alternative Payment Models

The Health Plan deploys several APMs for various provider types throughout our service area, including bonus payments, care coordination payments with shared savings for meeting quality measures, and total cost of care models. By analyzing multiple years of financial data, as well as three years of clinical-based analytic data, THP creates APMs that meet the "quadruple aim of health care"—that is, improving the quality of care, achieving lower costs, promoting better health outcomes, and reducing provider burnout.

THP adheres to a risk readiness approach to APMs developed by the Health Care Payment Learning and Action Network. THP seeks to meet providers and practitioners where they are on this risk continuum. To date, THP's APMs are either category 2A through C or 3A. These APMs include payment bonuses or upside risk only. No payments are taken back or withheld from the provider(s). THP may offer shared risk APMs in the future.

Source: Health Care Payment Learning & Action Network. *Alternative Payment Models (APM) Framework*. July 11, 2017.

THP collaborates with providers to develop APMs that are the best fit for their needs, as well as the needs of our members. THP does not have panel size requirements or other restrictions on its APMs. If your organization wishes to discuss APMs, please call 1.304.285.6508.

Marketing Guidelines

The Health Plan may conduct general advertising that does not specifically solicit the Medicaid population. The Health Plan must submit to BMS for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan and the Medicaid contract.

Prohibited Marketing Practices

The following prohibitions are applicable to The Health Plan, its agents, subcontractors, and The Health Plan providers:

1. Distributing marketing materials without prior department approval;
2. Using the word, "Mountain," or phrase, "Mountain Health," "Health Bridge", except when referring to Mountain Health Trust, West Virginia Health Bridge or other State programs;
3. Distributing marketing materials written above the sixth grade reading level, unless approved by the department;
4. Offering gifts valued over $15 to potential members;
5. Providing gifts to providers for the purpose of distributing them directly to The Health Plan's potential members or currently enrolled members;
6. Directly or indirectly, engaging in door-to-door, telephone, and other cold call marketing activities;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
9. Making any assertion or statement (orally or in writing) that The Health Plan is endorsed by CMS, a federal or state government agency, or similar entity;
10. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone or electronic means of communication;
11. Inducing or accepting a member's MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential members to contact The Health Plan , rather than the enrollment broker, for enrollment;
13. Portraying competitors in a negative manner;
14. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to the department;
15. Making any written or oral statements containing material misrepresentations of fact or law relating to the The Health Plan or the Medicaid program, services, or benefits;
16. Making potential member gifts conditional based on enrollment with The Health Plan;
17. Charging members for goods or services distributed at The Health Plan or Medicaid events;
18. Charging members a fee for accessing The Health Plan's website;
19. Influencing enrollment in conjunction with the sale or offering of any private insurance;

20. Tying enrollment in The Health Plan with purchasing (or the provision of) other types of private insurance;
21. Using marketing agents who are paid solely by commission;
22. Posting The Health Plan-specific, non-health related materials or banners in provider offices;
23. Conducting potential member orientation in common areas of providers' offices;
24. Allowing providers to solicit enrollment or disenrollment in an MCO or distribute The Health Plan-specific materials at a marketing activity (this does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific The Health Plan materials.);
25. Purchasing or otherwise acquiring mailing lists from third-party vendors, or for paying department's contractors or subcontractors to send plan specific materials to potential members;
26. Referencing the commercial component of The Health Plan in any marketing materials;
27. Discriminating against a member or potential member because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses;
28. Assisting with Medicaid MCO enrollment form;
29. Making false, misleading or inaccurate statements relating to services or benefits of The Health Plan or Medicaid program, or relating to the providers or potential providers contracting with The Health Plan;
30. Direct mail marketing to potential members.

MCO Social Media Marketing Practices

In addition to all marketing requirements outlined in this Contract, The Health Plan must comply with the social media Marketing practices as outlined below.

Social Media Marketing Guidelines

The following list is applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. At BMS' approval, The Health Plan may partake in forms of social media advertising (i.e. Twitter, Facebook, Instagram);
2. At BMS' approval, The Health Plan may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution;
3. The Health Plan may post The Health Plan Medicaid events on social media sources. The content of such posts must be approved by BMS approval prior to posting;
4. The Health Plan may post general non-advertising information regarding The Health Plan activities. The content of such posts does not require BMS' prior approval; and
5. Any enrollee complaints received through the social media sources must be processed and resolved through the general complaint intake system.

Social Media Prohibitions

The following prohibitions are applicable to The Health Plan its agents, Subcontractors, and The Health Plan providers:

1. Posting or sending any protected private information on social media source;
2. Advertising on social media platforms that entail direct communication with potential enrollees. This list includes, but is not limited to Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services;
3. Responding to any comments on social media posts from potential enrollees except when to provide general response, such as MCO phone number, links to The Health Plan web site or the enrollment broker phone number;
4. Partaking in individual communication on social media outlets;
5. Requesting followers or adding individuals as friends (i.e. friends on Facebook, followers on Instagram or Twitter); and
6. Tagging individuals on social media source.

Reporting and Investigating MCO Marketing Violations

The Health Plan must establish a process to ensure fair and consistent investigation of alleged violations of BMS' Marketing Policies.

Upon written receipt of any alleged MCO violation(s) from BMS, The Health Plan must:

1. Acknowledge receipt, in writing, within one (1) business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to BMS.

West Virginia Medicaid Provider Required Provisions

The Health Plan is contracted with West Virginia Bureau for Medical Services (BMS). The West Virginia Medicaid Program requires specific contractual provisions for all contracted providers that participate with the West Virginia Medicaid program or choose to provide services to West Virginia Medicaid recipients on an intermittent basis. In addition to the terms contained within the Agreement, the following provisions are applicable specifically to Facility, Physician, Practitioner, and Ancillary Medical Care Providers that provide services to West Virginia Medicaid recipients.

A. **Obligations of Emergency Care Providers**

- Emergency Care Providers must provide education to M edicaid members regarding the cost of their copay for non-emergency services received in the Emergency Department, including alternate locations where non-emergency can be obtained.

B. **Obligations of Providers with Respect to Member Copays**

- Enrollees will be held harmless for the costs of all Medicaid-covered services provided except for applicable cost-sharing obligations. Providers must inform enrollees of the costs or non-covered services prior to rendering such services.
- Providers agree that The Health Plan's enrollees may not be held liable for The Health Plan's debts in the event of The Health Plan's insolvency.
- In accordance with the regulatory requirements promulgated by BMS, providers may not routinely waive required copays.
- Providers may not charge a copay for the following services:
  - Family Planning Services;
  - Emergency Services;
  - Behavioral Health Services;
  - Members under age 21;
  - Pregnant women (including postpartum visit);
  - American Indians and Alaska Natives;
  - Members receiving hospice care;
  - Members in nursing homes;
  - Other services excluded under State Plan Authority;
  - Members who have met their maximum cost sharing obligation per quarter; or
  - Missed appointments.
- Providers must charge a copay for the following:
  - Inpatient and Outpatient Services;
  - Physician office visits;
  - Non-emergency use of an Emergency Department;
  - Caretaker relatives age 21 and above;
  - Transitional Medicaid members age 21 and above; and
  - Other members identified by The Health Plan not specifically exempt

C. **Other Obligations of Provider**

- Physician may not refuse to furnish covered services to the eligible member on account of a third party's potential liability for the service(s).
- Physician agrees to comply with The Health Plan's Quality Assurance/Performance Improvement (QAPI) Program requirements.
- Providers that order, refer, or render covered services must enroll with BMS, through the fiscal agent, as a Medicaid provider, as required by 42 CFR 438.602(b). Enrollment with BMS does not obligate provider to offer services under the BMS fee-for-service delivery system. The Health Plan is not required to contract with a provider enrolled with the West Virginia Bureau for Medical Services that does not meet The Health Plan's credentialing or other requirements.
- Provider must attest to the following certification for claims for Medicaid goods and services:
    - All statements are true, accurate, and complete;
    - No material fact has been omitted;
    - All services will be medically necessary to the health of the specific patient; and
    - The provider understands that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.
- Providers shall maintain malpractice insurance with minimum coverage requirements of $1 million per episode and $1 million in aggregate.
- Provider shall supply a certification that neither provider nor provider's director(s), officer(s), principal(s), partner(s), managing employee(s), or other person(s) with ownership or control interest of five percent (5%) or more in provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement. This certification shall state that all persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program. Provider shall notify The Health Plan immediately at the time it receives notice that any action is being taken against a physician or any other person above, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.
- Primary Care Physicians must comply with timeliness of access standards found in section 2.1.2.4 of the BMS Medicaid contract.

D. **The Health Plan's Reimbursement Responsibilities**

- The Health Plan is solely responsible for payment of covered and authorized services to West Virginia Medicaid recipients as long as the member is eligible for services on the date of service. Provider shall not seek reimbursement directly from West Virginia Bureau for Medical Services.
- The reimbursement terms for West Virginia Medicaid recipients are set forth in the Provider's Master Agreement.
- The Health Plan will not make specific payment, directly or indirectly, to provider as an inducement to reduce or limit medically necessary services furnished to any particular member.

E. **Reporting Actions against Physician, Owners, or Others**

- Provider must notify The Health Plan immediately after it receives notice that any action is being taken against provider or any physician, owners, persons with control interest, managing employees, partners, directors, and officers, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. The provider must agree to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

F. **Compliance with Health Insurance Portability and Accountability Act**

- Provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931, et. seq. Provider must treat all information that is obtained through the performance of the services contemplated by the agreement, including this amendment, as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This expectation of confidentiality shall include, but is not limited to, information relating to applicants or enrollees of BMS programs.

G. **Compliance with Deficit Reduction Act Requirements**

- Provider must comply with the Section 6032 of the Deficit Reduction Act of 2005 and the SMDL 06-024. If provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the provider must:
    - Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of physician. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
    - Include as part of such written policies detailed provisions regarding the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
    - Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

H. Required Disclosures by Provider

- Provider shall provide The Health Plan and BMS with all information requested of provider, including required disclosures regarding ownership and control, in accordance with 42 CFR § 455.104. In addition to any other information requested by The Health Plan or BMS, provider shall disclose the name and address of any person (individual or corporation) with an ownership or control interest in provider. In the case of individuals, such required information shall include date of birth and Social Security number for each individual having an ownership or controlling interest in Provider.

  Consistent with 42 CFR § 455.101, The Health Plan defines "ownership interest" and "ownership" as follows:

  - Ownership interest means the possession of equity in the capital, the stock, or the profits of provider.
  - Person with an ownership or control interest means a person or corporation that:
    - Has an ownership interest totaling 5 percent or more in a disclosing entity;
    - Has an indirect ownership interest equal to 5 percent or more in provider;
    - Has a combination of direct and indirect ownership interests equal to 5 percent or more in provider;
    - Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
    - Is an officer or director of a provider practice that is organized as a corporation; or
    - Is a partner in a provider practice that is organized as a partnership.
- In addition to the required ownership and control disclosures required by 42 CFR 455.101, provider shall disclose the name of any other Medicaid-recipient organizations in which any of its owners have an ownership or controlling interest, as required by 42 CFR 455.104(b)(3).
- A provider that is a business entity, corporation, or a partnership must disclose the name, date of birth, Social Security number, and address of each person who is provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider or in the provider's subcontractor. The address for corporate entities must include, as applicable, primary business address, every business location, P.O. Box address, and tax identification number.
- Provider must provide information on the interrelationships of persons disclosed per 42 CFR § 455.104(b). This required information includes whether the person (individual or corporation) with an ownership or control interest in provider is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which provider has a 5 percent or more interest is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling.
- Provider agrees to keep its disclosed information regarding ownership and control current at all times by informing The Health Plan, in writing, within thirty-five (35) calendar days of any ownership or control changes.

- Provider must disclose any significant business transactions, in accordance with 42 CFR § 455.105. Provider is required to disclose full and complete information about the following information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS or BMS:
  - The ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during the previous 12-month period; and
  - Any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor, during the previous five (5) years.
- Provider must disclose any healthcare-related criminal convictions, in accordance with 42 CFR § 455.106, of any physician or provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in provider, relating to Medicare, Medicaid, or Title XX programs. These disclosures are required at the time that provider applies or renews its applications for Medicaid participation or at any time on request. Provider must notify The Health Plan immediately at the time provider receives notice of any such conviction. For purposes of this amendment and the underlying agreement, and consistent with 42 CFR § 1001.2, "Convicted" shall mean:

  A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
  - There is a post-trial motion or an appeal pending, or
  - The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
  - A Federal, State or local court has made a finding of guilt against an individual or entity;
  - A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
  - An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.
- Provider shall report to The Health Plan all provider-preventable conditions associated with claims.

I. Maintenance and Access of Records

- If provider places required records in another legal entity's records, such as a hospital, the provider shall be responsible for obtaining a copy of these records for use by the government entities or their representative.
- Provider must provide to BMS:
  - All information required under The Health Plan's managed care contract with BMS, including but not limited to the reporting requirements and other information related to

a provider's performance of its obligations under its provider contract with The Health Plan; and

- Any information in provider's possession sufficient to permit BMS to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. If provider places required records in another legal entity's records, such as a hospital, provider is responsible for obtaining a copy of these records for use by the above-named entities or their representative.

J. **Use of Information Obtained Through Agreement**

- The provider shall not use information obtained through the performance of The Health Plan agreement, or this amendment, in any manner except as is necessary for the proper discharge of obligations and securing of rights under the agreement.

K. **Prohibition against Direct Marketing**

- Provider is prohibited from engaging in direct marketing to enrollees that is designed to increase enrollment in The Health Plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

L. **Non-Interference with Rights of The Health Plan and the State**

- Provider shall take no actions that interfere with or place any liens upon the State's right or The Health Plan's right, acting as the State's agent, to recovery from third-party resources.

M. **Compliance with Advance Directives Requirements**

- Provider shall comply with 42 CFR § 422.128 and West Virginia Health Care Decisions Act relating to advance directives.

N. **Right to Recover Overpayments from Provider**

- Provider shall notify The Health Plan, in writing, of any overpayment discovered by Provider. This required notification shall include the reason for any overpayment. Provider shall return the full amount of the overpayment to The Health Plan within sixty (60) calendar days after the date on which the overpayment was identified.
- BMS has the right to recover provider overpayments, including those overpayments due to Fraud, Waste, and Abuse, from provider if:
  - BMS or its contractor identifies an overpayment made by The Health Plan to provider;
  - The payment occurred outside the grace period, as defined by BMS;
  - The Health Plan has not previously identified the overpayment via the deconfliction process outlined herein;
  - The Medicaid Fraud Control Unit (MFCU) or other law enforcement entity is not pursuing provider; and
  - BMS, in its sole discretion, determines it is unable to collect from The Health Plan.

In the event the State collects overpayments directly from provider, provider's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.

Drug Testing Policy

Effective July 1, 2018, based on The American Society of Addiction Medicine (ASAM) published consensus statement, The Health Plan updated the guideline related to review of clinical drug testing for addiction treatment programs and pain management programs for all lines of business. Full ASAM guidelines can be found on the ASAM website

The Health Plan follows the benefit limits established by BMS

- Code limit for presumptive drug screens (80305, 80306, and 80307) is now 24 in combination per calendar year. Medical necessity authorization is required beyond service limits.
- Code limit for definitive drug screens (G0480, G0481, and G0482) is now 12 in combination per calendar year. Medical necessity authorization is required beyond service limits.
- G0483- definitive drug testing for 22 or more drug classes requires medical necessity prior authorization from the INITIAL service prior to service being rendered unless it is the result of an emergency room visit.
- G0659- definitive drug testing to identify drugs that do not have a specific test available requires medical necessity prior authorization from the INITIAL service prior to services being rendered.
- To exceed the benefit limit, providers must contact The Health Plan to obtain a medical necessity authorization.

The complete policy can be located on the BMS website

Breathalyzer Testing

Effective July 1, 2020, The Health Plan will deny all breath alcohol testing (procedure code 82075) performed in conjunction with any urine drug screen other than dipstick point of care testing (POCT), billed with procedure code 80305. Providers using more complex urine drug testing such as procedure code 80307 or a definitive screen are encouraged to include alcohol as a screened substance.

The Health Plan made this change in order to ensure the proper utilization of urine drug testing associated with pain management clinics and substance use disorder practitioners and facilities. We would like to remind providers that urine drug testing is most effective when 1) individualized rather than routine, 2) randomized, and 3) conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine.

ASAM strongly recommends against routine use of definitive testing. Please review the white paper at the link above. As always, all clinical procedures can be subject to post payment review of medical necessity.

Transplant

Members receiving transplant services will be transitioned back to fee-for-service.

Non-Par Provider

Non-participating providers must obtain prior authorization for claims to be reimbursed.

Prior Authorization

Effective January 1, 2017, all providers are required to request prior authorization before a service is rendered. This requirement includes both outpatient and inpatient services. If service is rendered after hours, over the weekend or on a holiday, providers are required to request authorization the next business day. Prior authorization requests received after the next business day will not be processed. Failure to follow prior authorization guidelines will result in denied claims.

Chiropractic Service

Manipulation and X-ray procedure codes along with 99201, 99202, and 99203 will be covered per contract. Effective April 1, 2020 physical therapy codes have been added as a covered service. Benefit limits are still in effect.

Physical and Occupational Therapy

Therapy codes are not payable without one of these modifiers to distinguish the discipline of the plan of care under which the service is delivered.

- **GO**: Indicates services delivered under an outpatient **occupational** therapy plan of care
- **GP**: Indicates services delivered under an outpatient **physical** therapy plan of care

Inpatient Claims

In order to be consistent with the payment policies currently utilized by CMS for Medicare, Medicaid's fiscal agent for WV Medicaid, and general industry standards for commercial payors, THP changed our claims processing policy regarding hospital and skilled nursing inpatient admissions. **Effective July 1, 2017**, THP began processing payments for inpatient admissions based on the discharge date of the inpatient stay. This affects any claim for an inpatient admission where the reimbursement terms of our contract are based upon a DRG, case rate, per diem or percent of billed charges methodology.

NDC Rebate Eligible Drugs

The Health Plan cannot reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the department's outpatient drug pharmacy program.

In accordance with 42 U.S.C. § 1396r-8, THP must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. THP is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The Medicaid drug rebate program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) which added Section 1927 to the Social Security Act and became effective on January 1, 1991. The law requires that drug manufacturers enter into an agreement with the Centers for

Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

Drugs administered by the physician and billed with an NDC must be rebateable in order to be eligible for payment, otherwise the drug will be denied. Providers can refer to the CMS website to determine if an NDC is manufactured by a company that participates in the federal drug rebate program or consult your wholesaler for assistance. **Failure to submit all required information such as NDC code, unit of measurement and quantity will result in a complete claim denial** (see provider billing instructions for requirements).

Unit of Measurement codes are:

- F2 -International Unit
- GR-Gram
- ML-Milliliter
- UN- Unit

340b providers are required to use modifier **UD** when submitting claims.

FAQs related to this requirement can be found on the Bureau for Medical Services website.

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Readmissions Review Occurring Within 30 Days

Effective November 1, 2018, all clinically related/potentially preventable readmissions occurring within a thirty (30) day period are subject to review and denied in the event it is determined that the patient was prematurely discharged from the same hospital, the facility failed to have proper and adequate discharge planning in place, or if there was a lack of proper coordination between the inpatient and outpatient health care teams. In the absence of information to determine the appropriateness of the readmission from hospital review staff, submitted records or physician contact with the plan, clinically related/potentially preventable readmissions within a seven (7) day period will be automatically denied and the provider will need to provide medical documentation to support the need for payment. Final review decisions will be made/confirmed by an employed medical director of The Health Plan.

Wrong procedures or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as "never events." As a reminder, all never events are considered not medically necessary and reimbursement is not allowed. Questions regarding claim denials may be directed to The Health Plan's provider number at 1.877.847.7901.

*See **Section 7** of this Manual for information on THP's 30 Day Hospital Readmission Utilization Management Review Guideline. See **Section 12** of this Manual for billing guidelines related to readmissions occurring within 30 days of discharge from an inpatient facility.*

SUD Provider Training and Education Requirements

SUD providers are responsible for providing training and education to their staff on the ASAM® Level of Care criteria and the application of the ASAM® criteria in the assessment process. During provider enrollment, The Health Plan will obtain attestation from the SUD provider that ASAM® criteria will be applied appropriately by the provider's SUD program staff. As part of BMS' quality monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM® Levels of Care and the Medicaid Provider Manual. BMS' ASO contractor will perform these retro reviews of providers to ensure SUD program providers are consistently applying ASAM® criteria throughout an individual's stay and that documentation and personnel records meet established Medicaid standards.

ER All-Inclusive

THP is following the requirements outlined in the BMS hospital manual around the all-inclusive rate for emergency services.

Medicaid covers five levels of emergency room services. There are five CPT procedure codes available for billing emergency room services.

The enhanced reimbursement is an **all-inclusive fee**, which is considered to include the following items:

- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies - routine EKG monitoring
- Oxygen administration and O_2 saturation monitoring

Diagnostic procedures including lab and radiology may be billed separately and in addition to the emergency room services

Outpatient Services for Acute and Critical Access Hospitals

Effective January 1, 2020, CPT/HCPCS codes are required to be submitted with the applicable revenue code for all outpatient services. Revenue codes that are submitted without the corresponding procedure code will be denied.

Surgical procedures must be billed with the appropriate CPT or HCPCS code and revenue code. Units are reported in fifteen (15) minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. If you wish to report multiple procedures, bill all additional lines with zero units and zero charges.

Paper Claim Submissions

For paper claim submitters, The Health Plan accepts the current standard paper claim billing forms:

- CMS 1500 (02/12) professional claim form
- UB-04 hospital claim form
- ADA dental claim form

Effective July 1, 2020, only **original** claim forms (red ink) are accepted. Copies made from an original claim form, faxed or scanned claims (black ink) **will be** rejected.

Handwritten claims are also not acceptable. As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan's provider portal. Contact your provider engagement representative to learn how. You may access contact information for the provider engagement representative assigned to your county by viewing the territory map located at https://www.healthplan.org/providers/overview/meet-provider-engagement-team.

Claim forms must be completed in their entirety. The Health Plan requires that all claims are submitted with accurate and current CPT-4, HCPCs, and ICD-10 codes, as appropriate.

24-hour nurse line:

1.800.624.6961

Members	Value Add
Access to CoreWellness. Online tool to help members learn ways to get and stay healthy	
Health risk assessments	
Dedicated care managers to help members manage medications, disease and improve overall health	
Specialized care managers for neonatal abstinence syndrome (NAS), NICU, high-risk obstetrics, hepatitis, and behavioral health. Face-to-face case management with high-risk members with specialized care managers	
One-on-one education with asthma nurse educator	Asthma pack with peak flow meter, spacer and carrying pack
HbA1c blood test, nephropathy exam and diabetic eye exam for diabetics (all three required)	$50 Gift Card
Diabetes education by case managers	
One-on-one education by diabetes educators on glucometer, insulin pump use and general diabetes education	
Unlimited calls to Member Services and free wellness and appointment reminder texts	Cell phone with minutes for text & voice
Personal assistance with applying for SSI	
One-on-one help to quit smoking with a certified coordinator	
<u>*Members 12 & older:*</u> Quit smoking packets with workbook, relaxation exercises and quit smoking survival kit	

1110 Main Street
Wheeling, WV 26003

healthplan.org

Already a member?

Call **1.855.577.7124** to learn more about getting these benefit.

Eligible for Medicaid?

The Health Plan is the right plan for you! Call **1.800.449.8466** to learn more.

Pregnant, New Moms & Mothers	Value Add
Maternity Outreach Program:	
• 1st trimester (up to 2 visits)	$50 Gift Card
• 3rd trimester (up to 4 visits)	$50 Gift Card
• Post-partum visit (between 7-84 days after delivery)	$50 Gift Card
Care coordination through baby's 1st year for mother's with high-risk pregnancies	
Care coordination through baby's 1st year for mother's with substance use disorder during pregnancy	
Text4Baby messages to keep mom and baby healthy	
NICU babies or babies with complex conditions	
Preventive dental (up to 2 visits, mothers 21+)	

Children	Value Add
Dental exam 2 – 3 years of age	$25 Gift Card
Yearly well visit 3 – 6 & 12 – 21 years of age	$25 Gift Card
Camp Kno Koma — Diabetes	Scholarship(s)

Help in your language

Do you need help communicating with us or reading what we send you? We provide our letters in other languages and large print at no cost to you. Call our toll-free Customer Service Department at 1.888.613.8385 (TTY : 711).

Plan On It.

healthplan.org

rvsd 2.21.20

Section 6

Office Copays, Medical Copays, Co-insurance & Deductibles

Office Visit Copays, Medical Copays, Co-insurance & Deductibles

The Health Plan offers a variety of benefit plans that require the member to be responsible for a portion of the cost of services. Member responsibility may take the form of copays for office visits or other medical services, co-insurance amounts, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer.

Office visit copay/medical copay

Generally, copays are a fixed amount, but may be a percentage of the allowed amount that is associated with a specific service such as an office visit, therapy visit, or diagnostic service and would be the member's responsibility. Members are expected to pay this amount at the time of service.

It is imperative that the offices ask for the member's ID card at every visit. A sample of The Health Plan ID card is shown on the product matrix located in **Section 3**.

Copays may not be waived, as this is in direct violation of the provider's contract.

The copay should be collected at the time of service, unless other arrangements have been made.

Copays DO NOT apply to hospital inpatient physician visit, preventive services and/or prenatal office visit (after the initial visit), physician nursing home visits, or patient home visits when determined to be medically necessary by the plan. Members of specific employer groups may have a copay for specific outpatient procedures.

Co-insurance

Generally, co-insurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A provider may request payment at the time of service. However, the provider must take care to determine the member's specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance. At no time should a provider collect more than the amount that is contractually obligated to be paid. The most accurate method to assure that the provider is collecting the correct amount may be to wait for the explanation of benefits (EOB) from The Health Plan showing the amount that is member responsibility. A copy of the EOB is also sent to the member letting them know the amount that is their responsibility.

Deductibles

Deductibles are an annual amount, defined by the member's benefit plan that members must satisfy before the plan pays for any services. A provider may expect payment from the member at the time of service, if the member has not satisfied their annual deductible. However, unless, the member knows that they have not met their deductible, it is generally difficult, due to claims lag, to determine if a member has met their deductible at any given point in time. At no time should a provider collect more than the amount that is the member's responsibility.

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Collecting copays when another insurance is primary

If the primary insurance pays equal to, or more, than the office copay amount, do not collect The Health Plan office copay.

Example: Member has a $10.00 copay and his primary insurance carrier pays $11.00, do not collect the $10.00 copay.

If you have questions regarding whether or not to collect office copay, please contact The Health Plan Coordination of Benefits/Funds Recovery Department at **1.740.695.7903** or **1.800.624.6961**, ext. 7903.

Determining a member's responsibility

Member copays for physician office visits and certain other services may be found on The Health Plan's provider secure portal myplan.healthplan.org or by calling The Health Plan Customer Service Department at 1.800.624.6961.

PLEASE NOTE: Deductible and coinsurance are not applicable for preventive services.

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. The Health Plan products affected by the ACA would be our commercial, HMO, PPO, POS, and self-funded employer groups.

Under the ACA, private health plans must provide coverage for a range of preventive services and **may not impose cost sharing (such as copayments, deductibles, or co-insurance)** on patients receiving these services. Please remember that annual well exams and other preventive services do not require a copay or coinsurance from the member, unless the employer group to which they belong, is "grandfathered."

Information about Medicare Preventive Services can be found on the CMS website.

Quick Reference of CPT Codes for Office Encounters

Office copays are usually applied to all services representing a face-to-face encounter with the physician or physician extender, except for surgical care and preventive services.

The following list of CPT codes represents the codes most frequently used to describe these services. This list represents most frequently used but is not all-inclusive.

OFFICE MEDICAL SERVICES		
99201	99368	99394
99202	99381	99395
99203	99382	99396
99204	99383	99397
99205	99384	99401
99211	99385	99402
99212	99386	99403
99213	99387	99404
99214	99391	99411
99215	99392	99412
99366	99393	99420
99367		
AUDIOLOGIC		
92557	92593	V5008
92590	92594	V5010
92591	92595	V5020
92592		
CONSULTATIONS		
99241	99243	99245
99242	99244	
OPHTHALMOLOGY		
92002	92012	
92004	92014	
OTORHINOLARYNGOLIC SERVICES		
92506		
SPECIAL SERVICES / REPORTS		
99058		

Section
7

Clinical Services

Clinical Services Introduction

The medical management program ensures the provision of appropriate health care to its members while addressing the effectiveness and quality of the care. The delivery of health care services is monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote the access of medically appropriate, holistic care in a timely, efficient manner across the network through population health-driven care, complex case navigation, prior authorization, admission and concurrent reviews, health and wellness programs, chronic disease management and pharmacy programs.

The primary goal of the medical management program is to measurably improve the utilization of care and services to our members in a way that is financially responsible and responsive to their individual health care needs. This goal is achieved by meeting the following objectives:

- Promote and provide appropriate allocation of health care services to our members.
- Perform utilization management processes with minimal disruption to the delivery of care and services, including clinical information gathering, documentation review, and communication of utilization management decisions.
- Identify members for social service referrals, care navigation assistance, complex case management, and high risk perinatal and chronic disease navigation programs.
- Assess medical management program performance by soliciting input from members and practitioners through surveys annually.
- Develop interventions based on input received from members and practitioners to improve the quality of services to all customers.
- Educate practitioners on the scope of the medical management program and Clinical Services Division.

Medical Prior Authorization & Notification Requirements

The Medical Prior Authorization and Notification Requirements are available **here**.

Palladian Health

Palladian Health is performing prior authorization and medical necessity review for musculoskeletal conditions and spine pain management.

This change affects all providers treating back pain and musculoskeletal conditions including chiropractors, physical therapists, occupational therapists, surgeons, orthopedists, neurologists, neurosurgeons, pain management specialists and clinics, physiatrists and anesthesia pain management specialists.

Medical necessity review and prior authorizations may be completed through The Health Plan's online provider portal, via fax at 1.844.681.1205 or telephonically at 1.877.244.8514.

Questions on this process may be addressed by calling THP's provider number at 1.877.847.7901 or by contacting your Provider Engagement Representative.

As part of our commitment to providing programs that support THP's Population Health Management initiatives, The Health Plan has partnered with Palladian Health to provide an evidence-based approach to coordinating and managing the treatment of musculoskeletal conditions and spine pain. The program focuses on improving health outcomes and ensuring appropriate treatment while engaging patients through a care advocacy program. The care advocacy program includes patient outreach, support and education, provides web-based self-management education, and a cognitive behavioral therapy telehealth program.

Palladian Health performs prior authorization and medical necessity review as follows:

- **All services related to spine care management,** (including injections, spinal surgeries, and spinal stimulation, etc.) require prior authorization and medical necessity review by Palladian Health
  - Includes all commercially insured fully funded plans (including HMO, PPO and POS plans), all Medicaid plans, and all Medicare Advantage plans.
  - Participants in self-funded plans are not included in this program
  - Diagnostic imaging reviews, MRI, etc., are reviewed for medical necessity and prior authorized by eviCore health care.
- **PT and OT** - the first 20 **combined** visits for physical therapy (PT) and occupational therapy (OT) per event and/or year do not require prior authorization.
- Palladian Health will review services for medical necessity and determine authorization status beginning with the 21st **combined** PT/OT visit.
- **Chiropractic care** - the first 20 visits for chiropractic services per event and/or year do not require prior authorization
  - Palladian Health will complete medical necessity review beginning with the 21st chiropractic visit.
  - **All X-rays performed in the chiropractic setting require prior authorization**
  - Visit limitations for THP Medicaid and Medicare lines of business will follow a calendar year.
  - Commercial plan (including HMO, POS, PPO and WV PEIA) visit limitations will be based on a contract year.
  - Self-Funded plans are excluded and default to the group plan document.

eviCore healthcare

The Health Plan has entered into a partnership with eviCore healthcare to manage medical necessity and prior authorization for the following services for all Medicaid, Medicare and fully insured lines of business. Services performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit are not subject to authorization requirements.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call **877.791.4104** for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care.

This prior authorization and review process does not include services provided to participants in *self-funded plans – please check plan benefits for coverage and prior authorization requirements.*

- **Sleep Studies**
- **Durable Medical Equipment (DME)**
- **Radiology/Cardiology**
  - CT / CTA
  - MRI / MRA
  - PET / PET CT
  - Myocardial Perfusion Imaging (Nuclear Stress)
  - Echo / Echo Stress
  - Diagnostic Heart Cath
  - Cardiac Imaging (CT, MRI, PET)
  - Cardiac Rhythm Implantable Device (CRID)
- **Post-Acute Care (Medicare/DSNP ONLY)**
  - Skilled nursing
  - Home health (all services)
  - Long term acute care
  - Inpatient rehab

Access to the list of CPT codes that require prior authorization are located at evicore.com along with eviCore healthcare's clinical guidelines and request forms.

Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

Telephone Directory

	During Business Hours (8 a.m to 5 p.m.)	After Hours Urgent/Emergent Issues
Admissions **Benefit/Eligibility**	1.800.304.9101	
Urgent or Emergent Notification UM Support 24/7 Availability – reverts to voicemail after hours	1.877.794.7152	1.866.NURSEHP (1.866.687.7347)
Prior authorizations ***Online submission for prior authorization is available at myplan.healthplan.org**	Fully Funded: 1.877.847.7902 ASO: 1.888.816.3096 Medicare: 1.877.847.7907 Medicaid: 1.888.613.8385 Palladian: 1.877.244.8514 eviCore: 1.877.791.4104	1.866.NURSEHP (1.866.687.7347)
Fax Number–Clinical information for referral review	1.888.329.8471	
Fax Number–Hospital demographics and clinical reviews	1.330.830.4397	
Medical Directors	1.800.624.6961, ext. 7644	1.866.NURSEHP (1.866.687.7347)
Administrative Assistant	1.800.624.6961, ext. 7644	
Medical Emergency Nurse Line available 24/7	1.800.624.6961	1.866.NURSEHP (1.866.687.7347)

Nurse Information Line

There is always access to a nurse navigator to assist practitioners regarding information about the medical management process and the authorization of care.

The nurse information line provides practitioners with access to a nurse navigator 24 hours a day, 7 days a week and has been a feature of The Health Plan since 1994.

You can contact the nurse information line by calling a nurse navigator directly at 1.866.NURSEHP (1.866.687.7347).

Admissions/Concurrent Review Process

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member's primary care physician (PCP) or referring participating specialist with the Medical Department's nurse navigators. This includes acute care, rehabilitation, skilled nursing facilities and long-term acute care facility (LTACF).

Notification of urgent/emergent admissions, by the admitting physician or facility, is required at the time of, or as soon as practically possible after admission into an acute care facility. This activity is performed for early discussion of member's needs as related to the admission or alternative health care services.

All out-of-plan and tertiary non urgent/emergent requests require prior authorization. Clinical information is reviewed for availability of service within the plan's network, clinical complexity, or other extenuating circumstances and should be supplied by the PCP or appropriate in-plan specialist (if referring within their specialty). This includes acute care, long-term acute care facilities (LTACF), rehabilitation, and skilled nursing facilities.

Concurrent review is the process of continued reassessment of medical appropriateness for inpatient care. Any member identified with potential discharge planning needs is referred by the Medical Management Department's inpatient navigator to case navigation, chronic disease navigation or the social workers as appropriate for early intervention. Concurrent review is performed by fax or telephonically and involves communication with physicians, hospital utilization review (UR) staff, social workers and family members as necessary.

The process of concurrent review utilizes nationally recognized criteria for inpatient admissions and continued stay. It is understood that the criteria cannot be applied to all cases. All factors such as the member's age, living conditions, support systems and past medical/surgical history are considered in applying criteria.

Please indicate if your request is emergent so that we may expedite the review. *Simply scheduling the testing/procedure does not warrant an expedited review.* Unless an emergency, scheduling should be done *after* being approved by The Health Plan.

30 Day Hospital Readmission Utilization Management Review Guidelines

Policy Overview: This administrative policy is applicable to in-network facilities based on a contracted DRG or case rate methodology for all of The Health Plan's fully funded lines of business and ASO groups or plans utilizing The Health Plan Network at participating network facilities. It defines payment guidelines for readmissions to an acute general short-term hospital occurring within thirty (30) calendar days of the date of discharge from the same acute general short-term hospital for the same, similar or clinically related diagnoses. In the instance of multiple readmissions, each admission will be reviewed against criteria relative to the immediately preceding admission.

Definitions:

- Clinically Related – an underlying reason for subsequent admission that is plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may involve the same or similar diagnosis or DRG group and may have resulted from the process of care and treatment during the prior admission (e.g. readmission for surgical wound infection, or readmission for appendectomy following an admission for abdominal pain with fever) or from lack of or improper post admission care coordination (e.g. failure to transmit orders to home infusion provider for antibiotics necessitating readmission) rather than from unrelated events that occurred after the prior admission (e.g. broken leg due to trauma following a medical admission).
- Readmission – an admission to the hospital occurring within 30 days of the date of discharge from the same hospital. For the purpose of calculating the 30-day readmission window the day of discharge is not counted.

Policy Statement

The Health Plan Medical Management Department shall conduct hospital readmission review to determine if the readmission was considered clinically related to the previous admission. Readmissions determined to be clinically related to the previous admission will not be separately reimbursed. Facilities will be notified that readmission authorization is denied for clinically related criteria and the previously approved inpatient authorization will be updated to cover the second stay. Facilities will receive written notice and instructions regarding how to submit a corrected claim.

Clinically Related Criteria:

- A medical readmission for a continuation or recurrence of the previous admission or closely related condition (e.g., readmission for diabetes following initial admission for diabetes)
- A medical complication related to care during the previous admission (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection)
- An unplanned readmission for surgical procedure to address a continuation or recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain with fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission (e.g. readmission for drainage of a post-operative wound abscess following an admission for bowel resection)

* Hospital readmission review determination as described above is specifically to determine if the readmission is clinically related and is not an assessment of medical necessity or appropriateness of setting.

Exclusions from hospital readmission review are:

- Transfers from out of network to in-network facilities
- Transfer of patients to receive care not available at the first facility
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy, transfusions for chronic anemia or staged surgical procedures
- Readmissions associated with malignancies (limited to those who are in active chemotherapy regimens), burns, or cystic fibrosis
- Readmissions for primary psychiatric disease
- Relapses for SUD causing readmission
- Readmission due to bone marrow transplants
- Admissions to skilled nursing facilities (SNF), long term acute care facilities (LTAC) and inpatient rehabilitation facilities (IRF)
- Readmissions where the first admission had a discharge status of "left against medical advice"
- Readmissions greater than 30 days from the date of discharge of the first admission
- Readmission for patients under 12 months of age at time of service
- Obstetrical readmissions

Refer to ***Section 12*** *for billing guidelines related to inpatient readmissions occurring within 30 days.*

Prior Authorization/Referral Management Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, his/her circumstances, medical history, and availability of care and services within The Health Plan network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the physician advisory committee. In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

InterQual® Review

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider/practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call The Health Plan's Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care. InterQual® review worksheets are available upon request.

The Health Plan uses InterQual® guidelines for most procedures and services other than for Medicaid Groups where West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services. Refer to The Health Plan's prior authorization list for specific details.

Primary care physicians (PCP) are responsible for directing care to specialty care physicians. The Health Plan does not require a referral to an in-plan specialist in most instances.

Please refer to the complete listing of in-plan services that require prior authorization and/or notification. Remember, additional services may require prior authorization based on specific plan requirements of some groups, especially those that are self-funded. Also, due to changes in medical technology and the accessibility of diagnostic equipment and services in an office/outpatient setting, as well as updated methods or approaches to performing procedures and services, there may be additional services that will require medical review. Contact The Health Plan if you have concern regarding a particular procedure or test.

The following are examples of services that require prior authorization:

Ancillary services require prior authorization by the Medical Department through the referral process. Some services that require prior authorization include**, hospice and durable medical equipment (DME) including all customizations and add-ons.** In addition, all DME repairs and replacements require prior authorization.

Diagnostic testing and imaging studies require prior authorization and medical appropriateness review, including but not limited to **MRI/MRA and CT scans (including cardiac advanced imaging), PET and PET/CT fusion scan, and SPECT MPI ordered by non-cardiologists.**

All out-of-plan and tertiary requests require prior authorization. Clinical information is reviewed for availability of service within the in-plan network, medical necessity, clinical complexity, and other extenuating circumstances that should be supported by the PCP or appropriate in-plan specialist's documentation (if referring within their specialty). Please refer to The Health Plan list of tertiary providers to assist you in directing members to appropriate providers.

All genetic testing requires prior authorization. This includes, but is not limited to, all prognostic gene expression profiling techniques, all gene and molecular expression assays, and all genetic testing for inherited susceptibility for a disease.

When genetic testing is being considered, it is imperative that the testing be authorized prior to completing laboratory requisitions. Information needed to obtain prior authorization for testing includes:

- Patient displays clinical features or is at direct risk of inheriting the mutation in question.
- Result of the test will directly impact the treatment being delivered to the patient.
- Documentation of a comprehensive history, physical examination, genetic counseling as indicated, and completion of conventional diagnostic studies.
- Genetic tests should be completed at an in-plan laboratory.
- Genetic testing is reviewed using nationally recognized criteria for molecular diagnostics.

Authorization can be obtained via telephone, fax or electronically through our provider portal. Prior authorization request forms are available on the provider portal under "Forms."

Additional services that require prior authorization include procedures that may have limited coverage under the plan benefits or that may be deemed experimental/investigational for some diagnoses. Also, high cost procedures and new technologies that have specific coverage guidelines must be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines. Cosmetic procedures are not covered. Please contact The Health Plan Customer Service Department if you have any concern regarding coverage of any service at 1.800.624.6961.

Please refer to the Behavioral Health Department and Pharmacy Department sections of this manual for specific information regarding the process for prior authorization of those services.

Any prior authorization that does not meet medical appropriateness review by the nurse navigator is referred to the medical director for review determination. The medical director may contact the PCP, consulting physician, or specialist for case discussion. Availability of services within the provider network and alternative levels of care for services may be offered as appropriate to the member's needs.

Please indicate if your request is emergent so that we may expedite the review. *Simply scheduling the testing/procedure does not warrant an expedited review.* Unless an emergency, scheduling should be done *after* being approved by The Health Plan.

Providers shall be informed of service and authorization requirement changes (include site of service changes) no less than 30 days prior to the implementation of such changes.

Requests for Second Opinion

Most "second opinion" evaluations may be achieved within the member's local network. In the event the services requested are not available locally, a tertiary level "second opinion" may be considered.

When requesting a **second opinion at a tertiary facility**, please understand that this request authorizes an **evaluation visit only and that any further visits, surgery, treatment, and testing would require additional prior authorization.**

Once the evaluation is completed, the consulting physician should send his/her report back to the referring physician, who will then discuss findings with the member.

Please indicate if your request is emergent so that we may expedite the review. *Simply scheduling the testing/procedure does not warrant an expedited review.* Unless an emergency, scheduling should be done *after* being approved by The Health Plan.

Specialist Coordination of Health Care Services

(Standing Referrals, Specialist Referrals and Secondary Care Providers)

It is the policy of The Health Plan to facilitate ongoing specialist care and coordination of the benefit for appropriate members. This would apply when the primary care practitioner, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is life-threatening, degenerative, or disabling.

The PCP is responsible for initiating a specialist referral if one is required and supplying appropriate member history to the specialist. A treatment plan is formulated by both physicians and the member. The plan of care is subject to review by the Medical Department.

Short-term specialist care (six months or less) is requested upon a *specialist referral* form ('SR' referral type), if required by the enrollee's group or specialist physician. Ongoing care over an extended period of time is requested on a *standing referral* ('SG' referral type). This is typically seen with tertiary or approved single case agreement provider referrals. The number of visits shall be based upon the treatment plan and shall be limited to a one-year period.

Additionally, some members may choose to list a Secondary Care (Specialist) Provider (SCP). When the member's care cannot be delivered in the primary care setting due to complexity of care or a particular disease process, the member may choose to select an in-plan participating specialist as SCP. Examples of a SCP may include endocrinology, oncology, nephrology or cardiology. Members requesting/requiring management by an SCP should be enrolled in care management.

With the listing of an in-plan specialist as SCP, the specialist practitioner is authorized to provide and refer for health care services in the manner of the primary care practitioner, providing th e care is relevant to the expertise of the specialist.

In order to assure appropriate coordination of care, the SCP or specialist granted a standing referral shall provide the primary care practitioner or treating practitioner with regular reports on the care provided to the member.

For a specialist to continue to coordinate care, an in-plan SCP must remain actively listed with The Plan or the continuation of a standing referral, the primary care practitioner is required to request an extension of the standing referral every year and to provide updated reports and treatment plans to support medical appropriateness.

Medicaid enrollees must have access to certified pediatric or family nurse practitioners and certified nurse midwives and may designate them as their primary care practitioner.

Specialist and standing referrals are subject to the Timeliness of UM Decisions and Notification Policy.

Member Health and Wellness Promotion

The Health Plan offers an array of primary preventive health interventions to help decrease the incidence or progression of illness and chronic disease. We engage the member in wellness and health promotion activities, such as education, physical activity and health screenings, to encourage a healthy lifestyle.

The Health Plan provides and promotes a health risk assessment (HRA), wellness information, clinical guidelines and other tools on our member website. These initiatives serve to educate and promote change regarding nutrition, exercise, stress management, tobacco cessation, alcohol use, mental health, driving safely and care of hypertension, diabetes, and hyperlipidemia.

Personal Health Risk Assessment (HRA)

The Health Plan attempts to complete an HRA on every Mountain Health Trust and Medicare Advantage member upon enrollment. HRAs are also conducted on members enrolled in complex case management, care management and disease management programs. Re-assessment is ongoing and member specific. Members are risk-stratified based on the HRA results and are navigated to the appropriate department at The Health Plan.

All adult members of The Health Plan may take an online HRA. This self-guided tool will provide a care plan and trigger an activity for THP care staff. Members are navigated to the appropriate department at The Health Plan based on the results of the HRA.

The Health Plan member website offers the following member features:

- Health and wellness educational materials may be requested to be mailed
- Health risk assessment
- Interactive health guidelines to help ensure members obtain the recommended preventive services in the time frames indicated
- Information for enrolling in tobacco cessation classes and other resource materials

Ongoing Educational Materials

Topics that The Health Plan offers education on include:

- Nutrition/Healthy Diet
- Healthy Weight
- Healthy Eating
- Smoking and Tobacco Use
- Stress Management
- Exercise/Physical Activity/Fitness
- Alcohol/Substance Misuse
- Preventive Care: Men's, Women's, Children, and Family
- Diabetes
- Mental Health
- Pregnancy
- Congestive Heart Failure
- Autism

The Health Plan member education is offered via:

- Telephonic Outreach
- Onsite Classes
- Mailing
- Newsletters
- Emails
- Social Media

Care Navigation

The care navigation program is a service offered to assist in directing individualized care for the member, usually on a short-term basis and intended to be episodic or situational. Care navigators can be registered nurses, licensed practical nurses or medically trained member advocates. The care navigator coordinates resources across the continuum to minimize costs while improving quality of care. Care navigation is a proactive approach that focuses on promotion of health education and member empowerment through self-management. Medical and Behavioral Health issues are addressed to provide the best possible outcomes. Assistance is provided with management of issues with social determinants of health such as housing, food insecurity and lack of safety in the home.

Members are identified according to established care navigation criteria and by clinical analytics, referrals from other areas of Clinical Services (pharmacy, prior authorization, hospital review, medical directors, or behavioral health), health risk assessments (Medicare, Medicaid), and episodes of transitional care. Additionally, providers, physicians and associated health professionals and employer groups may contact The Health Plan to request care navigation services by phone at 1.800.624.6961, ext. 7644 or online at healthplan.org. Members and family members can self-refer through the same process.

Care navigators perform a telephonic assessment to determine the member's needs. A plan of care is established by identifying goals and planning interventions to facilitate these goals. Care navigators may place referrals to other services within the Medical Management Department to assist with goals. Pharmacists, licensed social workers, and other health professionals often assist with medical care navigation. The care navigator functions include, but are not limited to managing admissions, facilitating transitional care alongside a facility's discharge planners, and assisting with referrals to long term acute care facilities, acute rehabilitation units, skilled nursing facilities, or long-term intermediate care placement. Additionally, coordination and authorization of home health services can be included, such as private duty nursing, hospice services, infusion services, outpatient services and assistance with obtaining DME. Care navigators will assist the member to optimize the home environment whenever possible in order to maximize successful healing and rehabilitation.

A schedule for telephonic follow-up with educational support is established with the care navigator's contact information provided to the member for interim questions/concerns. Care navigators may also provide their contact information to the member's providers to assist with coordinating services. Members are discharged from the program, with their permission, once goals are achieved and needs are met.

Triggers for Possible Engagement in Medical Care Navigation

1. Self-referral, practitioner referral, family/caregiver referral, group referral, web referral, Nurse Information Line request, or request with any identified need
2. Identification based on a trigger diagnosis with any identified risk factor (*diagnoses specified in complex case navigation are exempt as these are referred for complex case navigation). Sent in real-time by Medical Management Programs: inpatient, prior authorization, pharmacy, or Clinical Services staff
3. Readmissions within 30 days, identified in real time, by inpatient navigation/internal reporting with focus on those with re-admit for same diagnosis and identifiable risk factors increasing likelihood of further readmissions
4. Clinical analytics. Reports identifying specific at-risk populations based on various defined parameters and individualized criteria, stratified by care need index and predictive scores for targeted intervention
5. Risk identified by governmental HRA or outreach (Medicare/Medicaid) including identification of social necessity gaps
6. Enrollment in a clinical trial
7. Discharge outreach/readmission reduction assessment identified beyond the scope of inpatient navigation
8. Redirection of out-of-network or transitional care
9. High cost, stop loss/reinsurance identified post-service
10. Core Wellness needs identified based on online or external risk assessment data
11. Autism
12. ADHD
13. Suicide or homicide attempt within the past 14 days
14. Overdose/Narcan administration
15. Admission to crisis stabilization unit
16. Members with Substance Use Disorder seeking treatment/admission to a residential program
17. Acute inpatient psychiatric treatment
18. More than $20,000 in behavioral health expenses in one year unless member is served by ACT team
19. Individuals with diagnoses likely to represent chronic pain and need for pain management services
20. Prescription Lock In identified
21. Members diagnosed with complications from COVID-19

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Complex Case Navigation

The complex case navigation program is a service that helps case manage individual members, normally on a long-term basis, who are identified as high-risk due to catastrophic illness or injury. Members will receive a comprehensive and intensive level of care management provided by a health care professional. Complex case navigators are registered nurses, supervised by certified case managers. The case management process is dependent upon collaboration between treating physicians/facilities, member/families and the complex case navigator to develop and maintain a patient-specific care plan by coordinating resources that create flexible, quality, cost-effective health care options. The complex case navigator will provide a proactive approach that focuses on promotion of health education and member/caregiver empowerment through self-management. Medical behavioral, functional and social determinant of health needs are addressed to provide the best possible outcomes.

Members are identified by established complex case navigation criteria that are primarily diagnosis-driven and based on catastrophic illness/injury with the potential for high cost utilization. Identification can occur in real time, through a health risk assessment, during the prior authorization/referral process, during the inpatient review process, or by clinical analytics. Referrals can also be made from other areas of Clinical Services (pharmacy, medical directors, disease managers, outreach, or behavioral health). In addition, providers, physicians and associated health professionals, or employer groups may request complex case navigation services by contacting The Health Plan at 1.800.624.6961, ext. 7644, or by visiting healthplan.org. Family members and members can self-refer through the same process.

While enrolling the member in the program, the registered nurse will perform a disease-specific needs assessment over the phone.

A key aspect of the complex case manager's job is to assess the needs of the member from the holistic point of view, particularly identifying any potential behavioral health needs or gaps in social determinants of health such as housing and food security that must be addressed in order to help the member to achieve any proposed wellness goals. When those needs are identified, the complex care manager will make referrals and assist the member to locate necessary resources in their community.

After the assessment is complete, the complex care manager will develop a comprehensive personalized care plan that identifies and prioritizes goals and any potential barriers. After the care plan is created, associated interventions are formed and implemented with all problems identified. Complex case navigators may place referrals to other services within the Clinical Services Department to assist with goals. Pharmacists, licensed social workers, a clinical psychologist and medical directors often assist with complex medical case navigation. Care plan information is shared with the appropriate medical and behavioral providers, including utilization issues, gaps in care, and care need index scores. Referrals are placed to community resources as needed. The complex nurse navigator serves as the direct contact to coordinate care with all involved providers, resources, the member and family/caregiver as appropriate. The complex nurse navigator provides direction for appropriate utilization of health care resources. A schedule for telephonic follow-up, with educational support, is established with the member. The case navigator's direct contact information is provided to the member for interim questions/concerns.

Complex case navigator functions include, but are not limited to member assessment, education and the development of personalized goal driven care plans that focus on holistic health promotion and maintenance, self-management skills and improving access to care. The complex nurse navigator is also responsible for supporting medical and behavioral facility admissions when necessary, facilitating transitional care alongside a facility's discharge planners, and assisting with referrals to step down facilities or a level of care most appropriate to the member's needs. Services supported by the complex nurse navigator include facility-based care, home health services– private duty nursing, hospice, infusion services and Assertive Community Treatment– as well as outpatient services– intensive outpatient programming for behavioral health, dialysis, specialist care and assistance with obtaining DME. Ensuring that every member has the right care, at the right place at the right time is a core principle of the complex nurse navigator. The complex case navigators are here to support members and providers to ensure that medical and behavioral health benefits are understood, utilized and maximized to provide the best possible options and outcomes to our members.

Medical Complex Case Navigation Criteria

1. Transplant—organ and bone marrow/stem cell; includes evaluations, pending and post transplants
2. Catastrophic neuromuscular diseases such as multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis
3. Brain injury in active treatment
4. Cystic fibrosis
5. New spinal cord injury
6. Critical or major burns (1st or 2nd degree burns) covering more than 25% of adult's body or more than 20% of child's or 3rd degree burns on more than 10% body surface area or burns involving hands, feet, face, eyes or genitals
7. Immunodeficiency
8. Ventilator cases in home setting
9. Major congenital anomalies – atrial septal defect, valve stenosis and atresia, pulmonary artery stenosis, patient ductus arteriosus, craniofacial deformities, myelocystocele, myelomeningocele (such as spina bifida)
10. Premature birth (extreme) 28 weeks or less
11. Complex cancers in active treatment; with anticipated ongoing high cost care, including myelodysplasia
12. Children with special health care needs (CSHCN)
13. Hemophilia
14. Genetic abnormality with ongoing care, treatment or monitoring
15. Trauma – Complex needs in active treatment
16. Serious and persistent mental illness as evidenced by recurrent non-substance use related psychosis or mania with multiple emergent admissions (more than three admissions for CSU and/or inpatient psychiatric acute care per year)

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Social Work Services

The Health Plan's licensed social workers are available to assist members and their families with social determinants of health that may predispose the member to illness or interfere with obtaining the maximum benefit from their medical plan.

The Health Plan's social worker(s) coordinate with health care providers/practitioners and other THP department staff to identify members needing community resources. The social work staff assists our members with accessing needed services within the community.

Services provided by the licensed social worker may include:

- Providing education on how to access available benefits and resources to address out-of-pocket costs for members with financial difficulties and assisting with applications for assistance.
- Coordinating referrals to available resources such as Meals on Wheels, personal care or passport services, transportation services, waiver services and other appropriate supportive services.
- Giving caregiver support and counseling, as well as emphasizing the importance of caregiver self-care.
- Counseling to support members to develop self-advocacy skills to increase positive medical outcomes and quality of life.
- Assisting with discharge planning from a facility as a part of the transitional care team.
- Providing care navigation, per the set criteria, at the appropriate acuity level.
- Consulting or assisting the nurse navigators with procuring the appropriate community resources.

Providers identifying socio-economic needs of members of The Health Plan may contact the licensed social workers for referral for possible assistance programs or other supportive services at 1.800.624.6961, ext. 7644.

Chronic Disease Navigation Programs

The Health Plan's chronic disease navigation and health promotion programs are multidisciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes or pre-diabetes, chronic cardiac conditions such as coronary artery disease and chronic heart failure (CHF), and chronic obstructive pulmonary disease (COPD). The Health Plan's pregnant members are also identified and enrolled in either a low risk health promotion trimester education program or a high-risk perinatal program.

Chronic disease navigation programs support the practitioner-patient relationship and plan of care and emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies. The Health Plan programs continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health status. The elements of chronic disease navigation include understanding the course, clinical implications, and trajectory of specific diseases; identifying and targeting patients likely to benefit from intervention; focusing on prevention; and working toward resolution of resource-intense problems.

Program Content

Each navigation program includes **condition monitoring** that is ongoing and proactive. This allows the member, the practitioner, and the chronic disease navigator to assess how well the condition is being managed. Monitoring is done with regular clinical assessments with surveillance of pharmacological management, lifestyle management, and assessment of the member's understanding of the condition itself as well as the related co-morbid conditions likely to affect overall health status.

Member adherence to the program's treatment plan is an integral part of chronic disease navigation. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. High-risk members are called at periodic intervals. Detailed questions are asked about the member's condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life. Education is targeted at areas of concern based on the findings from a clinical assessment and functional inventory. Ongoing monitoring by the chronic disease navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the chronic disease navigator is determined by the severity of symptoms. This may result in daily contact in times of high-risk or concern. When home care is needed in high-risk cases, the chronic disease navigator works with the practitioner and a home care agency to coordinate necessary care and services.

In all instances, chronic disease navigation and health promotion programs must consider other health conditions that directly affect the member's overall health status. A multidisciplinary approach to chronic disease navigation enables the chronic disease navigator to develop a treatment plan that includes condition monitoring of co-morbid conditions frequently associated with chronic medical conditions such as depression and anxiety.

Because **lifestyle issues** are strongly linked with chronic disease and high-risk pregnancy, strategies to address current lifestyle and the need to modify behavior is addressed in every program. Whether members need interventions addressing issues such as smoking cessation or weight loss management, the chronic disease navigator can address readiness to change and to provide additional resources to affect needed change.

The Health Plan's chronic disease navigation and health promotion program elements include:

- Identification of best practice, evidence-based standards of care
- Intervention strategies and targeted outcomes
- Identification of the member and assessment of health status
- Proactive intervention to include the application of appropriate therapies and systematic surveillance of appropriateness of medication, education and counseling about daily self-management, and symptom management
- Tracking of the member's clinical and functional status over time
- Assessment of effectiveness of treatment and sharing of knowledge gained to achieve optimal member outcomes

Attention to all program elements and improvement in all of these areas will likely lead to improved outcomes for the many who are at risk or who suffer chronic diseases.

Please contact The Health Plan Chronic Disease Navigation Department at 1.330.834.2228 or enroll members online at healthplan.org.

Diabetes Program

The diabetes program is designed to modify risk factors associated with diabetes and pre-diabetes, as well as slow the progression of microvascular and macrovascular complications. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Members with diabetes require long-term, continual health care to maintain appropriate glycemic control and to decrease the risk of long-term complications such as neuropathy, nephropathy, and blindness. Program goals include:

- Glycemic control
- Reduction of risk factors
- Optimization of functional capacity
- Prevention of microvascular and macrovascular complications
- Facilitation and enhancement of the patient/doctor relationship

Program Content

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 294 and 295. Diagnosis codes include: E08.xx through E11.xx, E13.xx, and 024.xx. Other methods of identification include health risk screenings and direct referral by the primary care physician and specialist. Member stratification is based on severity of illness and co-morbid conditions.

The diabetes program relies on the population based HEDIS® comprehensive diabetes care measures for outcome analysis. The same measures are also used at the individual member level for those members stratified as high-risk and who participate in The Health Plan's telephonic diabetes navigation program. Primary attention is given to assisting the member in reaching and maintaining glycemic control. Daily self-blood glucose monitoring and quarterly A1C testing are the criteria used to monitor glycemic control. Additional criteria include lipid monitoring and control, dilated eye exam performance, and monitoring of kidney function.

Population-based chronic disease navigation strategies include the annual eye exam program, as well as appropriate educational mailings throughout the year. The provision of diabetic supplies and glucometers for self-monitoring of blood glucose and other diabetes benefits are important components of the program and are available through participating pharmacies for members with The Health Plan pharmacy benefit.

High-risk, moderate, low and pre-diabetes members receive telephonic chronic disease navigation intervention from a diabetes nurse navigator who provides individualized interventions that include the evaluation of appropriate medication use, education and counseling about self-management, surveillance of symptoms, and consideration of other health conditions based on nationally recognized American Diabetes Association (ADA) guidelines.

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the patient's condition and information is gathered about patient status, treatment plan adherence, functional status, and quality of life. Education is based on the ADA "Standards of Medical Care for Patients with Diabetes Mellitus." Ongoing monitoring by the chronic diabetes navigator ensures timely intervention in the event of a change in

risk status. The frequency of outbound calls to the member is determined by the severity of symptoms. This may result in daily contact in times of high-risk as well as consultations with the physician. When home care is needed, the chronic disease nurse navigator works with the home care agency to coordinate the necessary care and services.

A major component of the diabetes program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms of hyperglycemia and hypoglycemia are included. Each member contact includes a review of medications and medication compliance. Lifestyle issues are addressed through education and include the importance of exercise, diet, proper self-management skills, and when indicated, smoking cessation interventions. Members are also referred to certified diabetes educators and the Ohio Valley pharmacy care network (certified pharmacists in diabetes education), to increase member understanding of the disease process and enhance self-management skills.

A successful diabetes program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care each member receives from his/her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the chronic disease nurse navigator to coordinate the necessary care for the member. Evidence-based guidelines are available and recommended for use by the physician to medically manage their patients with diabetes.

Adult BMI Chart

The Adult Body Mass Index (BMI) Chart is available **here**.

Chronic Cardiac Conditions Programs

The chronic cardiac conditions programs are designed to modify cardiovascular risk factors and slow disease progression for members with heart failure and ischemic heart disease. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Program goals include:

- Reversal or stabilization of symptoms
- Optimization of functional capacity
- Improvement of quality of life
- Reduction in frequency of hospitalization
- Facilitation and enhancement of the patient/doctor relationship

Program Content

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 127. Diagnosis codes include: I21.xx, I22.xx, and I24.xx for ischemic heart disease and I50.xx for heart failure. Other methods of member identification include health risk screening and direct referral by the primary care physician or cardiologist. Member stratification is based on severity of illness using New York Heart Association classification.

The chronic heart failure program relies on population-based measures of assessment of left ventricular function, ACE inhibitor use, and hospitalization utilization. The same measures are used at the individual member level for those members stratified as high-risk and who participate in The Health Plan's telephonic chronic heart failure program. Primary attention is paid to the application of appropriate pharmacological therapies including the use of ACE inhibitors and beta-blockers, enhancement of self-management skills, and systematic surveillance of those with symptomatic heart failure to prevent hospitalization.

The ischemic heart disease program relies on population based - HEDIS® (1) measure of beta blocker usage for six months after a discharge for Acute Myocardial Infarction (AMI). The same measures are used at the individual member level for those members stratified as high-risk and who participate in The Health Plan's telephonic ischemic heart disease program. Primary attention is paid to the application of appropriate pharmacological therapies, lifestyle modification, enhancement of self-management skills, and systematic surveillance of those with symptomatic ischemic heart disease to prevent hospitalization or acute coronary event.

Population-based chronic disease navigation strategies include targeted educational mailings throughout the year. High-risk members receive telephonic chronic disease navigation intervention from a cardiac nurse navigator who provides individualized interventions that include the evaluation of appropriate medication use, education, and counseling about daily self-management, and member recognition of early signs and symptoms requiring intervention. Enrolled members receive home scales, referrals for nutritional education to address dietary compliance, referrals for home oxygen/respiratory therapy when indicated, and immunizations. Consideration of other health conditions, such as diabetes and chronic obstructive pulmonary disease are included in the management program.

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the patient's condition and information is gathered about patient status, treatment plan adherence, functional status, and quality of life. A specific plan of care is developed based on practice guidelines from the ACC/AHA. Guidelines for the Evaluation and Management of Chronic Failure in the Adult, Guidelines for the Management of STEMI and NSTEMI, and Guidelines for the Management of Stable Ischemic Heart Disease. Ongoing monitoring by the chronic cardiac conditions nurse navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to members by the nurse navigator is determined by the member's severity of symptoms.

This may result in daily contact in times of high-risk or concern as well as consultations with the physician. When home care is needed, the nurse navigator works with the physician and home care agency to coordinate the necessary care and services.

A major component of the chronic cardiac conditions programs is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. The warning signs are reviewed with each assessment call along with a review of medications and medication compliance. Lifestyle issues are addressed through education and include the appropriateness of exercise, diet, self-management skills, and when indicated, smoking cessation interventions. Patients are encouraged to keep a record of their daily weight and to notify the physician if they experience a weight gain of two pounds in one day to three pounds in one week.

A successful chronic cardiac conditions program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from his/her physician. The goal of the management program is to foster a collegial relationship between the physician and the nurse care navigator in order to coordinate the necessary and appropriate care for the member. Evidence-based guidelines are available on THP website and recommended for use by the physician to medically manage their patients with chronic heart disease.

Chronic Obstructive Pulmonary Disease Program

The chronic obstructive pulmonary disease program (COPD) is designed to modify risk factors associated with COPD as well as slow the progression of the disease. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Members with COPD require long-term, continual health care to maintain functional status and to help eliminate disease exacerbations. Program goals include:

- Slowing the progression or stabilization of symptoms of COPD
- Optimization of functional capacity
- Improvement in quality of life
- Reduction in frequency of hospitalization
- Facilitation and enhancement of the patient/doctor relationship

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 88. Diagnostic codes include: J41.xx, J42.xx, J43.xx, and J44.xx. Other methods of member identification include health risk screening and direct referral by the primary care physician or pulmonologist. Member stratification is based on severity of illness and frequency of hospitalization with exacerbations.

The COPD program relies on population-based measures of hospitalization utilization and emergency services utilization. The same measures are also used at the individual member level for those stratified as high-risk and who participate in The Health Plan's telephonic COPD management program. Primary attention is given to the evaluation of appropriate medication use, education, and counseling about daily self-management and recognition of early COPD exacerbations.

Population-based chronic disease navigation strategies include targeted educational mailings throughout the year. High-risk members receive telephonic chronic disease navigation intervention from a COPD nurse navigator specialist who provides individualized interventions that include the evaluation of appropriate medication use, education, and counseling about daily self-management and recognition of early signs and symptoms of COPD exacerbations requiring intervention. Enrolled members receive home scales, if needed, smoking cessation interventions, if indicated, referrals for nutritional education, referrals for home oxygen/respiratory therapy, when indicated, pulmonary rehabilitation, and immunizations. The Health Plan employs a smoking cessation member advocate that is certified through the American Lung Association in smoking cessation and instruction. Consideration of other health conditions, such as diabetes and chronic heart failure are included in the management program.

Initial management of acute exacerbations include identification of precipitating factors (e.g. infection, volume overload, pulmonary thromboembolism, environmental changes, or overuse of sedating medication) and tailoring drug therapy according to:

- The degree of reversible bronchospasm
- Prior therapy at a stable baseline
- Recent pharmacotherapy and prior medication toxicity
- Presence of contraindications to specific medications
- Specific therapies indicated by the precipitating cause of the exacerbation

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the member's condition and information is gathered about health status, treatment plan and adherence, functional status, and quality of life. Ongoing monitoring by the COPD nurse navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the nurse navigator is determined by the member's severity of symptoms. This may result in daily contact in times of high-risk or concern as well as consultations with the physician. When home care is needed, the nurse navigator will work with the physician and home care agency to coordinate the necessary care and services.

A major component of the COPD program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms are included in the teaching process. These warning signs are reviewed at each assessment call along with a review of medications and medication compliance. Education also includes the appropriateness of exercise, diet, self-management skills, the proper use of metered dose inhalers, and when indicated, smoking cessation interventions.

A successful COPD program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from his/her physician. The goal of the management program is to foster a collegial relationship between the physician and the complex case navigator in order to coordinate the necessary and appropriate care for the member. Evidence-based guidelines are available and recommended for use by the physician to medically manage their patients with COPD.

Perinatal Care Program

The perinatal care program is designed to improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing perinatal education, promoting safe health behaviors, and enhancing the management of maternity care for women identified at high-risk for premature labor and delivery. Program goals include:

- Reduction in the incidence of preterm births
- Reduction in the incidence of low birth weight babies
- Reduction in the number of neonatal intensive care unit days
- Provision of improved perinatal education, promotion of safe health behaviors, and enhanced management of maternity care for women identified as high-risk for premature labor and delivery

Program Content

Member identification and enrollment is initiated once a pregnant member is identified or a referral is received. Referrals may come from the physician, The Health Plan outreach program, self-referral, and claims data. Physicians are provided a perinatal risk screening tool to fill out and forward to The Health Plan.

The targeted time for enrollment of all members is between 12 to 15 weeks gestation. A telephonic assessment of the clinical and psychosocial status of the member is completed by outreach staff at enrollment and again at week 24. Consideration is given to other health conditions. The assessment tool, along with the perinatal risk screen completed by the physician, is reviewed by the program nurse navigator. The mother-to-be is placed in the appropriate low-risk pregnancy group or the high-risk pregnancy group to be case managed.

A late referral education component is available for those women enrolled after 34 weeks gestation. A partial program is offered for those individuals who decline to enroll in the complete program but who want to receive educational materials.

The identification of low-risk Medicaid pregnant women early in pregnancy is designed with the intent of improving the outcome of the pregnancy. Educating the pregnant woman on healthy lifestyle measures reduces risk factors throughout the pregnancy. The low-risk pregnant woman receives an initial assessment, a second trimester assessment, a third trimester assessment, and post-partum assessment conducted by the Outreach Department. The final call ensures the well-being of mother and child.

All Commercial and Self-Funded member pregnancies identified by claims data are offered participation in the prenatal program. After the initial assessment is completed, the program nurse navigator contacts the member every four to six weeks to follow-up on their status and provide education for uncomplicated pregnancies. High-risk members in these groups are followed per high risk protocol.

High-risk pregnancies are monitored and managed aggressively as early as possible and continuously throughout the pregnancy. This group receives general educational mailings as well as specific educational materials based on assessment findings. All participants receive proactive calls from the perinatal care nurse navigator. The perinatal nurse navigator promotes positive outcomes

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for the pregnancy through individualized interventions. A specific plan of care is developed based on the risk status. Ongoing monitoring by the perinatal care navigators ensures timely intervention in the event of a change in risk status. The frequency of outbound calls to participants by the perinatal nurse navigator is determined by the severity of pregnancy risks and complications. This may result in daily contact in times of high-risk or concern. When home care is needed in high-risk cases, the perinatal nurse navigator works with the physician and home care agency to coordinate the necessary care and services.

A major component of the program is to educate the pregnant woman on proactive and healthy lifestyle measures that reduce risk factors throughout the pregnancy. This is achieved by referring members to educational links on THP's website or providing mailings of educational materials upon request. Verbal education addressing perinatal care, birth alternatives, newborn care, pregnancy wellness and patient-specific risk factors are completed by the nurse navigator. Lifestyle issues such as illegal drug use and smoking are addressed. Smoking cessation interventions are a major focus for those members who are identified as smokers or recent smokers. ACOG and March of Dimes links are provided on THP's website.

All identified pregnant members receive an initial mailing to introduce them to the pregnancy program. Smoking cessation is offered telephonically as a major component of the program.

A successful perinatal care program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the perinatal nurse navigator to coordinate the necessary health care to promote a healthy mother and a healthy baby.

Advance Care Planning

At the beginning of 2016, the Centers for Medicare and Medicaid Services (CMS) established separate payments for Advanced Care Planning (ACP) services provided to Medicare beneficiaries. This provision allows for effective communication between patients and their providers to plan for the member's future care.

- CPT code 99497- ACP services provided as part of an Annual Wellness Visit (AWV)

*If the ACP is furnished on the same day, by the same provider, the visit is considered a preventive service. Therefore, the deductible and co-insurance are not applied to the codes.

Provider's Role:

1. Initiate a conversation with all members of The Health Plan over the age of 18.
2. Promote and support THP members' advance care planning. Document if the member does or does not have an advance directive. Provide them with educational material to help them understand the importance of such documents.
3. Honor their wishes as outlined by their advance care plan and do not discriminate against any member based on the existence or content of their advance directive.
4. Transfer any member whose advance directive you refuse to follow.

Compliance with advance directive policies is part of The Health Plan's quality review process. Annual audits will be conducted to ensure compliance.

If the member has signed an advance directive, a copy should be retained in the medical record.

To comply with guidelines, all members of The Health Plan 18 years old or older must have documentation on their chart that advance care planning has been discussed, reviewed, and updated at a minimum of every three years.

State-specific information regarding advance directives and The Health Plan Envelope of Life is available on our corporate website

Leadership and Committees

CMO and Medical Directors

The CMO and medical directors of The Health Plan provide leadership and direction for all utilization management and quality improvement activities. This team plays an important role in the development of the quality management program and supervises quality improvement plans and initiatives. One of the medical directors serves as chairman for each of the following committees:

- Quality Improvement Committee
- Credentialing Committee
- Medical Directors Oversight Committee
- Physician Advisory Committee
- Transplant and New Technology Committee
- Appeal and Grievance Committees

The medical directors are solely responsible for denials of authorization decisions based on medical necessity. They will communicate with primary care physicians, attending physicians, and specialist reviewers as necessary for case discussions.

Other responsibilities of The Health Plan medical directors include:

- Decision making regarding medical appropriateness of care and services
- Review of ALL appeals
- Physician education regarding practice patterns

One of The Health Plan's medical directors is available 24 hours a day, seven days a week and can be reached for emergencies via The Health Plan Nurse at 1.866.NURSEHP (1.866.687.7347) or during normal business hours toll-free at 1.800.624.6961, ext. 7644.

Physician Advisory Committee

The physician advisory committee is a collaborative committee established to receive input from the physician community to guide The Health Plan in its decision making related to medical policy affecting coverage and reimbursement for physician services and to discuss issues related to relationships and interactions between and among physicians, their patients, and The Health Plan.

These issues may include but are not limited to: (a) improvement of health care and clinical and quality through the establishment of clinical and quality guidelines; (b) improvement of communications, relations, and cooperation between physicians and The Health Plan; and/or (c) matters of a clinical or administrative nature that impact the interaction between physicians and The Health Plan.

In addition, physicians serving the Physician Advisory Committee (PAC) may also serve as specialty reviewers, based on board certification and field of expertise. The PAC functions as a subcommittee of the Medical Directors' Oversight Committee (MDOC).

Members of the committee shall include a representative sample of specialty areas that may include family practice, behavioral health, internal medicine, obstetrics and gynecology, orthopedics,

pediatrics, surgery and medical sub-specialists. Committee members may be asked to serve consecutive terms.

Meetings may be held as actual onsite meetings at central or regional locations with telecommunications accessibility. PAC members may also review guidelines, InterQual®, and other policy and procedural changes related to his/her expertise via mailings.

Medical Directors' Oversight Committee (MDOC)

The MDOC is comprised of The Health Plan's CMO, medical directors, and various other department leads in Clinical and Pharmacy Services, Quality Improvement and Population Health. The committee oversees the activities of the PAC and ensures issues are dealt with in a timely and appropriate manner. The key functions of the committee are to provide oversight to programs within clinical services, assist in identifying trends and practice pattern variations and develop and initiate interventions as needed.

Transplant and New Technology Committee (T&T)

The T&T Committee is comprised of The Health Plan's CMO, Medical Directors, and other clinical professionals as the topic dictates, nurses, psychologists, pharmacists, etc. The T&T Committee evaluates new medical technologies and the new application of existing technologies including medical procedures, drugs, devices, and transplants to determine medical efficacy and appropriateness of treatment in standard medical practice.

The T&T Committee is responsible for the development of coverage and review guidelines to assist in determinations of medical appropriateness based on current supporting documentation available at the time of the review or request of a particular technology service. Resources utilized in the committee review process may include:

- Centers for Medicare and Medicaid Services (CMS) coverage policies (national and local)
- Winifred S. Hayes, Inc. independent technology assessments
- Federal and state regulatory agency guidelines and mandates
- Clinical outcome studies and data in peer-reviewed published medical literature
- Positions of nationally recognized health professional societies and colleges
- Managed care organizations
- Technology and research agencies
- Opinions of physicians and practitioners in relevant clinical areas

Periodically, and upon request, the committee will revisit and revise previously rendered review guidelines to establish if changes or updates are needed based on updated information on the technology, procedure, or service. Information for review consideration may be forwarded to the committee via email at ttcommittee@healthplan.org.

Appeal and Grievance Committees

The Appeal and Grievance committees are composed of Clinical, Operations, Benefit Services, Quality, Compliance and other staff as needed. They are line of business specific for The Health Plan's Commercial, Medicaid and Medicare lines of business. These committees convene when necessary to impartially discuss and decide upon a request to reconsider coverage determinations when the member and/or provider are dissatisfied.

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy and Therapeutics Committee is responsible for the formulation and adoption of policies regarding the appropriate evaluation, selection, procurement, distribution, use, and safety of drug therapies. The committee recommends and assists in the development of programs and policies for participating practitioners in all areas pertaining to drug therapy for The Health Plan membership. The committee's composition includes physicians, pharmacists, and representation from The Health Plan. The Pharmacy and Therapeutics Committee reports quarterly to the Quality Improvement Committee.

Annual Program Evaluation

The medical management program and the quality management program are evaluated on an annual basis. A written summary is prepared from the evaluation process that includes utilization and quality management activities during the year, achievement of goals, and revisions for the upcoming year.

The annual program evaluation is approved by the Executive Management Team (EMT) and the Quality Improvement Committee.

Forms, Tools and Worksheets

- The Medical Prior Authorization and Notification Form is available **here**.
- The Molecular Pathology Request Form is available **here**.

Section 8

Population Health

Population Health Management

The Health Plan has a population health management strategy that identifies and stratifies our enrollment population based on medical conditions, risk factors, and social determinants of health.

Data is reviewed to assist in developing programs to meet the needs of various risk groups and engage both members and providers in improving the overall health of the populations.

The population health management team completes a population assessment by evaluating trends of prevalence and financial burden of medical conditions, both chronic and episodic, utilizing analytical software, claims data, business intelligence reporting and care navigation engagement reporting and outcomes.

The intent of the analysis is to develop specific programs to support the four focus items of population health management:

- Keeping members healthy
- Managing members with emerging risk
- Outcomes across healthcare settings
- Managing multiple chronic conditions

Integration of data for this assessment includes medical and behavioral claims and encounter information, pharmacy claims data, laboratory claims, lab values and results. Additionally, information obtained from health risk assessments is analyzed to identify social determinants of health and barriers to care. Electronic health records may also be available through shared portal access with providers. Other various data points include clinical assessments performed by Clinical Services Department nurse navigators and member outreach as well as vendors who may be providing in-home assessments. Data available through licensed software are also incorporated into the analytical process.

The population assessment is completed to determine:

- Needs across The Health Plan service areas
- Which members should be targeted for various care navigation
- Disease management and social services programs
- Whether the current programs are meeting the needs of the population

Included in the assessment is the review of gaps in care related to evidence-based practice as well as member satisfaction with clinical services programs. Data are reported in aggregate and by product line to facilitate an understanding of similarities and differences in health needs and status according to geographical influences. Additionally, further analysis of specific high-risk groups, such as children with special healthcare needs, members with disabilities, and those with severe and persistent mental illness, is completed to ensure the needs of those members are identified.

Examples of social determinants of health that are identified as barriers to care include:

- Transportation and/or lack of transportation
- Mobility issues
- Food insecurity
- Social isolation

The analysis of this comprehensive assessment is shared internally at The Health Plan as well as with network physicians to support alternative payment relationships, including value-based arrangements.

Provider Analytics Program

The Health Plan's mission is to improve healthcare costs and quality. Sharing data is the initial step in preparing for future value-based reimbursement payment. The Health Plan has developed a provider analytics process that uses CCGroup Marketbasket SystemTM analytical software to build episodes of care from claims data and tie them to specialty-specific medical conditions most commonly seen in clinical practice. The episodes are analyzed for trends related to cost, utilization, and adherence to evidence-based quality measures in order to create comparative peer-to-peer physician scorecards with provider efficiency and effectiveness scores.

The first step in introducing this comparative analysis is to provide historical data to primary care providers. This is completed via face-to-face meetings with large practice groups or on The Health Plan's secure provider portal. Reports will provide insight into utilization of services and quality of care measures related to patient care and a comparative peer-to-peer analysis.

Additional information explaining the CCGroup Marketbasket SystemTM methodology and our Provider Analytics Program is available on the provider portal to assist with understanding the information presented in the reports.

HEDIS®

Healthcare Effectiveness Data & Information Set (HEDIS®)

The HEDIS® audit contains a core set of performance measures that provide information about customer satisfaction, specific health care measures, and structural components that ensure quality of care. Annually, The Health Plan is required to report performance measures set forth by HEDIS, to NCQA, CMS, and BMS.

The HEDIS audit takes place annually between January and June and administrative (claim) data is used when applicable. The Health Plan contracts with an outside vendor to assist with medical record retrieval needed for each of the applicable performance measures. A representative from our vendor may contact the office for chart retrieval. There may be an instance that our nurse(s) may need to visit the office and every effort will be made to coordinate the onsite visit to accommodate the provider and office staff.

To support performance measurement, the Population Health unit produces care gap reports to identify members with gaps in care according to HEDIS quality measures specifications. The Health Plan provider engagement representatives can distribute these gap reports to primary care physicians. Gap reports are run monthly based on a proactive review of members' claim history. Gap reports can be run by TIN, PCP, or quality measure.

Appropriate coding by measure is outlined in the HEDIS 2020 Coding Guide. The HEDIS coding guide is updated annually and is available **here**, on the THP corporate website, or by request from your THP provider engagement representative.

In addition to utilizing care gap reports and the appropriate HEDIS codes for services rendered, providers can submit clinical documentation for HEDIS measures via fax to the Population Health team at 1.304.433.8208 or by contacting your provider engagement representative.

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Dilated Fundus Exam

The population health team requests that our eye care physicians complete and submit the form below upon the completion of all diabetic eye exams. The completed form provides supporting documentation of the examination results to meet the Comprehensive Dia betes Care quality measure. Forms can be submitted with your claim or to the population health team via fax at 1.304.433.8208.

The Dilated Fundus Examination Form can be found **here**.

Quality Improvement

Introduction

The Health Plan Quality Management Program consists of quality improvement projects, and the collection and analysis of data to identify and track quality of care issues or concerns. Interventions are based on recognized industry standards, and the outcome of projects is objectively measured.

Goals and Objectives

1. Demonstrate compliance with external Quality Management regulators and programs
   - The National Committee for Quality Assurance (NCQA)
   - Centers for Medicare and Medicaid Services (CMS)
   - Qlarant - External Review Organization for WV DHHR
   - West Virginia and Ohio Departments of Insurance
2. Establish standards and processes for measuring and improving the quality of care and services provided to members
   - Clinical Care Indicators
     - Medical/Surgical Variance Investigation
     - Behavioral Health Variance Investigation
     - Medicare and Medicaid / CMS Driven Investigations
       - Never Events (NE)
       - Hospital-Acquired Conditions (HAC)
       - Health Care-Associated Conditions (HCAC)
   - Customer Satisfaction Indicators
     - Member Complaint Investigation
     - Physician Change Report Reviews
   - Care and Service Indicators
     - Clinical Practice Guidelines
     - Standards for Patient Records and Access to Care and Services
       - Medical Record Audit
   - Quality Management document annual review and revision
     - Quality Management Evaluation
     - Quality Management Program
     - Quality Management Work Plan– The work plan is an annual document that designates each department's quality management priorities for the year and tracks progress towards meeting these goals. The work plan provides detail on the organization's identified priorities and describes the activities undertaken to address the quality and safety of clinical care and members' experience. The Health Plan utilizes the work plan as a method for interdepartmental communication.
     - Quality Management Policies and Procedures
3. Utilize a multi-disciplinary approach to identify areas where improvement is needed
   - Implement and monitor corrective action plans
   - Collaborate with nursing, medical directors, and pharmacy
   - Demonstrate improvement in the quality of medical care and services provided to members as a result of quality management initiatives

Quality of Clinical Care Indicators

The Quality Management Department monitors quality of care concerns centered on evidence-based guidelines. A Nurse Quality Coordinator performs a root cause analysis on each quality of care concern. If the concern is found to be valid, it is forwarded to the Program Integrity Team to determine reimbursement.

The guidelines used can be found at:

- Agency for Healthcare Research and Quality (AHRQ) for PSI 90 Patient Safety Indicators
- National Healthcare Safety Network (NHSN) for healthcare-associated infections
- National Quality Forum (NQF) for serious reportable events

Customer Satisfaction Quality Indicators

The Health Plan investigates and tracks every complaint, grievance, or report of member dissatisfaction. Member complaints, grievances, and/or dissatisfactions are registered with the Customer Service Department or the Quality Management Department.

Indicators of dissatisfaction include:

- Quality of Care
- Access
- Attitude/Service
- Billing/Financial Service by The Health Plan
- Quality of practitioner office site

Review Process for Clinical and Customer Service Quality Indicators

Anyone within The Health Plan organization can identify a customer satisfaction or quality indicator. When any of these indicators are identified, the potential issue is forwarded to the Quality Management Department. A Nurse Quality Coordinator performs a case analysis on the potential issue and obtains medical records to review. A letter of inquiry may be sent to the facility or practitioner, requesting review or clarification of an issue. The letter may include a request for a written analysis or opportunities for improvement established by the facility or practitioner based on the complaint. The Health Plan is dedicated to ensuring that all Federal and State Laws, rules, and regulations are compiled in a timely and effective manner, including The Center for Medicare and Medicaid Services (CMS), The Bureau for Medical Services (BMS) and The Department of Insurance.

* If The Health Plan decides that a practitioner is practicing medicine in a manner that is not keeping with reasonable and prevailing standards of care, a corrective action plan may be requested. If the Quality Improvement Committee (QIC) determines that corrective action is needed, the practitioner will be notified in writing. Corrective measures may vary according to the situation and might include any or all of the following:

- A written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review per medical record or claim data reviews
- Requiring the practitioner to enter into a preceptor relationship with another practitioner
- Requiring the practitioner to complete continuing medical education specific to the tre atment, procedure or service in question
- Setting limitations on the practitioner's privileges or authority to perform specific procedures

Continuity and Coordination of Care

The Health Plan strives to support and enhance the partnership of members and primary care practitioners, to ensure continuity and coordination of care, and member understanding of and participation in their care. All practitioners/providers involved in a member's care must share clinical information with each other and the member in a timely fashion. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate the treatment plan's implementation. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion. The Health Plan's policy regarding continuity and coordination of care states that:

- The primary care practitioner (PCP) bears primary responsibility for coordinating the member's overall health care in a manner consistent with the member's own goals and preferences. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate the implementation of the treatment plan. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion. (Refer also to CL-24).
- Practitioners/providers must document member input in all treatment plans submitted for authorization; Clinical Services/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services.
- When required, nurse navigators will educate members regarding their rights and responsibilitiesto provide input to practitioners/providers as to their care preferences, and document such education appropriately.

  Nurse navigators, will, where appropriate, advise members and practitioners/providers of available training in self-care, health promotion, etc. This advice should include information about non-covered community resources, as well as, The Health Plan coverage for such services as dietary consults, smoking cessation programs, certified diabetic education, home health nurse educators, wound or ostomy care teaching, home infusion services, etc. and are documented.
- The Health Plan does not prohibit a health care professional from advising and advocating on behalf of a member.
- Health care practitioners should provide information about the findings, diagnoses, and treatment options regardless of coverage, so the member has the opportunity to decide among all relevant treatment options.
- The member should be given information about the risks, benefits, and consequences of treatment or non-treatment. They should be provided a choice to refuse treatment and discuss their preferences about failure treatment decisions.
- Nurse navigators will periodically review treatment plans with their members to ascertain progress and compliance. These reviews will be shared with the primary care practitioner, and updated plans requested where appropriate. This process and outcomes are documented.

Standards for Access to Care and Services

Appointment Accessibility Standards for PCPs

Routine Non-Urgent/ Preventive Care (well exams, annual physicals, routine screenings, preventive care, blood pressure checks, wound checks, etc.)	Within 14 calendar days (exceptions permitted at specific times when PCP capacity is temporarily limited)
Urgent Care (sprains/strains, minor burns, etc.) If not treated, it could result in a more intense level of treatment.	Within 48 Hours (2 days)
Not Urgent/Sick Care (symptomatic care for cold/ flu, sore throat, etc.)	Within 48 Hours (2 days)
Emergent Care (requires immediate evaluation & treatment. May be sent to ER for chest pain/heart attack, paralysis/stroke, etc.)	Immediately (same day) or send to ER or call 911 seven days a week
Pediatric Urgent Care	Same day
Physical Exams	Scheduled within 180 calendar days
Preventive/EPSDT Services	Scheduled per EPSDT guidelines and the EPSDT Periodicity Schedule within 30 days

***In-office waiting for appointments must not exceed one hour from the scheduled appointment time.**

After Hours Accessibility

After Hours/Week-Ends/Holiday Care Accessibility – Primary care physician/practitioner or a designated covering practitioner should be available to The Health Plan members within **one hour** of their leaving a message or contacting the answering service.

Prenatal Care Accessibility

Appointment Accessibility Standards For OB/GYN – An initial prenatal care visit must be scheduled within 14 calendar days of the date when the woman is found to be pregnant. First and second-trimester visits must be scheduled within seven days of the request. Third-trimester visits must be scheduled within three calendar days of the request. For high-risk pregnancies, appointments must be scheduled within three calendar days of identification as high-risk.

Specialty Care

Specialty care providers should provide appointment access within 30 days for new or established patients. Appointment access should be granted sooner for cases where it is medically appropriate or indicated. In-office waiting for appointments must not exceed one hour from the scheduled appointment time.

Behavioral Health Appointment Accessibility Standards

Initial Visit for Routine Care	≤ 10 Working days
Follow-up Routine Care of an initial visit for a specific condition Prescribers Non-prescribers	 ≤ 30 Working days ≤ 20 Working days
Follow-up after Inpatient Stay	≤ 7 days of discharge
Urgent Care - Experiencing worsening of symptoms or new symptoms, that if not treated, could result in a more intense level of treatment.	≤ 48 hours
Non-Life-Threatening Emergency Care - Extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, compromised ability to function, or is otherwise agitated and unable to be calmed.	≤ 6 hours
Emergency Services	Immediately

Behavioral Health

Introduction

The Health Plan strives to ensure the highest quality of care for our members. The Health Plan collaborates with providers/practitioners and members to coordinate care. Our staff works directly with providers/practitioners and members to make available resources known within the provider and community network. Our customer service representatives, nurse navigators, and member advocates are available to assist providers/practitioners and members in obtaining and locating needed services.

The Health Plan's nurse navigators, also referred to more familiarly as care managers, blend behavioral components (such as motivational interviewing with disease management and other aspects of medical and behavioral health case management) to address the member holistically to provide the best possible outcomes. The care manager may link the member to primary care, specialty care, and behavioral providers/practitioners, as well as address social determinants of health.

Please refer to ***Section 7*** for information that may assist providers in obtaining integrated care for their patients.

The Health Plan's 24-hour phone number is 1.866.NURSEHP (1.866.687.7347) for any patient needs. This number is answered by nurse navigators who will be able to assist providers/practitioners and members.

Requests for prior authorization of treatment may be submitted telephonically at 1.877.221.9295, electronically through the secure provider portal or by fax to 1.866.616.6255. This fax is secure. Forms are available on The Health Plan website.

Behavioral health admissions may be reported by phone to 1.800.304.9101 24 hours a day/7 day a week (reverts to voicemail after regular business hours).

Information may be emailed to The Health Plan's secure email at behavioralhealthdocuments@healthplan.org.

Remember, The Health Plan does not require prior authorization for crisis encounters or in plan psychotherapy visits. In plan medication management visits do not require prior authorization for any fully funded or governmental line of business. However, prior authorization may be necessary for these and all other services for employer-funded groups *based* on individual plan documents. Behavioral health customer service representatives can be reached by calling 1.877.221.9295 for any questions regarding prior authorization requirements.

Refer to ***Section 5*** for behavioral health services, prior authorization requirements, covered services and instructions specific to the West Virginia Medicaid line of business.

Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, his/her circumstances, medical history, and availability of care and services within The Health Plan network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the physician advisory committee. In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

InterQual® Review

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider/practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call The Health Plan's Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care. InterQual® review worksheets are available upon request.

The Health Plan uses InterQual® guidelines for most procedures and services other than for Medicaid groups for whom West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services (see provider manuals at wvdhhr.org/bms). Refer to The Health Plan's prior authorization list for lines of business other than Medicaid located at healthplan.org "For Providers," "Prior Authorization and Referrals."

Refer to ***Section 5*** to receive Medicaid Behavioral Health specific details.

Please indicate if your request is emergent so that we may expedite the review. Simply scheduling the testing/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by The Health Plan.

See authorization request forms for necessary prior authorization information related to behavioral health services located on the provider portal "Forms," "Behavioral Health Forms".

Behavioral Health Prior Authorization and Notification Requirements

The Behavioral Health Prior Authorization and Notification Requirements are available **here**.

Review of Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation

All inpatient services require admission, concurrent and discharge review by The Health Plan. Only elective admissions may require a preauthorization. Substance Use Disorder residential treatment facilities and Medicaid Crisis Stabilization Units are permitted the first three days of stay without prior authorization in order to maximize the clinical information available at the first authorization review. Intensive Outpatient Programs and Partial Hospitalization Programs are outpatient services that provide a less intensive level of care and The Health Plan amended authorization requirements for these services to allow the first 30 sessions free of authorization for in network providers.

Information may be provided to The Health Plan electronically via the secure provider portal, by fax or telephonically. Faxes should be sent to 1.888.329.8471. For telephonic reviews, call 1.800.304.3101. This number reverts to secure voicemail after normal business hours. This information will be accessed by authorized personnel only.

Forms used in requesting authorization for services are available on The Health Plan's provider portal under "Forms," "Behavioral Health Forms." This information may also be submitted on facility forms. Note that for Medicaid substance use disorder admissions, providers may utilize the form approved for common use by the Bureau for Medical Services or the form developed by The Health Plan is equally acceptable. Both are available as described above.

Reviews are expected on the day of admission with the exceptions described above. If the admission occurs late in the day, on a holiday or weekend, the facility is requested to notify THP immediately and to provide complete clinicals on the next working day. When the admission is approved, the date for concurrent review will be established and conveyed to the provider. This does not apply to admission reviews governed by state law. The Health Plan abides by mandated guidelines.

If the information submitted does not meet review criteria for admission, The Health Plan nurse navigator will forward the clinical information for review to a physician for evaluation. The physician will utilize nationally recognized criteria to provide a clinical review of the case and provide a medical appropriateness determination. A peer to peer discussion may be requested of the facility clinical staff with THP medical directors. The provider/practitioner will be notified when a determination is made. If there is an adverse decision, the provider has an opportunity for reconsideration and further review or the member or their designated representative may appeal as per policy for line of business. A provider may request a peer to peer consultation with a The Health Plan physician at any time.

Intensive Outpatient Services (IOP)

Intensive outpatient services are an intermediate level of care in which individuals are typically seen as a group and individually at least three times per week, three hours per day, depending on the structure of the program. IOP for WV Medicaid members must be conducted in programs certified by the Bureau for Medical Services. The first 30 sessions are permitted without authorization.

- Concurrent reviews may be submitted after 30 sessions by fax, phone or electronic transmission.
- If the sessions meet criteria for continued programming, the nurse navigator will continue to allow the course of treatment and inform the facility of the date when the next concurrent review is due. This will continue until discharge.
- Discharge clinicals may be submitted in the same manner as admission and concurrent reviews.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for physician review prior to denial of services.
- IOP services must be preapproved after the initial 30 sessions.. Facilities providing IOP to WV Medicaid members must be certified by the Bureau for Medical Services.

Partial Hospitalization (PH)

Partial hospitalization is an intermediate level of care for behavioral health c onditions. Services are rendered by an accredited program in a treatment setting for behavioral health and/or substance use disorder. The program is an alternative to, or a transition for, traditional inpatient care for members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. Members participate in this structured program up to five days per week, usually four to five hours per day. Medication management is an integral aspect of partial hospitalization services.

Facilities are expected:

- After the first 30 sessions, authorizations will be issued for the appropriate number of visits. Continuing services must be reviewed concurrently as advised by utilization management. A continued authorization form for these specific services is available.
- If the sessions meet criteria for continued programming, the nurse navigator will continue to allow the course of treatment and inform the facility of the date when the n ext concurrent review is due. This will continue until discharge.
- Discharge clinical information may be submitted in the same manner as concurrent reviews.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for medical director review to determine medical necessity.
- Facilities providing partial hospitalization to WV Medicaid members must be certified by the WV Bureau for Medical Services.

Observation

Observation is a facility-based treatment providing a level of service lower than inpatient, however providing a safe environment to stabilize the member's conditi on in an emergency situation. After the observation period has expired, if the member is not ready for discharge, he/she will be transitioned to another level of care. **Please note that observation is not a covered benefit for behavioral health for WV Medicaid members.**

Inpatient Acute Psychiatric and Detoxification Services

Inpatient services are acute psychiatric or detoxification services delivered in a psychiatric, unit of a general hospital or in a free-standing psychiatric facility. The acute care services provided include assessment, individual and group therapies, medication management and attention to medical problems with all care coordinated by the physician. Inpatient hospitalization is usually a short-term stabilization and treatment of an acute episode of behavioral health problems.

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member's primary care physician (PCP), referring participating specialist or admitting provider/practitioner with the nurse inpatient navigators.

Notification of urgent/emergent admissions by the admitting facility is required at the time of admission. Clinical information is expected within 48 hours of admission. This activity is performed for early discussion of member's needs as related to the admission, alternative health care services and discharge planning. The Health Plan has a process in place for post stabilization care to ensure continuity of care for members requiring post stabilization medical and behavioral care and services out of plan or when network providers are temporarily not available or accessible.

All out-of-plan and tertiary requests require a referral and prior authorization. Clinical information is reviewed for availability of service within the in-plan network, urgent/emergent situation, or other extenuating circumstances and should be supplied by the behavioral health provider/ practitioner.

Concurrent review is the process of continued reassessment of member progress and discharge planning. Any member identified with potential discharge planning needs is referred by behavioral health's nurse inpatient navigator to the complex case nurse navigator, the care navigator or social worker, as appropriate for early intervention. Concurrent review is performed telephonically, by fax or by electronic transmission. For facility convenience, admission and concurrent or discharge review information forms, as well as a substance use disorder forms are available. These reviews involve communication with physicians, hospital UR, social workers, and family members, as necessary. Any time a quality of care issue is identified or suspected, the case is referred to The Health Plan Quality Improvement Department for review.

Inpatient rehabilitation facilities

THP will reimburse for treatment in inpatient rehabilitation facilities such as Substance Use Disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities for Medicaid individuals under age 21 (PRTF), for adult psychiatric rehabilitation facilities depending on benefit plan and short-term residential eating disorder programs depending on the terms of a specific benefit plan. All such treatment must meet medical necessity criteria and must be authorized. Admission to a SUD residential program must be authorized within 72 hours and the program must be approved by the Bureau for Medical Services for WV Medicaid members. Please call customer service to obtain information regarding a member's specific benefit plan at 1.800.624.6961.

Outpatient Prior Authorization and Referral Management

Members are afforded direct access to behavioral health practitioners. No prior authorization is necessary for crisis visits or any urgent or emergent service. Authorization is no longer needed for psychotherapy visits if the member group follows The Health Plan prior authorization list.

Psychological testing may be provided without authorization if the units of service remain within the authorization-free guidelines, depending on the specific benefit plan.

Please refer to the following list of psychological tests that are reimbursable by THP. The chart explains the unit of service, if it is available via telehealth, if prior authorization is required, and any qualifying conditions that must be met.

Psychological Testing

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
96112	Developmental test administration by qualified professional with interpretation and report	First hour	No	No	Interqual	May only be billed one per event, may only be performed once per year per provider
96113	Developmental test administration by qualified professional with interpretation and report	Each additional 30 minutes	No	Yes after 6 Units	Interqual	Billed in conjunction with 96112, may not be billed in conjunction with any other psychological testing code other than 96130 and 96131, once per year per provider
96130	Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers	First hour	No	No	Interqual	May be billed in conjunction with other psychological testing codes, maximum one unit, may only be billed once per year per provider

Psychological Testing, continued

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
96131	Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers	Each subsequent hour	No	Yes, after one unit	Interqual	May be billed in conjunction with other psychological testing codes, may only be billed once per year per provider
96132	Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers	First hour	No	Yes	Interqual	May be billed in conjunction with 96136 and 96137 once per year per provider, maximum one event
96133	Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers	Each additional hour	No	Yes	Interqual	May be billed in conjunction with 96132, 96136, 96137 once per year per provider
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method	First 30 minutes	No	No	Interqual	May be billed only once per event, may not be used for administration of screening tools, may be billed in conjunction with any other testing code other than 96112 and 96113 once per year per provider, maximum one event

Psychological Testing, Cont.

Code	Descriptor	Units of service	Available by telehealth?	Authorization required?	Criteria	Notes
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method	Each additional 30 minutes	No	Yes after 6 units	Interqual	Billed in conjunction with 96136, may be billed in conjunction with any other psychological testing code except 96112 and 96113, may not be used for administration of screening tools, once per year per provider
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only	Event	No	No	Interqual	May be billed in conjunction with other psychological testing codes
96116	Neurobehavioral status exam, administration, face to face time with patient and time interpreting test results and preparing report	Event	No	No	Interqual	One per six months per provider, must be performed by qualified professional

*** Grid is THP policy until development of BMS manual and standards for Medicaid members. Non par providers must obtain prior authorization for all events.
*** Non par providers must submit authorization request for all services.

Remember that additional services may require prior authorization based on specific plan requirements; some may require prior authorization for all services (i.e., ASO depending on group plan documents).

There may be additional services that will require medical director review. Contact The Health Plan if you have a concern regarding a particular procedure or test.

All out-of-plan and tertiary requests require a referral and prior authorization. Clinical information is reviewed for availability of service within the in-plan network, urgency/emergency of the situation, or other extenuating circumstances. This information should be supplied by the behavioral health provider, PCP or appropriate in-plan specialist (if referring within his/her specialty).

Authorization may be obtained via telephone, fax, website or electronic submission. Copies of all treatment request forms are included in the prior authorization section to assist you in obtaining prior authorization for these services. These forms are available on the secure provider portal. They may also be submitted directly from the website or printed and faxed or mailed in for review. Additional services that require prior authorization include procedures that may have limited coverage under the plan benefit. Also, high cost procedures and new technologies that have specific coverage guidelines should be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines. Please contact The Health Plan Clinical Services Department if you have any concern regarding coverage of any service.

Any referral that does not meet medical appropriateness review by the nurse navigator is referred to a medical director for review determination. The medical director may contact the behavioral health provider for case discussion. Availability of services within the provider network and alternative levels of care for services may be offered as appropriate to the member's needs.

Services that require a prior authorization are listed on The Health Plan Behavioral Health Services prior authorization list.

Please indicate if your request is emergent so that we may expedite the review. Simply scheduling the test/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after the service is approved by The Health Plan.

Retroactive reviews for utilization: The Health Plan reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure that the member met medical necessity criteria for the service in question and to review the quality and appropriateness of the service provided.

Drug Screening and Testing

Please be advised that effective **July 1, 2020**, The Health Plan will deny all breath alcohol testing (procedure code 82075) performed in conjunction with any urine drug screen other than dipstick point of care testing (POCT), billed with procedure code 80305. Providers using more complex urine drug testing such as procedure code 80307 or a definitive screen are encouraged to include alcohol as a screened substance.

The Health Plan is making this change in order to ensure the proper utilization of urine drug testing associated with pain management clinics and substance use disorder practitioners and facilities. We would like to remind providers that urine drug testing is most effective when 1) individualized rather than routine, 2) randomized, and 3) conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine located on the ASAM website.

ASAM strongly recommends against routine use of definitive testing. Please review the white paper at the link above. As always, all clinical procedures can be subject to post payment review for medical necessity.

This affects the following lines of business: Commercial, Medicaid, Medicare.

Self-funded groups default to the individual group plan document.

Please direct any questions to the Clinical Services Department at 1.800.624.6961, ext. 7644.

Credentialing and Billing

The Health Plan requires credentialing of all independently licensed behavioral health practitioners operating within a physician's practice.

Unlicensed personnel may not bill for behavioral health services within a physician's practice with the exception of supervised psychologists officially approved by the WV Board of Examiners of Psychology. THP will only reimburse supervised psychologists when providing services to our Medicaid members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV located here.

Please note that this policy does not apply to physician's offices within Licensed Behavioral Health Centers. Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

Please further note that The Health Plan, in conformity with mental health parity rules, does not require prior authorization for clinic-based behavioral health outpatient services. Our authorization list is available on the website under the "For Providers" section.

The Health Plan defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP 's Customer Service Department.

Medicare And Most Commercial Plans

The Health Plan conforms to Medicare billing requirements for behavioral health "incident to" services provided by a physician. A very concise summary of these requirements was developed by the National Council for Behavioral Health .

To summarize: if a licensed behavioral health practitioner is employed or contracted by a physician whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the physician's NPI, with no modifiers. Examples of such rendering practitioners would include: LICSW, Psychologist, LCSW, LGSW, and LPC. Certified Addictions Counselors may also bill under the physician's NPI if the scope of the service provided is consistent with the counselor's certification.

As a reminder, any staff person providing services incident to physician's services must be credentialed with The Health Plan.

To further clarify, if a physician is federally certified as a Medication Assisted Treatment provider, regardless of the physician's specialty, the physician may have behavioral health practitioners employed or contracted in his office billing incident to the physician's services only so long as the service being provided relates to the physician's practice as a MAT provider if the physician's specialization is not traditionally behavioral health (examples: anesthesiology, internal medicine). A psychiatrist may employ or contract with a behavioral health licensed practitioner to provide a much broader range of services than MAT.

The supervising physician must see the patient initially for assessment and must order the treatment in the patient record as an aspect of the patient's plan of care. The supervising physician must provide regular reviews of the patient's status which must be documented in the patient's record.

Medicare will reimburse "incident to" claims at 100% of the established Medicare rate for the service. Conversely if the licensed behavioral health practitioner is listed on the claim as the rendering

provider, the claim will reimburse at 85% of the established Medicare rate. All services must be provided at place of service 11, clinic.

Medicaid

For information regarding guidelines for billing under the physician or physician extender's NPI, in conformity with Medicaid requirements, please see **Section 5** of this manual.

The Health Plan utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on CAQH or WV Department of Insurance.

Be aware that this will require that the rendering provider have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the NPPES website.

Should you have any questions regarding these instructions please feel free to contact our behavioral health provider engagement representative, Seth Shockey at sshockey@healthplan.org or clinical psychologist Sheila Kelly at skelly@healthplan.org.

Providers should be aware that commercial and self-insured policies may vary. Please call our customer services line at 1.877.221.9295 should there be questions regarding these types of policy coverages.

The Health Plan will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan's Special Investigations Unit for fraud, waste and abuse. New network providers may be requested to submit planned procedures for prepayment review. All out of network providers are required to submit all procedures for prior authorization.

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Annual Program Evaluation

The Health Plan's utilization management program and the population health driven, care continuum quality management program are evaluated on an annual basis. A written summary is prepared from the evaluation process that includes utilization and quality management activities during the year, achievement of previously identified goals, and revisions of goal statements for the upcoming year.

The annual program evaluation is submitted to, and approved by, the Executive Management Team (EMT) and the Quality Improvement Committee.

Access to Care

To comply with NCQA standards, The Health Plan holds to the following standards for access to care for behavioral health cases:

- Practitioners/providers should provide care within six hours in an emergent, non-life-threatening situation.
- Practitioners/providers should provide care within 48 hours of a request for service when the need is urgent.
- Practitioners/providers should provide a follow-up appointment within seven days of discharge from an inpatient facility.
- Practitioners/providers should provide a new routine office visit within 10 working days of request.
- Prescribing practitioners/providers should provide a follow-up visit within 30 working days of the initial visit.
- Non-prescribing practitioners/providers should provide a follow-up visit within 20 working days of the initial visit.

If the practitioner/provider is not available, the member should be made aware of how to access care. This would apply to after hours and weekend coverage as well as other situations.

Continuity and Coordination of Care

The Health Plan Clinical Services Department advocates continuity and collaboration of care between behavioral health and physical health practitioners/providers. Continuity and coordination is an important aspect in the delivery of quality health care as behavioral and medical conditions interact to affect an individual's overall health. Information is expected to be exchanged between behavioral and physical health care providers whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner/provider to communicate with the PCP and the PCP to communicate with the behavioral health practitioner/provider. Any information that is shared between practitioners/providers should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, the Clinical Services Department is available to provide this service.

All federal and state confidentiality laws should be followed. The Health Plan expects that information be shared accordingly and recognizes the right to keep progress notes private. The Health Plan also understands that there are special situations where information cannot be shared. A continuity of care consultation sheet is available on The Health Plan's secure provider portal for use in facilitating integrated communication.

Behavioral Health Services Forms

The following forms are provided to assist practitioners/providers in requesting services for patients and providing information necessary for continuity and coordination of care. Behavioral health prior authorization and review forms can be transmitted to The Health Plan via the provider secure web portal. These transmissions are received in a secure, restricted fax management queue. The forms listed below are available online at myplan.healthplan.org. Prior authorization requests are also accepted telephonically, electronically, by fax or by email to behavioralhealthdocuments@healthplan.org. Admission, concurrent, and discharge reviews may be called to the nurse inpatient navigator.

- Authorization to Disclose Health Information to PCP
- Admission Review Form
- Concurrent Authorization for ABA/Behavioral Services Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Initial Authorization for ABA/Behavioral Services Form
- Psychological Testing Prior Authorization Request Form
- Treatment Continuation Request Form
- Substance Use Disorder Clinical Review Information Form (for non-Medicaid)
- Universal Substance Use Disorder Clinical Review form for Medicaid Member Services
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – Medicaid Lines of Business only
- Request for ECT/TMS

Telehealth Services

Telehealth services will be paid to behavioral health practitioners/providers when face -to-face services are not feasible. Services that are eligible for telehealth include, but are not limited to , psychotherapy, pharmacological management, diagnostic interview, and neurobehavioral status exam.

Practitioners/providers who are eligible to provide telehealth include , but are not limited to, licensed psychiatrists, psychiatric nurse practitioners, clinical nurse specia lists, physician assistants, licensed clinical psychologists, licensed professional counselors and therapists, and clinical social workers.

The Health Plan follows Medicare criteria for telehealth services for all lines of business, with the exception of our WV Medicaid product line. WV BMS policies are followed for the WV Medicaid product line.

Telehealth services must be conducted through the use of an interactive audio and video telecommunications system that permits real-time communications between the practitioners/providers and the member in a secure manner compliant with federal and state privacy regulations. The telecommunication equip ment must be of a quality to adequately complete all necessary components to document the level of service for the CPT or HCPCS codes to be billed. The equipment utilized must be HIPAA compliant and meet current Medicare and WV Medicaid standards.

Follow-Up Care after Behavioral Health Admissions

It is extremely important in the care of those with behavioral health conditions, to receive timely follow-up care after discharge from an in-patient stay. The HEDIS® standard is for the member to be seen by a provider/practitioner within seven days of discharge.

The Health Plan is asking for your cooperation and assistance to achieve this important goal.

We would appreciate your facilitating this by:

- Communicating to the hospital discharge planners that follow -up appointments should be scheduled within seven days of discharge.
- Faxing a member's discharge instructions to our Utilization Management Department at 1.330.830.4397 if you are a facility provider so that we may help to reinforce your discharge plan .
- Communicating to the scheduling staff in your office that it is imperative to schedule appointments for discharging patients within seven days of discharge .
- If you require assistance in this process, please contact our Clinical Services Department for a health care navigator.

Standards and Guidelines of Care

The Health Plan has adopted nationally recognized guidelines to assist our providers/practitioners in providing care to our members. These guidelines address the treatment of depression, the treatment of substance use disorder and guidelines for the diagnosis, evaluation and treatment of ADHD in children and adolescents. Links to these guidelines are posted on The Health Plan website.

These guidelines have been approved by The Health Plan's Physician Advisory Committee, Medical Director Oversight Committee and the Executive Management Team.

If you have any questions regarding these guidelines, call the Clinical Services Department at 1.800.624.6961, ext. 7644.

Section 11

Pharmacy Services

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Introduction

The Health Plan shall promote optimal therapeutic use of pharmaceuticals by encouraging the use of cost effective generic and/or brand drugs in certain therapeutic classes.

The Health Plan has processes in place that explain how members, pharmacists, and physicians determine which medications are covered under the members' pharmacy benefit, any utilization management requirements and where members can fill medications.

1. The Health Plan publishes a prescription formulary at least annually for all lines of business and posts the formularies on our corporate website. The formulary includes listings of generic, brand and specialty drugs that are available through the pharmacy benefit. The formulary indicates a drug's copay tier as well as utilization management requirements including prior authorization, step therapy or quantity limit requirements.

   In therapeutic classes where The Health Plan has preferred drugs for the treatment of certain diseases, only those drugs are to be used. The Health Plan has utilization management criteria in place to steer members to preferred drugs. The Health Plan publishes the utilization management criteria on the provider portal for our prescribers. In cases where the physician has written a prescription for a drug not on the formulary or for a drug that requires authorization, the dispensing pharmacist will contact the prescriber to change the medication, if possible, to a preferred drug in the class. Therapeutic substitution is only permitted with authorization by the prescriber in the form of a new prescription.

2. Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug. This is also known as "AB" rated.

   The Health Plan pharmaceutical management program allows consideration of medical necessity exceptions for members in obtaining coverage for non-preferred drugs and brand drugs when a generic is available.

3. Prescriptions can be filled at any participating THP pharmacy within the member's pharmacy network. THP does reserve the right to redirect medications to a specific pharmacy such as a specialty pharmacy for certain medications. Any medication redirection will be communicated to providers via the authorization notification letter.

Clinical Criteria for Pharmaceutical Management Program

The Health Plan's pharmacy benefit manager utilizes standard criteria to construct the formularies for each line of pharmacy business managed by The Health Plan. The clinical criterion used is taken from relevant clinical literature.

1. Quality Criteria: After FDA approval, each drug is reviewed with regard to its: therapeutic indications, efficacy, dosage frequency, adverse events, therapeutic index, potency, and any compliance factors.
2. Cost Analysis: Each drug is reviewed with regard to its cost in comparison to any formulary alternative in its class. If there is no formulary alternative, the drug is placed on the formulary. If the drug under review has a lower cost alternative, continued review is indicated.
3. Quality vs. Cost: Other cost considerations are examined and include a pharmacoeconomic perspective that evaluates drug therapy cost-effectiveness as it relates to physician visits, patient costs, emergency room visits, laboratory costs, hospitalizations, and sick days.
4. Special Considerations: Criteria is in place for prior authorization of identified drugs, education of physicians and members, drug inclusion in clinical guidelines, and placement of quantity limits on drugs dispensed.
5. Clinical Literature: This is used in every decision to add or exclude pharmaceuticals on the formulary. Clinical evidence shall come from appropriate government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee develops policies and procedures for the utilization management of prescription drugs for The Health Plan. These policies and procedures are designed to enhance the appropriate use of prescriptions in both a clinical and cost-effective manner.

Specialty Pharmacy Program

Specialty drugs are high-cost, high complexity or high touch medications. Specialty drugs are used to treat very specific diseases and require extensive management for safety and effectiveness. Dosages need to be monitored for effect and adjustments might be needed for adequate response to effectively treat the disease.

Specialty drugs require prior authorization to ensure an appropriate candidate for the drug. Additionally, oversight is an integral part of the prior authorization process. Dispensing might be limited to pharmacies with specific skills and distribution programs to ensure proper delivery of these medications. Diseases targeted to receive therapy include, but are not limited to, rheumatoid arthritis, severe chronic psoriasis, multiple sclerosis, hepatitis C, hemophilia, certain cancers, growth deficiency, cystic fibrosis, Crohn's disease and organ transplant.

Coverage for these agents are provided under the members' Specialty Pharmacy Benefit. The list of specialty drugs is available on the corporate website under "For Providers" "Prior Authorization and Referrals"

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Pain Management Program and Opiate/Opioid Management

The Health Plan limits the acute use of opioid medications for moderate to severe pain from acute injury, medical treatment or surgical procedure for fully insured and employer funded members. The first fill of an opioid medication will be limited to a 5-day supply. This limit is for the first fill of an opioid medication for a member who has no history of opioid usage in the past 130 days.

For those members needing further management of their pain, a prior authorization will be required if:

- The opioid exceeds 80 morphine milligram equivalents
- Is taken for greater than 90 consecutive days
- Is a long acting opioid
- Is being taken with a medication that could cause respiratory depression.

A pharmacist will review the case to evaluate that the opioid is being utilized safely and appropriately. Additionally, the member can be limited to one prescriber and one pharmacy, if needed.

Formulary medications will be preferred over non-formulary medications. Step therapy rules will be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited.

Obtaining a Prescription

Locating a Pharmacy in The Health Plan Network

A THP member may obtain a prescription at any participating THP pharmacy. For the location of a participating pharmacy, call our prescription benefit manager at 1.800.988.2262 or expressscripts.com. The member's THP ID card must be presented to the pharmacist to allow dispensing of the prescription. The member may be required to pay a copayment which will be collected at the time of service based on the prescription drug plan of the member.

Choosing a Preferred Formulary Drug

Formulary Tier Definitions

- Prescription – Drugs that can only be dispensed upon order (prescription) by a qualified provider of care. Additionally, only drugs which are labeled "Caution: Federal law prohibits dispensing without a prescription" will be considered eligible.
- Generic – A drug available as a chemically and therapeutically equivalent copy of a brand name drug. It is usually available from several manufacturers. Generics must meet federal standards for potency and bioavailability.
- Brand Drug – A prescription item only available from a single source supplier.
- Multi-Source Brand Drugs – Brand name drugs which are manufactured by more than one producer. These agents are usually available as generic equivalents.
- Over-the-Counter Drugs (OTC) – Drugs which are not restricted to prescription-only status. These agents are available for purchase without physician approval and are not covered by THP.
- Home Delivery Service – Certain group benefit designs allow members to receive medications at home via the mail. (See your specific benefits for details).

Pharmaceutical Substitution and Interchange Program

Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug.

Generic Difference Policy

If a prescription order specifies that a brand name drug must be dispensed when the generic equivalent is available, or the prescription order allows for generic substitution and the member elects to have the prescription filled with a brand name drug instead, the member must pay the brand copayment plus the difference between The Health Plan cost of a brand name and its generic equivalent (i.e., The Health Plan only pays for the generic cost.) *Please note non-formulary brand versions of generic drugs require coverage review.*

Pharmacy Prior Authorization and Notification Requirements

Pharmacy Pre-Authorization and Notification Requirements are available **here**.

Formulary

The Health Plan formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Drugs not listed are not covered without written medical statements of necessity by the prescribing phys ician. Coverage requests may be requested non-urgently or urgently. Requests for non-urgent coverage determinations received after 5 p.m. will be processed the next business day. All requests for coverage determinations will be processed within the applicable state, federal or accrediting agency timeframes.

Multi-source drugs must be dispensed as the generic. Failure to dispense the generic will subject the member to a higher copayment. This higher copay consists of the brand copayment plus the cost difference of the brand drug and generic drug.

Non-Formulary Requests (Exception Policy)

Certain non-formulary medications are eligible for coverage only after a patient-specific approval has been authorized. Patient-specific criteria may include age, gender, and clinical conditions determined by the physician for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member's representative or physician. A Formulary Exception Request Form may be accessed on THP's secure provider portal "Forms," "Other Forms" or by contacting Pharmacy Services at 1.800.624.6961, ext. 7914. Exception requests may be requested non-urgently or urgently. Requests for non-urgent exceptions received after 5 p.m. will be processed the next business day. All requests for exceptions will be processed within the applicable state, federal or accrediting agency timeframes.

The Health Plan Pharmacy Service Department is available Monday through Friday 8 a.m. to 5 p.m. and after hours via telephonic auto attendant's emergency option seven days a week, including holidays. They may be reached at 1.800.624.6961, ext. 7914; fax 304.885.7592.

Requests will be reviewed according to the following criteria:

1. The request for the non-formulary drug is for a condition or medical need not met by existing drugs on The Health Plan formulary.
2. In the physician's medical judgment, the formulary alternatives have been ineffective in the treatment of the member's disease or condition (documentation in the member's clinical record is required).
3. The formulary alternative causes, or is reasonably expected by the prescriber to cause, a harmful or adverse reaction in the member (documentation in the member's clinical record is required).

Authorization for Coverage

Authorization for coverage consists of rules-based programs for determining whether members qualify for coverage of a requested drug based upon the plan's predefined benefit criteria. Predefined benefit criteria are based on recommendations of The Health Plan's Pharmacy and Therapeutics Committee. These rules are periodically reviewed for appropriateness.

Mandatory Generic Policy and Formulary Override Procedure

Pharmacy benefits with a mandatory generic component require that if the prescription item ordered is available from a generic supplier, The Health Plan will cover the maximum allowable cost of the generic. Any additional costs of brand name medication will be the responsibility of the member. This is regardless of any dispense as written indicators (DAW).

Exemption Review Request Procedure

At the time of dispensing, the pharmacist will transmit a claim to The Health Plan claims processor. If the item submitted is available as a generic, the claims processor returns the cost of the prescription in the following manner:

Brand submitted	Generic submitted
The brand copay is assessed + the difference in the cost of the generic and brand product to arrive at a brand penalty copayment. Copay = brand copayment + penalty	The generic copayment is assessed, and it is the member's responsibility to pay at the time of dispensing

Exemptions

The following agents are exempt from mandatory criteria:

Generic drugs not listed in the FDA "orange book" of generic equivalents with an "AB" rating. "AB" rating is defined as therapeutic and generic equivalent.

In cases of defined medical necessity, an exemption to the mandatory generic policy may be authorized. Exemption requests can be called to pharmacy services at 1.800.624.6961, ext. 7914 or faxed to 304.885.7592.

The requests must include:

- Supporting medical literature describing treatment failures of the generics.
- Defined allergic potential to a specific component in a generic NOT found in the brand product. (i.e., fillers, dyes, preservatives)
    - Documented treatment failure of a specific member with supporting clinical assessment and appropriate lab readings.
    - Member refusal to take the generic is not acceptable.

Prior Authorizations

Program Description

The Health Plan Pharmacy Services Department handles customer service calls and coverage review determinations as well as eligibility and prior authorization updates.

Traditional Prior Authorization (TPA)

A program where The Health Plan Pharmacy Services Department adjudicates coverage review determinations as well as authorization updates. This program criteria is developed and conforms to plan coverage conditions for client review and selection and in administering prior authorization protocols. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member qualifies for coverage for use of the drug, based upon The Health Plan's pre-defined benefit criteria.

Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules use sophisticated logic in conjunction with available medical history, drug history, patient reported health information, and medical claims information to determine whether or not a member qualifies for coverage for use of a drug based on the plan's pre-defined benefit criteria. Smart rules and the pharmacy benefit manager's system capabilities allow coverage management programs to more efficiently qualify for coverage of those claims that are consistent with the benefit. As a result, smart rules limit reviews for coverage to only those claims where the member's request is least likely to be appropriate for coverage. Authorizations for coverage smart rule capabilities include qualification or disqualification by medical and prescription history.

Qualification-by-history logic searches the member's history for the presence of data that will qualify the member for coverage without a requirement for coverage review. Only that member for whom such data is absent requires review for coverage. Disqualification-by-history logic searches the member's history for the presence of data that will disqualify the member for coverage without a requirement for coverage review. Only those members for whom such data is present require review for coverage.

Authorizing Amount of Coverage

Authorization of amount for coverage is a collection of rules-based programs for determining whether members qualify for coverage of the full amount of drug requested based on the plan's pre-defined benefit criteria. Authorization of amount for coverage programs use smart rule logic to determine if members qualify for coverage for medications beyond drug- specific thresholds for a quantity, dose and/or duration deemed reasonable for most uses.

Quantity Per Dispensing Event

Quantity per dispensing event rules set dispensing quantity thresholds that reduce client exposure to unnecessary cost, without creating obstacles to access for the vast majority of users. In addition, through coverage review and traditional prior authorization, members can be qualified for additional coverage where warranted by special circumstances and consistent with the intent of the benefit.

Prior Authorization Forms

Prior authorization forms can be found on The Health Plan's secure provider portal.

Section 12

Billing

Billing Procedures

1. Electronic claim submission is preferred and encouraged. However, if you choose to submit claims in paper format all paper claims and supporting documentation should be submitted to:
   The Health Plan
   1110 Main Street
   Wheeling, WV 26003

   Only original claim forms (red ink) will be accepted. Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will be rejected. As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan's provider portal, myplan.healthplan.org. Contact your provider engagement representative to learn how.

   Claim forms must be completed in their entirety. The efficiency with which the claim form is completed directly affects the efficiency with which the claim is processed for payment. Submission of a clean claim ensures timely and appropriate processing of payment. A clean claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim review for medical necessity.

2. The Health Plan requires that all claims are submitted with accurate and current **CPT-4, HCPCs**, and **ICD-10** codes, as appropriate. For each procedure that is listed on the claim a diagnosis code (ICD-10) must support the services (listed in block 24D on the CMS 1500 form) to ensure expeditious and accurate processing of the claim. You must relate the diagnosis(es) listed in block 21 to the individual service lines. You need **ONLY** to relate diagnosis A, B, C, etc. **NOT** the ICD-10 code in block 24E. **THP encourages the use of category II codes to report performance measures. Use of category II codes will decrease the need for medical record abstraction and chart review.**

3. The Health Plan accepts the standard current billing forms: the CMS 1500 (02/12) professional claim form, UB-04 hospital claim form and the ADA dental claim form.

4. When indicating the member ID number on the billing form, the entire number, including the nine-digit ID number and two-digit suffix should be indicated as shown on The Health Plan ID card.

   The patient ID number starts with the letter H, the remaining eight digits are numeric. The suffix identifies the family member.

   Example: John Doe H01234567-01 Subscriber
   Jane Doe H01234567-02 Spouse
   Mary Doe H01234567-03 Child (eldest)

5. Access the NPI registry to locate the NPI number of referring providers and facilities to assist in completing the section related to referring provider on claim forms (blocks 17, 17a and 17b).

6. All services must be billed within 180 days from the date of service.

7. Coordination of benefits (COB) claims (where another carrier has primary responsibility for making payment), must be submitted within 180 days from the date of service or three months

from the date of the primary carrier's explanation of benefits (EOB). If you do not receive payment or rejection from the primary carrier and the 180-day time limit is approaching, you must bill The Health Plan before the 180 day deadline, whether or not you have received the EOB from the primary carrier. *Refer to **Section 14** of this manual for additional COB information.*

8. All claims are paid within 30 days from the date of receipt by The Health Plan or as otherwise required by prompt pay requirements. If a clean claim is not paid within the applicable timeframes, appropriate interest will be applied to the claim when it is paid as required by state law, Medicare or Medicaid. For WV Medicaid services, interest will be paid to in-network providers at 18 percent per annum calculated daily for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.
9. Payment and payment vouchers are available electronically or mailed by request bi-monthly, depending on the line of business. *Refer to **Section 13** for information regarding electronic remittance.*
10. Questions concerning payment or denial must be submitted to The Health Plan the greater of 180 days from the payment/denial date of the claim or 180 days from the date of service. *Refer to **Section 15** for additional information on claims resubmission procedures.*
11. When submitting a refund check to The Health Plan for overpayment (e.g., coordination of benefits, workers' compensation, subrogation, etc.), include a copy of the payment voucher underlining or circling the claim, and document the reason for the refund. If unsure of the voucher date for the paid claim, you may contact the COB/funds recovery representative at 1.800.624.6961, ext. 7903. Please include detailed information: member name, member ID number, date of service, and the reason for the refund. *Refer to **Section 15** for more information regarding overpayments and offsetting.*
12. The provider should collect applicable deductible, copayments, or co-insurance at the time of service whenever possible. Copayments may not be waived (with the exception of COB) as this is in direct violation of the physician contract with The Health Plan.
13. The Health Plan members are NOT to be billed directly or balance billed for covered services.
14. Procedural manuals will be supplied by The Health Plan to all participating providers, upon request, to assist with The Health Plan guidelines and procedures. The manual can be found on The Health Plan's corporate website, healthplan.org. Procedural manuals are also available on CD.
15. The Health Plan will NOT reimburse physicians, nor can the member be billed, for the following services:
    - Services not rendered
    - Phone calls (including phone consults)
    - Canceled/missed appointments
    - Making referrals
    - Normal postoperative care
    - Completion of paperwork

- Unnecessary services not indicated by diagnosis
- Mileage
- Stat charges
- Educational services
- Prescriptions
- False information/fraudulent billing
- Never events/avoidable hospital conditions/provider preventable conditions

16. Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by The Health Plan on the date of notification . *Refer to* ***Section 5*** *for policies regarding changes to Medicaid fee schedules.*
17. The Health Plan will comply with Ohio, West Virginia and Medicare prompt pay requirements . Contact The Health Plan at 1.888.816.3096 for self-funded claim and appeal information. Self-funded lines of business default to individual group policy requirements regarding timely filing.

Never Events and Avoidable Hospital Conditions

Never Events

Wrong procedures, or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as "never events." These never events are not medically necessary as they are not required to diagnose or treat an illness, injury, disease, or its symptoms and are not consistent with generally accepted standards of medical practice. All never events involving a wrong procedure, or a procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary, and reimbursement is not permitted. Hospitals generally refrain from billing members for these never events. In the instance where The Health Plan does receive bills for such services, these shall appropriately be denied for lack of medical necessity.

Avoidable Hospital Conditions

Avoidable hospital conditions (a.k.a. hospital-acquired conditions) are conditions "which could reasonably have been prevented through application of evidence-based guidelines." These conditions are not present when patients are admitted to a hospital but present during the stay.

Effective October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) identified the following as preventable hospital acquired conditions:

- Foreign objects retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers stages III and IV
- Falls and trauma
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection and surgical site infection
- Mediastinitis, following coronary artery bypass graft (CABG)
- Manifestations of poor glycemic control
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity; and
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

CMS provided that effective October 1, 2007, hospitals should begin submitting inpatient hospital charges with a present on admission (POA) indicator. POA is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the emergency department, observation, or outpatient surgery are considered as POA.

The Health Plan reviews and tracks admissions with identifiable never events and avoidable hospital conditions. When it is determined there were additional hospital inpatient days at a participating provider facility, which directly and exclusively resulted from an avoidable hospital condition (not

present on admission), reimbursement for additional inpatient days and/or services may be denied. Further, avoidable hospital conditions and never events shall not be considered in DRG determinations for facilities reimbursed through a DRG methodology. Denials for inpatient hospital days or services which are the result of such circumstances are not billable to the member. These reimbursement denials will not apply to hospital admissions in which the avoidable hospital condition was present on admission, or where another secondary diagnosis is a major complicated/comorbidity (MCC) or complication/comorbidity (CC) in addition to the POA diagnosis, and potentially impacted the avoidable hospital condition.

Never Events Codes/Hospital-Acquired Conditions/Healthcare Associated Conditions

Codes	Events	Examples
NA	Preventable	Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
NB	Serious Preventable	Any death or serious injuries associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
NC	Serious Preventable	Patient death or serious injury associated with unsafe administration of blood products or the administration of incompatible blood.
ND	Catheter	Urinary tract infections associated with a catheter.
ND	Pressure Ulcers	Stage III & IV (decubitus ulcers) acquired after admission/presentation to a health care setting.
NF	Vascular	Catheter associated infection
NG	Surgical Site Infection	Mediastinitis within 30 days of coronary artery bypass surgery (CABG).
NH01	Hospital-Acquired Injury	Falls and fractures
NH02	Hospital-Acquired Injury	Dislocations
NH03	Hospital-Acquired Injury	Intracranial injury
NH04	Hospital-Acquired Injury	Crushing injury
NH05	Hospital-Acquired Injury	Burns
NH06	Hospital-Acquired Injury	Other unspecified effects of external causes
NH07	Hospital-Acquired Death	Postoperative death of a healthy patient (ASA Category 1).

Codes	Events	Examples
NI	Poor Glycemic Control	Diabetic ketoacidosis, non-ketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
NJ	Surgical Site Infection	An infectious or inflammatory reaction due to the implant of an orthopedic device following specific orthopedic procedures (spine, neck, shoulder, elbow) within 365 days.
NK	Surgical Site Infection	Surgical site infection within 30 days of bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
NL	DVT/PE	DVT or PE following specific orthopedic procedures (total knee/hip replacements), or a DVT that has occurred in an acute hospital and is diagnosed during the hospital stay.
NM	Surgery/Invasive Procedure NEVER EVENT	A surgery or invasive procedure on the wrong body part.
NN	Surgery/Invasive Procedure NEVER EVENT	A surgery or invasive procedure on the wrong patient.
NO	Surgery/Invasive Procedure NEVER EVENT	Wrong surgery/invasive procedure performed on a patient.
NP	Surgical Site Infection	Surgical site infection following a cardiac implantable electronic device (CIED).
NQ	Iatrogenic Pneumothorax	Iatrogenic pneumothorax caused by the diagnosis, manner, or treatment of a physician (i.e., inserting venous catheterization).

When any of the above variance codes are identified, a case is generated. Each case is assigned a number, and medical records are ordered to be reviewed. A written evaluation of findings is created, and cases may be reviewed at an interdisciplinary team meeting. If immediate review is necessary, the situation is immediately brought to the attention of the medical director.

Never events, hospital acquired conditions (HACs), and healthcare associated conditions continue to be investigated by The Health Plan. Any of the diagnoses or conditions that are clearly documented as present upon an inpatient admission are not preventable by CMS guidelines.

Electronic Billing – Documentation Submission

To assist with the submission of required documentation for claims adjudication, The Health Plan has a dedicated fax line to submit your documentation. The fax number is **740.699.6163**.

In order to assure the required documentation is routed correctly, you must accurately complete The Health Plan fax cover sheet in its entirety. A copy of the Fax Cover Sheet to Support Electronic Claim Submission is available **here**. Failure to complete the fax cover sheet may result in claim denials. A separate fax cover sheet is required for each document faxed.

*Your electronic claim should be marked in the **claim note** or **claim line** area with notification stating additional documentation has been faxed. Placing the word **FAX** in the **claim note** area will alert our claim reviewers.*

You must fax all required documentation within 24 hours of your electronic claims transmission.

Credit Balance Explanation

When a claim is credited against your account, the credit amount can carry over more than one payment. Accordingly, it may be necessary to hold multiple vouchers and post them all at once. In order to assist your accounts receivable representative, here are the basic steps to follow in order to balance out to your deposit when credits have been applied over more than one voucher process.

1. You will need to make sure to **evaluate every voucher you receive**, even those that are not accompanied by a check or electronic deposit. Vouchers with zero payments often include denials that need to be worked as well as credits applied to current and future paid claims. In the event that a credit balance appears on the voucher you will want to hold the voucher in order to reference the credit activity until the credit has cleared (i.e., until your next voucher with a positive payment amount. This excludes any voucher that **only** show "Claims in Process," no payments or credits).
2. In the meantime, please be sure to resubmit corrected claims for all claims denied because the information submitted on the original claim was incorrect. This will avoid a timely filing denial and ensure those claims are promptly reprocessed for payment upon correction.
3. Once the credit has been satisfied and you receive a voucher with a check or an electronic deposit, you can post all of the debits and credits that you have been holding, along with the voucher indicating that you received a check or deposit. After all debits and credits have been posted, you will balance out to the check or deposit.

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Example: *(see sample vouchers **here**)*

- $319.03 (Plus on to member's account – this is where your credit begins)
- $132.66 (Payment - Credit off of member's account)
- $186.37 Outstanding Credit Balance (HOLD Voucher)
- $ 34.90 (Payment - Credit off of member's account)
- $151.47 Reduced Outstanding Credit Balance (HOLD Voucher)
- $ 67.97 (Payment - Credit off of member's account)
- $ 83.50 Reduced Outstanding Credit Balance (HOLD Voucher)
- $102.27 (Payment - Credit off of member's account)
- $167.49 (Payment - Credit off of member's account)
- $102.27 (Payment - Credit off of member's account)
- $ 68.28 (Payment - Credit off of member's account)

$356.81 **(As you can see, if you post all the debits and credits together, you will balance out to your check or electronic deposit.)**

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Notice of Readmissions Review Occurring Within 30 Days

Attention Hospital Providers

Effective November 1, 2018, all clinically related /potentially preventable readmissions occurring within a thirty (30) day period are subject to review. Readmissions will be denied when any of the following are determined:

- A patient was prematurely discharged from the same hospital,
- A facility failed to have proper and adequate discharge planning in place, OR
- If there was a lack of proper coordination between the inpatient and outpatient healthcare teams.

In order for proper payment to occur, providers are required to follow the below guidelines:

- Hospital readmissions within 30 days for the same or similar diagnosis/DRG should be billed and paid as one claim.
- The hospital should combine both stays on one claim and bill with corrected bill type 117.
- Once the corrected claim is received by THP, the 1st admission payment will be reversed, and the corrected claim will be reviewed and processed.
- The corrected claim for the combined stay will process through the DRG calculator/grouper to determine the correct DRG payment for the combined stay. This will assure the correct DRG payment is allowed.

In the absence of information to determine the appropriateness of the readmission, clinically related/potentially preventable readmissions within a seven (7) day period will be automatically denied and the provider will need to submit medical documentation to support the need for payment. Final review decisions will be made/confirmed by an employed medical director of The Health Plan.

Refer to ***Section 7*** *for more information on the 30-day hospital readmission review guideline.*

Questions regarding claim denials may be directed to the customer service department at 1.800.624.6961.

Section 13

EDI

Introduction

- The Health Plan makes available to their providers various methods of electronic data information (EDI). Access the secure provider portal at myplan.healthplan.org The provider portal requires a user ID and password for participating health care providers. Helpful information that providers can obtain related to EDI on the provider portal includes:
  - Claim status and submission
  - Member eligibility and benefits
  - Pre-authorization status and submission
  - PCP patient rosters
  - Payment vouchers
- Participating Clearinghouses
- Direct FTP connection
  - Electronic Claims Submissions/837
  - Electronic Payment Vouchers/835/ERA
  - Eligibility HIPAA 270/271 Filing
- Direct Deposit

If you cannot find what you are looking for on our website, please contact:

EDI Support Center
The Health Plan
1110 Main St.
Wheeling, WV 26003

Telephone: 1.877.903.7508

THP Trading Partner Electronic Submitters

National Payer ID: 95677

CLEARINGHOUSE	PAYER ID
Apex EDI	95677
Alveo/Consult ECP	HPUOV
Availity	95677
CPSI/Trubridge	CPSINET
ClaimLogic	HPUOH
Claim Source	270704425
Cortex	CX029
Emdeon*	34150*
eSolutions	481213987
Etactics	UOVOH
Gateway EDI/TriZetto	00162
Healthcare IP	
MD Online/Ability	15THP
MedAssets/ nThrive/ Visient	
MTBC	
Office Ally*	34150*
Optum*	34150*
PNC	10060
Practice Insight	HPUOV
Quadax	NHPL
RelayHealth/McKesson	95677
Rocket System Laboratory	
SSI Group	95677
ZIRMED/Waystar	10060

*Electronic voucher 835/ERA not available

Updated 06/2020

Coordination of Benefits (COB)

Coordination of Benefits (COB)

COB is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical treatment. COB is designed to eliminate the opportunity for a person to profit from an illness as a result of duplicate group health care coverage. By allowing two or more insurance carriers to work together, the insurance companies can ensure that claims are divided fairly and can avoid paying the same medical bills twice.

Each employer group contracting with The Health Plan has a COB provision in their contract. In accordance with your provider contract, claims for members with another insurance should be submitted to the primary carrier first for payment. The primary plan (plan that pays benefits first) always pays the same benefits it would pay in the absence of any duplicate coverage. The secondary plan (plan that pays benefits second) pays the difference of their allowable amount and whatever the primary plan paid. In accordance with your contract, when The Health Plan is the secondary payer, The Health Plan will consider the balance of covered services not paid by the primary plan, so long as the total payment does not exceed 100 percent of the rates agreed to in your contract. This may mean in some cases that if the primary payment is greater than The Health Plan's allowable amount, you will receive no additional payment from The Health Plan. Please remember that the patient may not be billed for this balance.

Some lines of business follow NAIC guidelines for COB calculation. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

WV Medicaid Members

For members that have primary insurance coverage from a source other than Medicaid, THP will honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If THP is responsible for Medicaid services that are carved out of the primary carrier's benefit package, THP has utilization management responsibility for those carved out services.

Order of Benefit Determination Rules

Non-Dependent or Dependent: The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan. Example below:

- **Employee:** The plan covering the person as an employee pays benefits first. (If the patient is our subscriber The Health Plan is primary.)
- **Spouse:** The plan covering that person as a dependent pays benefits second. (If the patient is the spouse of our subscriber, The Health Plan is secondary to the spouse's insurance.)

Dependent children: The plan covering the parent whose birthday falls earlier in the year is determined before those of the plan of the parent whose birthday falls later in that year. The term "birthday" refers only to the month and day of birth during the calendar year. (If both parents have the same birthday, the benefits of the plan that covered the parent the longest is the primary plan.)

Dependent children of separated or divorced parents: When parents are separated or divorced, the birthday rule applies when the court decree does not designate a specific parent to carry insurance for the child as primary. However, if specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is primary.

In the absence of a court decree, the following rules apply:

a. The plan of the parent (with custody) who is the residential parent and legal custodian of the child pays first.
b. The plan of the spouse of the parent (with custody) who is the residential parent and legal custodian of the child pays next.
c. The plan of the parent (without custody) who is not the residential parent and legal custodian of the child pays next.
d. The plan of the spouse of the parent (without custody) who is not the residential parent and legal custodian of the child pays last.

Active/inactive employee: The primary plan is the plan that covers a person as an employee who is neither laid off nor retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or the employee's dependent. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-dependent or dependent rule can determine the order of benefits.

Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Procedures Regarding COB

When a member has another insurance as their primary, please bill that insurance first even if there is a deductible to be met so that the service can be applied to the deductible.

Billing the primary insurance first and attaching the explanation of benefits (EOB) will expedite payment from The Health Plan. **All payments indicated on the claim must be supported by an EOB or the claim will be denied.** If *billing electronically, COB information must be included in the electronic submission.*

Each COB claim is reviewed to determine whether The Health Plan is primary. In cases where we are incorrectly billed as the primary payer, the claim will be denied "C," indicating other insurance primary. The claim will show on your voucher as denied "C" – OTHER INSURANCE PRIMARY. Please bill the primary insurance carrier, then resubmit COB by sending a new claim with the EOB attached to The Health Plan for processing.

Please remember, claims must be submitted to The Health Plan with an EOB within **180 days** from the date of service, but no later than ***three months from the date of the primary carrier's EOB***. Any claims billed to The Health Plan after this time frame will be denied "F" – "TIMELY FILING" and the amount you have billed to The Health Plan must be written off. **The member cannot be billed for the balance due.** Claims that are submitted after the timely filing limit must have documentation explaining the reason for the delay in submission. This will be reviewed. **Please note that self-funded lines of business default to individual group policy requirements regarding timely filing.**

Copayments are not to be taken if the primary insurance pays more than The Health Plan copay. The collection of the copay is the responsibility of the individual office. If The Health Plan is primary, the copay may be billed to the member's secondary coverage if applicable. If a copay is collected at the time of the visit, the provider's office should refund the copay to the member if the payment voucher shows no copay is due.

If you have double coverage through The Health Plan, the copay, deductible , and/or co-insurance shown on the payment voucher for the primary ID number should be billed to The Health Plan using the secondary ID number. To submit this charge, a HCFA 1500 must be submitted showing the secondary ID number and indicating clearly "billing for copayment." Also, attach a copy of your voucher showing The Health Plan's payment under the primary ID number. This amount will be entered on your claim, by The Health Plan's COB Department, in the COB amount field, and we will process your claim for the copay, co-insurance, or deductible due.

There is often confusion concerning billing procedures for HMO members on Medicare. Therefore, in order to clarify billing procedures for Part B charges for the three types of HMO Medicare members, the billing process to follow when Medicare members present their ID cards is listed.

1. **REGULAR MEDICARE (red, white and blue card):** The Health Plan evaluates primary and secondary coverage with Medicare in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Please call the COB Department at The Health Plan at 1.800.624.6961, ext. 7903 for clarification of primary responsibility for Medicare members with this ID card.
2. **SECURECARE HMO/SECURECHOICE PPO**: Bill The Health Plan directly for all charges. We are the Medicare carrier for Part A and Part B services.
3. **MEDICARE Supplement:** Bill Medicare first and then bill The Health Plan for any co-insurance or deductibles. (See Medicare crossover notice)

Medicare Crossover Notice

Effective as of Dates-of-Service 8/29/2016

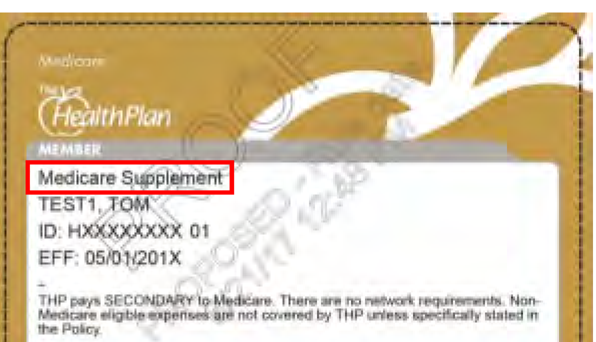
<u>For Medicare Supplement Plans ONLY!</u>

When your patient presents this ID card from The Health Plan, you will no longer have to submit a claim to The Health Plan after Medicare pays.

Medicare will send us your claim information and we will then process for the remaining copayment, co-insurance, or deductible.

As a reminder, this plan will only cover those services that have been allowed or paid by Medicare. If Medicare denies the service, The Health Plan will also deny your claim.

FRONT



BACK

If The Health Plan decides to do Medicare crossover claims for other lines of business, we will notify you at that time.

Medicare Primary

Any physician who has submitted an assigned claim to Medicare has agreed to accept Medicare's reasonable charge as payment in full for his services. Per Medicare's Carriers Manual, section 3045.1, the physician is in violation of his signed agreement if he bills or collects from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the reasonable charge. The Health Plan, as a supplemental insurer, is functioning as a private insurer. Therefore, we will be reimbursing the physician on any services covered by The Health Plan, provided such co-insurance amount *does not exceed* The Health Plan's normal fee.

The Health Plan will pay deductibles, copayments, co -insurances, and other member responsibility amounts not paid by the primary carrier so long as the total payment does not exceed the amount The Health Plan would pay as the primary carrier. This process is applied to each individual service.

Commercial Credit Adjustment Example

Original Claim Paid as Primary

CPT	BILLED	ALLOWED	DISALLOWED	COPAY	COINS	DEDUCTIBLE MEMB RESP	COB	PAID	REF W/H	NON Ref W/H	ADMIN FEE	DSCNT	ADJ CD
99244	225.00	133.67	91.33	15.00	.00	.00	.00	112.74	5.93	.00	.00	.00	L
TOTAL	225.00	133.67	91.33	15.00	.00	.00	.00	112.74	5.93	.00	.00	.00	

Credit Adjustment

CPT	BILLED	ALLOWED	DISALLOWED	COPAY	COINS	DEDUCTIBLE MEMB RESP	COB	PAID	REF W/H	NON Ref W/H	ADMIN FEE	DSCNT	ADJ CD
99244	225.00-	133.67-	91.33-	15.00-	.00	.00	.00	112.74-	5.93-	.00	.00	.00	
TOTAL	225.00-	133.67-	91.33-	15.00-	.00	.00	.00	112.74-	5.93-	.00	.00	.00	12

Claim Paid with COB Amount Applied

CPT	BILLED	ALLOWED	DISALLOWED	COPAY	COINS	DEDUCTIBLE MEMB RESP	COB	PAID	REF W/H	NON Ref W/H	ADMIN FEE	DSCNT	ADJ CD
99244	225.00	133.67	91.33	15.00	.00	.00	62.62	112.74	5.93	.00	.00	.00	L
COB	62.62-	.00	62.62-	15.00-	.00	.00	.00	41.69-	5.93-	.00	.00	.00	
TOTAL	225.00	133.67	91.33	.00	.00	.00	62.62	71.05	.00	.00	.00	.00	

Assuming the allowable amount was the same for The Health Plan as it was for the primary payer.

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Medicare Primary Payment Example

The Health Plan Employer Group Coverage Secondary

BILLED AMOUNT	140.00
MEDICARE ALLOWABLE	81.90
MEDICARE PAYMENT	65.52
MEDICARE CO-INSURANCE	16.38
HEALTH PLAN PAYMENT	16.38

THE ABOVE ARE EXAMPLES AS THEY WILL APPEAR ON YOUR PAYMENT VOUCHER

Medicare Primary Payment as Displayed on Voucher

CPT	BILLED	ALLOWED	DISALLOWED	COPAY	COINS	COB AMT	PAID	REF W/H	NON Ref W/H	ADJ CD
99205	140.00	81.90	.00	.00	.00	65.52	16.38	.00	.00	.00
	(Reduced to Medicare's Allowable)									

Helpful Hints

We have listed a few helpful hints that will help us better serve you and will assist in promoting faster responses and payments.

1. If billing on paper, please send a separate EOB for "EACH" claim submitted to The Health Plan. (Do **not** attach several claims to one EOB.)
2. When your claim has been denied "C" - OTHER INSURANCE PRIMARY, bill the primary payer for payment/denial. After you have received a response from the primary payer, send a "NEW CLAIM" to The Health Plan with EOB attached for processing. Following this step will expedite your payment.
3. Refer to your voucher for claim status prior to calling The Health Plan. If you still have questions, please have the member's ID number and date-of-service ready.
4. When sending a refund to The Health Plan, include the member's name, ID number, date-of-service, claim number, and reason for refund, with documentation in the form of another carrier EOB or voucher. This should be sent to Attention: Funds Recovery, The Health Plan, 1110 Main St, Wheeling, WV 26003.
5. COB filing limitations are calculated from the actual date-of-service, not from the date a claim is received by The Health Plan.
6. After receiving your payment voucher, direct your call to The Health Plan COB Department only for claims denied for COB reasons at 1.800.624.6961, ext. 7903 or 1.740.695.7903. All other calls regarding your voucher are to be directed to the Customer Service Department at 1.800.624.6961.
7. When sending documentation to the attention of the COB Department, please indicate what you are questioning – even if you previously spoke to us about this situation over the phone.
8. When The Health Plan is the secondary payer, all THP guidelines for referrals and pre-authorizations apply.
9. **REMINDER:** The Health Plan and other health insurance carriers are always primary over Medicaid/Mountain Health Trust (MHT), Medicaid SSI and WV Health Bridge (WVHB).
10. When sending any claim or inquiry to The Health Plan, **do not HIGHLIGHT.** ***Please*** circle, star, or bracket any information you want us to review.

COB Denial Codes

Type	Description
C	Other insurance primary
CB	Explanation of benefits required for paid amount shown.
CD	Improper primary carrier denial code – primary carrier requesting additional information from provider
CF	Incorrect EOB attached (e.g., patient name does not appear on EOB or DOS/charges on EOB disagree with claim).
CG	Require explanation/definition of primary carrier's denial remarks/reason code
CHS	Member has enrolled in Hospice.
CI	Member did not follow primary carrier guidelines; therefore, service is non-covered by The Health Plan.
CJ	This code/charge did not appear on EOB. Resubmit with EOB that corresponds.
CK	**FOR MOUNTAIN HEALTH TRUST MEMBERS ONLY** Member did not follow primary carrier guidelines; therefore, service is non-covered by Mountain Health Trust.
COB	**Other insurance primary – Medicaid Member**
U	Workers' compensation primary (for hospital claims)
UU	Workers' compensation primary (for ancillary claims)

Section 15

Payment Voucher and Claims

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Payment Voucher Introduction

A sample provider voucher is included in this section with the key areas indicated by red numbers. Descriptions of the numbered areas are on the last page of the sample voucher to assist you with reading your payment voucher.

Your payment voucher is divided into three sections:

- Claims paid by line of business
- Claims denied by line of business
- Claims in process

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Claim Numbers

Your claim numbers have a meaning.

2020 296 21234

1. The first 4 digits represent the year: **2020**
2. The fifth, sixth, and seventh digits represent the Julian date or numeric day of the year. *In the example above*, **Julian day 296 = October 22, 2020**
3. The last five digits are for The Health Plan's in-house record keeping, please disregard these numbers.

Age of Claim Determination

By reviewing the "claims in process" section of your payment voucher, you can determine the payment/denial date and the age of your claims.

The Health Plan is bound by WV prompt pay laws and THP pays clean claims within 30 days of receipt.

Example #1: Establishing your payment/denial date

CLAIM DATE: 2020010 (January 10, 2020)
Add "30" to the claim date = (Julian Date) 010 + (WV prompt pay law) 30 = (Julian Date) 40
Payment/denial date = 40th day of the year or February 9, 2020

Example #2: Establishing the age of your claim

TODAY'S DATE: August 26, 2020 (Julian Date 2020239)
Date of your claim = June 9, 2020 (Julian Date 2020161)
Subtract 2020239 – 2020161 = 78
Your claim is 78 days old

If your claim has been denied or you wish to correct a claim previously paid, you have **the greater of 180 days from the claim payment/denial date or 180 days from the date of service** to do so.

By following the examples above, you can track your claims from the time they enter The Health Plan's system to the time you receive your payment or denial.

Claims in Process

Claims that have been received by The Health Plan, but have not been adjudicate d, will be listed under the "claims in process" heading of your payment voucher. The Health Plan recommends that providers check their aging reports at 45 days against The Health Plan's most recent "claims in process" report. This will enable you to track all claims submitted to The Health Plan. If you have an outstanding claim on your aging report that does not appear on your most recent "claims in process," you should contact The Health Plan's Customer Service Department at **1.800.624.6961** to verify the status of the claim.

IT IS THE RESPONSIBILITY OF THE INDIVIDUAL PROVIDER TO REVIEW THE VOUCHERS TO ASSURE ALL CLAIMS ARE RECEIVED.

Resubmission of Claims Denied for Documentation

The following procedures have been implemented in order to expedite the processing of claims that are denied for additional documentation when the diagnosis does not support the level of service for Medicare, Commercial and Self-funded lines of business.

Initially, the claim will be reviewed and if it is determined that the diagnosis does not support the level of service, the claim will be denied with the more descriptive denial codes. If the provider agrees with the denial they may resubmit the claim with the appropriate level of service or if the provider disagrees with the denial they may submit appropriate documentation such as office notes, progress notes, etc. to support the level of service originally billed. The provider has **the greater of 180 days from the claim payment/denial date or 180 days from the date of service to correct and resubmit the claim or supply additional documentation to support the level of service billed.**

Level I:

Once The Health Plan receives the additional documentation to support the level of service, it will be sent to the Claims Department for review by a claims reviewer other than the original claims reviewer. If the documentation supports the level of service, the claim will be reprocessed and, depending on the review date, will show on your next voucher as paid. If the documentation does not support the level of service, the claim will continue to deny. At this time the provider may correct the claim with the appropriate level of service.

Level II:

If the provider feels that the level of service is appropriate, the provider may submit a written request for a third review with additional documentation and it will be sent to a medical director for review. The claim will be paid or denied upon completion of the medical director review. If the medical director agrees with the initial adjudication of the claim, the claim will deny. Send medical director review requests to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

Level III:

If the provider does not agree with the medical director's decision the provider may submit a written request for an outside independent review of the claim with the appropriate documentation to support the level of service. Send independent review requests to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

The results of this review will be sent back within 30 days from the date of the payment voucher reflecting the medical director's determination.

Once the decision has been received from the independent reviewer the practitioner/provider will receive written notice of their decision. If it is determined that the documentation supports the claim as submitted the claim will be reprocessed at the level of service billed. If the reviewer determines that the documentation does NOT support the claim as submitted, the provider may resubmit the claim with the appropriate level of service.

If the independent outside reviewer agrees with The Health Plan's adjudication of the claim, the provider will be responsible for the charges of the independent reviewer, which may vary depending on the hourly rate and the number of claims reviewed. An invoice will be sent to the provider along with the outside reviewer's decision.

If the independent reviewer rules in favor of the provider, the charges for the review will be the responsibility of The Health Plan. **The decision of the independent reviewer is final** and the provider will have **30 days from the date of the determination letter to resubmit a corrected claim.**

Medicaid Claims Have One Level of Reconsideration/Appeal

If a provider does not agree with the decision made by The Health Plan, they have the right to file a reconsideration. Providers are limited to one level of reconsideration/appeal. A provider has the greater of 180 days from The Health Plan's denial or 180 days from the date of service to request a reconsideration.

Process to Resubmit a Denied Claim

THP prefers that claims be resubmitted electronically. However, you may resubmit a claim on paper

When resubmitting a claim on paper, please include the following:

- Only a completed original (red ink) CMS 1500 or UB04 claim form will be accepted.
  - Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will be rejected.
- Box 22 on the HCFA 1500 professional claim form must contain one of the following codes:
  - 7 – Replacement of prior claim
  - 8 – Void/cancel prior claim
- Use Bill Type 117 on the UB04 facility claim form to represent a hospital inpatient replacement or corrected claim
- Attach a copy of the payment voucher with the member circled or underlined (The Health Plan's optical character reader will black out any highlighted text)
- A clear explanation and/or additional documentation as to why the claim is being re-submitted
- Indicate on the claim form "corrected claim" or "resubmitted claim"

Mail corrected paper claims to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan's provider portal. Contact your provider engagement representative to learn how.

To resubmit a claim electronically through a clearinghouse:

- Use reason code "7" in claim information 2300 Loop Segment CLM05 to indicate replacement of a prior claim
- If you wish to void/cancel a claim, use "8" as the reason code in claim information 2300 Loop Segment CLM05
- Please Indicate the original claim number in the free text field

Failure to follow the resubmission guidelines could result in a claim being denied as a duplicate.

If you have questions, please contact Customer Service at **1.800.624.6961** for assistance on why a claim denied and how to resubmit your claim.

Claim Resubmission Form

The Claim Resubmission Form is available here.

Perpetual Julian Calendar

Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	*	88	119	149	180	210	241	272	302	333	363
30	30		89	120	150	181	211	242	273	303	334	364
31	31		90		151		212	243		304		365

*Add an extra day in years divisible by four (2020, 2024, 2028, etc.) for leap year

Overpayments and Offsetting

An overpayment can be identified by the provider or The Health Plan. If the provider identifies the overpayment, they can either submit a refund check with an explanation of the refund and/or explanation of benefits to The Health Plan or they can call **1.800.624.6961** and request to speak with the Funds Recovery Department to approve a recoupment from any future payments to the provider.

If The Health Plan identifies an overpayment, the provider will be informed of any overpayments or other payments owed within 365 days of the date of the claim payment or within the timeframe as noted in your provider agreement. You will have forty (40) days to notify us of your intent to pay or appeal the overpayment determination. If you have not refunded us within forty (40) days, we will offset the recovery amounts identified in the initial notification against your next payment voucher, or in accordance with the terms of your provider agreement, unless an appeal or refund is received. Resolution of appeals and collection of overpayments subject to appeal will be conducted in accordance with your provider agreement or applicable state law. *Refer to **Section 18** Special Investigations Unit* in this manual for information on provider self-audits and overpayments.

Payments should be sent to:

> The Health Plan
> Attn: Funds Recovery Department
> 1110 Main Street
> Wheeling, WV 26003

For Medicaid identified overpayments, please refer to ***Section 5*** of this Manual.

Section 16

Credentialing

Credentialing

The Health Plan is accredited by the National Committee on Quality Assurance (NCQA) and as such is required to comply with quality assurance standards on credentialing. In addition, The Health Plan is required to comply with the states of West Virginia and Ohio, West Virginia Medicaid and CMS credentialing guidelines, as well as other states and regulatory requirements.

The initial credentialing process includes:

- An office site survey of primary care physicians who provide service to West Virginia Medicaid recipients
- In addition to primary care physicians, an office site survey will be performed on obstetrics (OB)/gynecologists (GYN) and designated high-volume specialists who provide service to West Virginia Medicaid recipients
- Medical record review
- Physician application

Copies of:

- Licensure(s)
- Clinical privileges
- DEA registration
- Complete malpractice history
- Board certifications
- Proof of cultural competency training

Upon expiration of any of the above listed credentials, the credentialing department may request copies of the above expired credentials. **It is imperative that we receive this information as quickly as possible.**

The practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

If you wish to review the information submitted to The Health Plan, in support of the credentialing/recredentialing application, please call the Manager of Credentialing at 1.740.699.6129 to schedule an appointment to come to The Health Plan. You will have access to your credentialing application and primary source verification documents received during the most current credentialing/recredentialing cycle. You will not have access to protected peer review information, references or recommendations.

Recredentialing

The Health Plan recredentials all practitioners, at a minimum within 36 months of the initial credential date.

This recredentialing process includes primary verification of:

- Licensure(s)
- Clinical privileges
- Valid DEA
- Board certification
- Adequate malpractice insurance
- Professional liability claims history
- Reappointment application
- Member complaints and quality of care issues
- Verifying the information contained on the reappointment application

Practitioner's Credentialing/Recredentialing Rights

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the manager of credentialing services. The manager of credentialing services will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The manager of credentialing will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be returned by secure fax at 740.695.7883 or via postal mail to the manager of credentialing, or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

  If no response is received by the credentialing representative within 15 days of contact, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the manager or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee's acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes: the application is still in process; it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.696,1 ext. 6279 or via e-mail at hpecs@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within five business days of the request.

The practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

If you wish to review the information submitted to The Health Plan, in support of the credentialing/recredentialing application, please call the manager of credentialing at 740.699.6129 to schedule an appointment to come to The Health Plan. You will have access to your credentialing application and primary source verification documents received during the most current credentialing/recredentialing cycle. You will not have access to protected peer review information, references or recommendations.

WV practitioners: The State of West Virginia mandatory credentialing and recredentialing applications are located on the West Virginia Insurance Commissioner's website. They may also be found on The Council for Affordable Quality Healthcare's (CAQH) website if you are a member of CAQH.

OH practitioners: The Health Care Simplification Act HB125 (ORC 3963.05) requires all Ohio physicians to complete the CAQH form. The Health Plan subscribes to CAQH; therefore, can retrieve the practitioner's application from the CAQH website. If the practitioner has not yet completed their initial application through CAQH, they may access the application electronically through CAQH.

OH ancillary providers: Ancillary applications are located on the Ohio Department of Insurance's website. If the practitioner is unable to obtain these forms electronically, please contact Provider Relations at 1.800.624.6961 and these forms will be sent to you via secure fax, email, or certified mail.

Office Orientation and Medical Site Survey Form

The Office Orientation and Medical Site Survey Form is available here.

Office Orientation and Behavioral Health Site Survey Form

The Office Orientation and Behavioral Health Site Survey Form is available here.

Standards for Participation

To become a THP provider, a physician must meet the standards of participation as developed by The Health Plan. Practitioners cannot provide medical care to our members until they are fully credentialed.

A physician must have the following credentials:

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA
- Professional liability – minimum amount of $1 million, any amount below minimum will be reviewed by the Credentials Committee
- Admitting privileges at a participating hospital
- Clear report from the National Data Bank
- Board-certified or board eligible. If not board-certified or board-eligible, the physician must demonstrate appropriate training for specialty listed
- Signed and dated agreement
- Office site survey for primary care physicians (PCP), OB/GYN and those providers designated by the plan as a high-volume specialist who provides service to Medicaid recipients.
- Proof of current medical license(s)
- Sufficient information concerning any malpractice actions.
- NPI number and UPIN or PTAN number
  - The Centers for Medicare and Medicaid (CMS) has made it their goal to increase the accuracy of provider directories and is requesting that providers review their demographic information in the National Plan and Provider Enumeration System (NPPES) registry and make necessary corrections to the data and then attest to the accuracy of the data.
- Completed application
- Proof of cultural competency training

Practitioners/providers eligible for participation with The Health Plan are:

- Medical doctor
- Doctor of osteopathy
- Doctor of podiatric medicine
- Doctor of dental surgery
- Doctor of chiropractic medicine
- Audiologist
- Certified nurse practitioner – must submit a copy of their collaborative agreement and/or prescriptive authority (if applicable) with a physician who is a participating practitioner with The Health Plan
- Certified nurse midwife – must have a collaborative agreement with an obstetrician
- Physician assistant – the collaborating physician must be participating with The Health Plan and the PA must submit a copy of the practice agreement with the collaborating physician
- Independent physical therapist
- Optometrist
- Fully licensed psychologist
- Clinical licensed master social worker

- Ambulance provider
- Durable medical equipment – must be accredited and possess a surety bond; if applicable
- Independent speech language pathologist
- Registered dietitian, diabetic educator and nutritionist
- Counselor therapists

Provider/facilities eligible for affiliation in The Health Plan network are:

- Ambulatory surgical centers – must be accredited
- End-stage renal disease facilities
- Federally qualified health centers
- Rural health clinics
- Home health care facilities
- Infusion therapy providers – must be accredited
- Hospitals – must be accredited
- Critical access hospitals
- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Skilled nursing facilities
- Accredited behavioral health facilities

Providers and facilities must meet certain requirements to be a participating provider with The Health Plan. Please contact our contracting department or provider relations department for specific requirements by calling 1.800.624.6961.

The agreement will not be executed on behalf of The Health Plan until the credentialing process has been completed and the practitioner has been approved for participation. Practitioner cannot see members of The Health Plan until they are fully credentialed with the plan.

Notification of acceptance and/or rejection will be sent, in written form, within 60 days of the decision.

The Health Plan will complete the credentialing process within 90 days of receipt of the application or 180 days from the date of signature on the attestation statement of the application.

In addition to the above credentials, The Health Plan quality improvement committee has identified the following behaviors and expectations for The Health Plan physicians, who should:

- Have 24-hour availability, seven days a week, with backup coverage
- Accept members of any or all THP products, as required by The Health Plan
- Admit THP patients to participating hospitals
- Accept and support The Health Plan policies
- Allow medical records and office to be reviewed as part of a collaborative quality program
- Have records and office meet criteria established by The Health Plan and participating physician
- May not discriminate against The Health Plan patients or "de-market" The Health Plan
- Admit under own service to participating hospitals if patient's condition is within physician's range of expertise and scope of privileges
- Meet the CME requirement that is required for state licensure

The following guidelines are for PCPs only:

A PCP shall be required to provide a minimum of 20 hours per week of patient care availability in a county to be considered as a PCP in that county. The only exception shall be practitioners who provide services at multiple sites.

In the instance of multiple sites, these shall be acceptable providing the alternate location is within 30 miles or 60 minutes driving time of the primary location and the alternate location meets all the necessary requirements, as determined appropriate by the credentials committee and/or the executive management team. The PCP must also provide coverage 24 hours a day, seven days per week and have privileges at a provider facility or have arranged with a contracting provider/hospitalist group to handle all inpatient care for his/her patients.

The PCP maintains at least 50% primary care practice.

The following guidelines are for specialty providers (specialists and secondary care physicians):

Specialist practitioners who provide patient care access fewer than 20 hours per week in a THP county shall be considered as a practitioner in that region only if the specialty service of the physician is not otherwise available through sufficient plan practitioners residing in that region. Furthermore, the ability of the specialist to provide the necessary service locally including inpatient care, surgery and backup support shall be considered by the credentials committee and/or executive management team in making the determination of the acceptance of the practitioner as a plan provider.

The committee shall consider the specific needs of the specialty and how the physician will accommodate his/her patient needs. Practitioners who provide only limited services locally shall not be permitted to be accepted as a plan provider. In addition, if it is determined that the physician specialty requires the physician to be available locally, the practitioner shall not be accepted as a plan provider.

Practitioners Credentialing Rights

The practitioner has the right, upon request, to review information in support of his/her credentialing/recredentialing application by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279. The review will be at The Health Plan office and limited to the results of the primary verification of credentials. References, recommendations or other peer review protected information will not be shared with the practitioner.

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the director/manager of credentialing services. The director/manager of credentialing services will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The manager of credentialing will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be

returned by secure fax at 740.695.7883 or via postal mail to the manager of credentialing, or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

If no response is received within 15 days of contact by the credentialing representative, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the manager or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee's acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes if the application is still in process, it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279 or via e-mail at hpecs@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within 5 business days of the request.

Initial Certification

During the credentialing procedure, information that the physician submits to The Health Plan as part of the application process is verified. This information includes, but is not limited to, medical licensure and board certification, plus the credentials listed in a previous section. In addition, each primary care physician, OB/GYN and designated high-volume specialist who provide medical service to Medicaid recipients must take part in an office site survey at the initial credentialing process, unless the practitioner has joined an existing group and that office has previously completed a site survey. Applicants and their practices are reviewed using certification standards developed by The Health Plan and approved by The Health Plan's physician committee.

The Health Plan Standards for Patient Records

The medical record should be organized with the various types of information placed in a consistent location to enable easy access for reviewing the chart. **Practitioners are responsible for medical records that were created in their office only.**

1. **Patient Identification**
   Each page in the record or electronic file contains the patient's name and date of birth or chart ID.
2. **Advance Directives**
   There is evidence that advance directives have been executed or that information regarding advance directives was provided to The Health Plan members age 18 and over.
3. **Completed Problem List**
   A problem list noting significant and/or chronic medical/surgical conditions is in the medical record.
4. **Completed Medication List**
   Medication list includes name of medication, dosage, frequency, start date and stop date. The medication list should be reconciled at each visit. Any change to medications requires either dating and initialing the change or entering a stop date for the initial entry and re-entering the medication with the change. For patients that have had admissions to an acute or non-acute facility, the medication reconciliation should include documentation indicating current medications and discharge medications were reconciled.
5. **Allergies and Adverse Reactions**
   Medication/food allergies and adverse reactions are prominently noted in the record. Absence of allergies should be recorded as NKA. The documentation for allergies should be in a consistent location in all charts.
6. **Provider Identification**
   All entries in the medical record should contain the author's signature and credentials. (If EMR, electronic signatures and credentials are acceptable). Initials may be used only if there is a signature log identifying first initial, last name, and credentials. This standard excludes ancillary documents such as problem list, medication list, flow sheets e.g., The Health Plan Diabetic Flow Sheet.
7. **Dated Entries**
   All entries are dated.
8. **Legibility**
   The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer. A second reviewer can be office staff. Non-compliance occurs when a second reviewer cannot read the entry.

9. **Vital Signs: Blood Pressure**
   Blood pressure measurements should be checked using an optimal technique at every visit with a primary care physician and recorded in the medical record. If the blood pressure reading is abnormally high or abnormally low based on the patient's age, gender, medical/surgical conditions, etc., the blood pressure measurement should be repeated. Both blood pressure readings should be recorded.

10. **History and Physical (H&P)**
    The history and physical documents contain subjective and objective information. H&Ps performed by other medical professionals participating in a member's care meets compliance. Patient-completed questionnaires count as evidence of compliance for the history component.

11. **Lab/Other Studies**
    All lab and other studies are ordered as appropriate for member age, gender and symptoms, as well as chronic conditions per The Health Plan guidelines.

12. **Plan of Action/Treatment**
    There must be evidence of a plan of action/treatment for presenting problem(s).

13. **Return Visit/Follow-Up**
    Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.

14. **Problems from Previous Visits**
    Unresolved problems from previous office visits are addressed in subsequent visits. An unresolved problem is defined as an illness or symptoms that are not responding to treatment.

15. **Pain**
    Documentation in the medical record must include evidence of a pain assessment and the date it was performed. This may include a result of an assessment using a standardized pain assessment tool such as a numerical rating scale or pictorial pain scales for example or documentation including negative or positive findings for pain.

    Screening for chest pain alone or documentation of chest pain alone does not meet overall pain assessment.

16. **Cognitive and Physical Development/Functional Assessment**
    Cognitive assessment is meant as an assessment of conscious intellectual activity (as thinking, reasoning, remembering, imagining, or learning words). Assessing and documenting cognitive status on an annual basis during the annual wellness visit, allows practitioners an opportunity to identify delays in mental developmental for children and monitor cognitive decline in patients over time.

    Physical development and/or functional assessment is meant as an objective review to identify the milestones of normal growth and development and the signs of developmental delay for children as well as, prevent functional decline, and improve health-related quality of life. Optimizing functional status as an outcome of care is not limited to the elderly but is of major concern for individuals of all ages with chronic illness or disability. Functional status can include such things as ambulation/mobility, sensory ability (hearing/vision/speech), taking medications, ADLs and self-care to name a few.

17. Continuity and Coordination of Care
If a consultation is requested, there should be a note from the consultant in the record. The record should indicate communication and feedback between the primary care physician and all specialists. Specialists that necessitate patients' having frequent visits (ex: daily, biweekly, weekly) for care and treatment purposes such as chemotherapy, physical therapy, counselor/therapists, wound care etc. do not need to provide feedback with each visit. It is expected that any positive and/or negative outcomes be relayed to the primary care provider timely.

18. Emergency Room Visits
There is evidence in the medical record of visits to emergency rooms, *when applicable*.

19. Hospital Admissions
There is evidence in the medical record of admissions to hospitals, *when applicable*.

20. Tobacco Use
For patients age 11 and over, assessment of the use of tobacco and smokeless tobacco must be documented. Counseling must occur with identification of tobacco use.

21. Alcohol Use
For patients age 11 and over, assessment of the use of alcoholic beverages must be documented. Counseling must occur with identification of alcohol use.

For patients age 21 and over, assessment of the use of alcoholic beverages must be documented. Moderate drinking is defined as no more than one drink a day for women and no more than two drinks a day for men. Twelve ounces of beer; 5 ounces of wine; or 1.5 ounces of distilled spirits (80 proof) counts as one drink. Counseling must occur if alcohol abuse is identified.

22. Substance Abuse
For patients age 11 and over, assessment of substance abuse must be documented. Counseling must occur with identification of substance abuse.

23. Preventive Services
There is evidence that preventive screening and services are offered in accordance with The Health Plan Preventive Health Guidelines.

24. Immunization Record
An immunization record for children and adults is up-to-date according to The Health Plan Preventive Health Guidelines. Practitioners not providing immunizations in their offices are responsible for obtaining updated information from the source providing the immunizations.

25. Audit Trail
The office maintains an audit log to track access to patient information including username, document(s), and description of use.

Electronic Health Record (EHR)

1. **Copy/Paste or Cut/Paste**
   The office has a policy/procedure to monitor and audit information "copied and pasted" or "cut and pasted" into the EHR to ensure copied information includes proper validation including name, credentials, date, time, and source of data.

2. **Defaults**
   Defaults are defined as data that is entered that does not require a positive action or selection, or data is entered by abbreviated words or keystrokes.

   The office has a policy/procedure to verify the validity of auto-populated information.

3. **Multiple individuals adding text/addendums to the same process note, entry, flowsheet**
   Documents with multiple authors or contributors retain signatures so that each individual's contribution is clearly identified.

4. **E-prescribing**
   For offices currently utilizing E-prescribing, they have a policy/procedure for monitoring to prevent fraud, waste, and abuse.

5. **Technical Specifications**
   The office has a policy/procedure such as a backup system to prevent loss or destruction of EHR.

6. **EHR Health Information Exchange**
   The office has a policy/procedure to ensure secure, authorized electronic exchange of patient information.

Resources used in standard development:

- The Bureau for Medical Services (BMS)
- Centers for Disease Control
- The Centers for Medicare and Medicaid (CMS) Quality Improvement Standards
- Qlarant (formerly Delmarva) Quality Improvement Standards
- The Health Plan Guidelines
- The Health Plan Quality Improvement Committee
- US Department of Health and Human Services

Medical Records and Confidentiality Statement

The medical records and confidentiality statement ensure that a separate comprehensive medical record is created and maintained in a confidential manner for each member, as well as, provides easy access to all biographical and medical information and promotes quality care.

All participating physicians and providers shall maintain a separate onsite and up-to-date member medical record in accordance with The Health Plan standards for patient records. Providers shall comply with all federal and state laws and regulations which are consistent with good medical and professional practice.

All physicians shall preserve all records related to members for a period of not less than 10 years and retain records longer if the records are under review or audit.

The medical records shall be made available, as needed, to each physician treating the member. These records will be made available upon request of an authorized representative of The Health Plan for medical audit, utilization review, fiscal audit, and other periodic monitoring.

All medical records and discussion of details regarding patient information should only take place to complete normal job duties. Such discussion outside of regular working duties and home is strictly prohibited.

Members shall have the opportunity to approve or deny the release of identifiable personal health information by the physician or the provider except when the release is required by law. Member information shall not be released without signed authorization.

Copying member medical records and other data containing patient health information should be kept to the minimum that is needed to accomplish the required job. Member information, whether personal or medical, shall be released only when necessary.

All member's medical record information should be kept confidential.

- All files should have limited access and not left open where they could be casually read.
- Computer system files require special password capability for access. All computer terminals accessing the mainframe should be logged off at the close of each day to prevent unauthorized access to system data.

All member medical records requiring disposal should be placed in appropriate receptacles for shredding. Burning may be used in lieu of shredding.

All physicians should require the review of this policy with any new employee, and with all employees on an annual basis.

Office Procedure Review

The Office Procedure Review form is available here.

Signature Log Form

Physician offices should sign all entries in patients' charts either by a signature or initials (full name and title). When initials are used, a record of the initials, along with the person's name, should be kept on file in each office.

For your convenience, we have devised a signature log for your use and is available here. The form contains the following sections:

- **Legible name** — print the employee's name
- **Credentials** — MD, DO, DPM, DDS, CNP, NP, PA, etc.
- **Legal signature with credentials** — have the employee sign their name with credentials
- **Any signature variations** — employee signature if different from their legal signature

The signature log form may be reproduced.

Onsite visits of physician offices will be conducted spontaneously to review charts, office procedures, hazardous waste disposal and pharmaceutical and narcotic storage.

The network provider engagement department attempts to educate offices regarding these areas as we receive additional information. It is the office's responsibility to implement these procedures.

The contact information for the provider engagement representative assigned to your county can be located on the website under "For Providers," "Meet the Provider Engagement Team."

Telephone Message Form

At the request of many offices, we have devised a telephone message form for your use. This form contains the necessary information needed to document phone calls received from patients. It provides space for recording times and intervention that may be important. By using this form, you may reduce the number of messages contained in your charts.

In today's legal climate, it is increasingly important to document information accurately and in a comprehensive manner. One office had indicated that a form such as this afforded them the protection and documentation necessary to defend their office against a liability claim.

Use of this form is recommended but not mandatory. The form is available here.

Section 17

Phone Directory

Phone Directory

The Health Plan General Telephone Number: 1.800.624.6961

ASO Benefits, Claim Status and Pre-Authorization Intake Reps (Providers Only)		
Self-Funded (ASO)	Zappos.com	1.877.794.7153
	Murray Groups	1.877.794.7151
	All Other ASO Groups	1.888.816.3096
Benefits, Eligibility, Claim Status and Pre-Authorization (Provider or Members)		
HMO, PPO & POS		1.888.847.7902
Medicare		1.877.847.7907
Medicaid		1.888.613.8385
Self-Funded (ASO)		See Numbers Above
Coordination of Benefits (COB) Issues and Questions (Providers or Members)		
All Lines of Business		1.800.624.6961, ext. 7903
Member Questions, Changes, Complaints and Concerns		
HMO, PPO & POS		1.888.847.7902
Medicare		1.877.847.7907
Medicaid		1.888.613.8385
Self-Funded (ASO)	Zappos.com	1.877.794.7153
	Murray Groups	1.877.794.7151
	All Other ASO Groups	1.888.816.3096

Section

18

Compliance, Fraud, Waste and Abuse

Fraud, Waste and Abuse Regulations and Guidelines

Fraud, Waste and Abuse (FWA) Policies and Related Laws

The Health Plan's fraud, waste and abuse policies were established to prevent, detect and correct fraudulent, wasteful or abusive practices perpetrated by employees, members, providers and facilities, including providers and facilities not contracted with The Health Plan. Compliance with these policies is the responsibility of each and every employee and anyone providing services to members of The Health Plan. Providers should ensure that ALL staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. The Health Plan expects its first tier, downstream, and related entities (FDRs) and its providers to operate in accordance with all applicable federal and state laws, regulations, and Medicare and Medicaid program requirements including, but not limited to the following:

1. **Health Care Fraud (18 U.S.C. §1347)**

   The Health Care Fraud statute makes it a crime for anyone to knowingly and willfully execute or attempt to execute a scheme to defraud any health care benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a health care benefit program in connection with the delivery of or payment for health care benefits.

2. **Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)**

   The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:

   a. Knowingly submitting a false or fraudulent claim for payment to the United States government;
   b. Knowingly making a false record or statement in order to get a false or fraudulent claim paid or approved by the government;
   c. Conspiring to defraud the government in order to get a false or fraudulent claim paid or approved by the government; or
   d. Knowingly making a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

3. **Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)**

   Federal law makes it a criminal offense for anyone to make a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offense carries a criminal penalty of up to five years in prison and a monetary fine.

4. **Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))**

   This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. Kickbacks can take many forms such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is inconsistent with fair market value. Kickbacks may also include the routine waiver of copayments and/or co-insurance. Penalties for anti-kickback violations include fines of up to $25,000, imprisonment for up to five years, civil money penalties up to $50,000, and exclusion from participation in federal health care programs.

5. **The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))**
   This statute makes it illegal to offer remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order or specialty pharmacy.
6. **Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)**
   The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. Stark Law also prohibits the designated health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Penalties for Stark Law violations include overpayment/refund obligations, FCA liability, and civil monetary penalties. Stark Law is a "strict liability" statute and does not require proof of intent.
7. **Fraud Enforcement and Recovery Act (FERA) of 2009**
   FERA made significant changes to the False Claims Act (FCA). FERA makes it clear that the FC A imposes liability for the improper retention of a Medicare overpayment. Consequently, a health care provider may now violate the FCA if it conceals, improperly avoids or decreases an "obligation" to pay money to the government.

FWA Training and Education

All health care practitioners/providers or staff who render health care services to Medicare Advantage enrollees, provide Medicare Part C services, administer the Medicare Part D prescription drug benefit, or provide services to Medicaid recipients should complete FWA training. FWA training may be completed through the practitioners'/providers' own internal compliance program or using The Health Plan Compliance and FWA training slides available on The Health Plan website. FWA training should be completed upon hire (within 90 days) and annually thereafter.

Practitioners/providers must maintain records of their completion of FWA training, as well as their employees', for a period of at least ten years.

Reporting

The Health Plan Special Investigations Unit (SIU) and Compliance Department actively review all reports of suspected FWA and non-compliance. To report suspected fraud, waste or abuse and/or suspected issues of non-compliance, call the hotline at 1.877.296.7283. The Health Plan maintains a non-retaliation policy for anyone reporting issues in good faith; everyone should feel conf ident that NO adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

A number of resources, including training slides are available on The Health Plan provider portal under "Resource Library," "Compliance."

Special Investigations Unit

Medicaid and Medicare guidelines require The Health Plan to have an effective program in place to prevent, detect, and correct fraud, waste and abuse. The Health Plan values its relationship with providers and recognizes the importance of providing valuable care to the community. The Health Plan is committed to ensuring quality care for its members and proper payment to providers for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship, honoring the commitment to The Health Plan's network and its members, and ensuring compliance with federal regulations.

The Special Investigations Unit (SIU) plays a vital role in detecting, preventing, and correcting fraud, waste and abuse, in ensuring payment integrity, and in recovering overpayments as required by state and federal regulations. SIU activities may include, but are not limited to, data mining, pre- and post-payment reviews, site visits, audits, and the facilitation of provider self-audits. In the event fraud or abuse is suspected, information is referred to the appropriate regulatory authorities and/or law enforcement.

The SIU utilizes a skilled team capable of analyzing, auditing, and investigating claims. Providers may be contacted by the SIU as a result of routine post-payment monitoring, or in response to a specific concern. Providers are expected to cooperate with the SIU and must comply promptly with requests for records or other information to ensure timely completion of audits and reviews.

Provider Self-Audits

All parties have an obligation to ensure that submitted claims are billed and paid properly. Federal and state regulations require managed care organizations that serve the Medicaid and Medicare populations to have procedures in place designed to detect and prevent fraud, waste, and abuse.

The Health Plan is committed to ensuring payment integrity across all lines of business. In furtherance of this objective, the Special Investigations Unit (SIU) may review paid claims either as part of a proactive payment integrity program, or in response to specific allegations. One tool the SIU incorporates into its payment integrity processes is the provider self-audit.

A provider self-audit is an audit, examination, or review performed by and within a provider's business. A self-audit may be performed proactively by a provider as part of their own efforts to ensure payment integrity or at the direction of The Health Plan based on the discovery of questionable billing patterns. Self-audits are often preferred by providers because they are reviewing their own records, versus having SIU staff and/or government regulators on-site conducting an in-depth review. Additionally, a self-audit process is generally educational for the provider and their billing staff, resulting in a greater likelihood of future compliance.

Self-audits will be narrowly focused while still sufficient to address the relevant issues and will be limited in scope and duration. Self-audits may be utilized for cases meeting the following criteria:

1. Clear indications that an overpayment has occurred;
2. The overpayment is likely to be expansive;
3. No previous or immediate indicators of intent to defraud; and
4. High likelihood that the issue(s) can be resolved without significant SIU intervention.

Providers will be notified in writing when a self-audit is required. Self-audits will be designed on a case-by-case basis, depending on the specific circumstances giving rise to the audit. However, in all instances a self-audit notification will include the purpose of the review, the universe of claims and how that universe was determined, a deadline for completion, and instructions on how to remit any overpayments. Overpayments made under any federal health insurance program must be recovered. Refer to **Section 15** "*Payment Voucher and Claims, Overpayments and Offsetting*" in this manual for timelines and processes related to overpayment recoveries.

The self-audit results will be reviewed by The Health Plan. The SIU may review documentation to validate the results and/or may meet with the provider or their staff to discuss any questionable items or further concerns. The provider should maintain copies of self-audit information and documentation for future reference. The provider will be notified in writing upon conclusion of the self-audit review.

Acceptance of a provider self-audit or subsequent repayment does not necessarily constitute agreement with the audit results or the overpayment amount, if it is later discovered that the self-audit results contained material misrepresentations or that supporting documentation or other relevant information was altered.

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Compliance Through Training

The Health Plan uses education as a tool to ensure our members receive the highest quality of care by you, the provider. We achieve this through periodic reminders, updates and by communicating various compliance topics to facilitate our preventative approach.

- Compliance and FWA training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training documents provided by The Health Plan.
- Training should be completed within 90 days of the initial hire date or the effective date of contracting and at least annually thereafter.
- Click the link to access the U.S. Department of Health & Human Services Office of Inspector General's *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse* : oig.hhs.gov/compliance/physician-education/index.asp.
- Annual D-SNP training and attestation are required if you provide health care services to five or more of The Health Plan's D-SNP members in the prior quarter. Your provider engagement representative will contact you to inform you of the requirement to complete training and provide you with the training materials and attestation form.
- You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means determined by you to document completion of these obligations.
- It is recommended that you verify with your outside billing and/or management companies that they are conducting compliance and FWA training as part of the seven core elements of an effective compliance program.

For additional information or assistance, please contact the Provider Relations Department at providersupport@healthplan.org.

The Health Plan Resources

The Health Plan provides training materials to assist providers with required and recommended training. Please visit The Health Plan's provider portal under "Resource Library" to take advantage of the following training documents:

1. THP Medicare Advantage D-SNP Training
2. FDR-Subcontractor Standards of Conduct
3. THP 2020 Hotline Poster (for download in your office)
4. THP Code of Conduct
5. THP Fraud, Waste and Abuse Training
6. OIG Training Roadmap for New Physicians
7. 2020 Cultural Competency and SDoH Provider Training

Government Resources

1. Compliance Guidance for Individual and Small Group Physician Practices
   oig.hhs.gov/authorities/docs/physician.pdf
2. Compliance Guidance for Medicare Choice Organizations
   oig.hhs.gov/fraud/docs/complianceguidance/111599.pdf
3. Health Insurance Portability and Accountability Act (HIPAA)
   hhs.gov/hipaa/for-professionals/index.html
4. Stark Law (Physician Self-Referral)
   cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html?redirect=/PhysicianSelfReferral/

Compliance Through Reporting

The Health Plan believes it is the duty of every person who has knowledge or a good faith belief of a potential compliance issue to promptly report the issue or concern upon discovery. This reporting obligation applies even if the individual with the information is not in a position to mitigate or resolve the problem. This obligation applies to all of The Health Plan's first tier, downstream and related entities (FDRs) and its contracted providers.

The Health Plan also believes that an issue involving potential or actual non-compliance or FWA can be best investigated and remediated if an entity feels comfortable reporting such incidents through designated channels. There are various mechanisms available to confidentially report compliance concerns or suspected FWA.

- If your organization does not maintain a confidential FWA and compliance reporting mechanism, The Health Plan provides

various reporting resources: a confidential FWA and compliance hotline at **1.877.296.7283**, email at compliance@healthplan.org, SIU@healthplan.org or on our website at healthplan.org. These reporting mechanisms are available and widely publicized to all employees, providers and contractors to report potential issues involving FWA and/or non-compliance.

- The Health Plan has adopted and requires all FDR and provider entities to adopt and enforce a zero-tolerance policy for intimidation or retaliation against anyone who reports, in good faith, suspected or actual misconduct.

Federal law prohibits payment by Medicare, Medicaid or any other federal health care program for an item or service furnished by a person or entity excluded from participation in these federal programs. As a Medicare Advantage organization, Part D plan sponsor and Medicaid contractor, The Health Plan, its FDRs and providers are prohibited from contracting with, or doing business with, any person or entity that has been excluded from participation in these federal programs. Prior to hire and/or contracting, and monthly thereafter, each First Tier Entity and provider must perform a check to confirm its employees, governing body, volunteers and downstream entities that perform administrative or health care services for The Health Plan's Medicare and Medicaid lines of business are not excluded from participation in federally-funded health care programs according to the OIG List of Excluded Individuals and Entities and the Systems for Award Management (SAM) exclusion databases.

- Office of Inspector General (OIG) list of excluded individuals and entities: exclusions.oig.hhs.gov
- General Services Administration (GSA) Systems for Award Management (SAM): sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf
- In the event any of your employees or downstream entities are found on either of these exclusion lists, you must immediately remove the individual/entity from work related directly or indirectly to The Health Plan's Medicare and Medicaid programs and notify The Health Plan of your findings.
- You must maintain a record of checking the exclusion lists (i.e., logs or other records) to document that each employee and downstream entity has been checked through the exclusion databases in accordance with current laws, regulations and CMS requirements.
- For further information on exclusion list requirements, refer to §1862(e)(1)(B) of the Social Security Act, 42 C.F.R. §422.752(a)(8), 42 C.F.R. §423.752(a)(6), 42 C.F.R. §1001.1901, the CMS Managed Care Manual, Chapter 21, Section 50.6.8 and the CMS Prescription Drug Benefit Manual, Chapter 9, Section 50.6.8.

The Health Plan will continue to educate our providers with reminders, bulletins and updates to promote compliance, and foster a continued and long-standing relationship with all of our valued providers. Thank you for your dedication and continued hard work toward satisfying the overall health care needs of our members.

Other Resources:

1. Health Care Administrators Association (HCAA): hcaa.org
2. Heath Care Compliance Association (HCCA): hcca-info.org

3. Society of Corporate Compliance and Ethics (SCCE):
   corporatecompliance.org
4. American Health Lawyers Association (AHLA):
   healthlawyers.org
5. National Health Care Anti-Fraud Association (NHCAA):
   nhcaa.org
6. Institute for Health Care Improvement (IHI):
   ihi.org
7. A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse:
   oig.hhs.gov/compliance/physician-education/index.asp

HIPAA Privacy and Security

The Health Plan is committed to ensuring the privacy and integrity of our members' protected health information, or PHI. HIPAA privacy rules mandate that The Health Plan and our business associates learn and apply the privacy and security rules regarding PHI and abide by the m. An individual's PHI must be protected.

PHI includes individually identifiable information that relates to an individual's past, present or future health condition whether in written, spoken or electronic form.

HIPAA, The Health Insurance Portability and Accountability Act, is a federal law that requires The Health Plan, our contracted providers and our First Tier, Downstream and Related Entities (FDRs) to:

- Properly secure protected health information (PHI) (physically and electronically)
- Protect the privacy of member/patient information
- Abide by the "minimum necessary" standard for the use and disclosure of member/patient information
- Address member/patient rights for the access, use and disclosure of his or her health information

The Health Information Technology for Economic and Clinical Health (HITECH) Act and the HIPAA Final Omnibus Rule updated the original federal HIPAA privacy and security standards to include:

- Requirements for breach notification
- Member/patient rights to obtain electronic copies of their electronic health record
- Makes business associates directly liable for compliance with HIPAA provisions
- Increased fines and penalties for violations
- Civil penalties range from $100 - $1,500,000 per year
- Criminal penalties range from $50,000 - $250,000 and imprisonment of up to 10 years

Who Does HIPAA Apply To?

HIPAA laws and regulations apply to health plans, health care providers and health care clearinghouses as well as business associates who perform services on their behalf.

Safeguarding PHI
Here are some ways to protect member/patient information:

- Use PHI only when necessary as part of job duties
- Use only the minimum necessary information to perform job duties
- Double check printers, faxes and copiers when finished using them
- Never leave PHI unattended in a bag, briefcase or vehicle
- When mailing documents, verify that each page belongs to the particular patient
- Ensure that computers are locked when unattended
- Create strong passwords, and never share usernames or passwords

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- Do not install unknown or unsolicited programs onto work computers
- Ensure that information on monitors/screens is not visible to patients or visitors
- Never share patient information through social media, even if it is public knowledge
- When discussing patient care, take steps to reduce the likelihood others will overhear
- Keep paper documents that contain PHI out of view from others
- Dispose of PHI properly when no longer needed.

These are just a few ways to help ensure the confidentiality of patient PHI. Trul y protecting the information that is entrusted to healthcare providers requires a commonsense approach that depends upon strict adherence to established policies and procedures.

The Health Plan has implemented HIPAA related training for all of its employee s, which is distributed to staff upon hire and annually thereafter. It is recommended that all entities who work with PHI establish their own privacy and security program for their individual organization, and execute an inclusive, well-rounded training regimen to keep employees informed of their responsibilities surrounding patient/member rights and protections under the law.

HIPAA information and related forms can be found on our website.

Resources:

- U.S. Department of Health and Human Services- Office for Civil Rights (OCR): hhs.gov/hipaa/for-professionals/index.html
- HIPAA Frequently Asked Questions for Professionals (FAQs): hhs.gov/hipaa/for-professionals/faq

Aetna Better Health® of West Virginia 2019-2020 Member Handbook

AetnaBetterHealth.com/WestVirginia

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Helpful Information

Aetna Better Health® of WestVirginia
Member Services
1-888-348-2922 (TTY: 711)

Website
AetnaBetterHealth.com/WestVirginia

Hours of operation
8:30 a.m. to 5 p.m.

SkyGen USA Dental
1-888-983-4693

Non-Emergent transportation – Logisticare
1-844-549-8353

Prescription Drugs
DXC Technologies Customer Services **1-888-483-0797**

HELP IN YOUR LANGUAGE

If you do not speak English, you can call us at **1-888-348-2922** (TTY: **711**).We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: Si usted no habla inglés, llámenos al **1-88-8348-2922** y **711**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

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WELCOME

Welcome to Aetna Better Health's Medicaid managed care program! We are glad that you have enrolled with us. This handbook will provide you with the information you need to know about your health care plan, also known as a managed care plan. Please read this handbook from cover to cover to understand the way your plan works. This handbook will help you get the most from Aetna Better Health. It will answer many of the questions that come up about your benefits and the services offered by Aetna Better Health. You can also ask us any questions you may have by calling us at **1-888-348-2922**. If you are speech or hearing impaired, please dial **771**. If you would like a printed copy of this handbook, please call us and one will be mailed to you within five (5) business days of your request.

ABOUT OUR PLAN

Aetna Better Health has a contract with the West Virginia Department of Health and Human Resources [DHHR]. Under managed care, we are able to select a group of health care practitioners and providers to form a provider network. Usually provider networks are made up of doctors and specialists, hospitals, and other health care facilities. Our practitioners and providers help to meet the health care needs of people with Medicaid. The Provider Directory lists all of our network providers you can use to get services statewide. It can be found online at our website, **AetnaBetterHealth.com/WestVirginia**. If you would like a printed copy of the Provider Directory or information about a practitioner's education, such as medical school and residency, cultural competency, or board certification, please call **1-888-348-2922** (TTY: **711**).

It is important to us that you receive quality health care and customer service. Your satisfaction matters to us. The Quality Management (QM) program ensures our services meet high standards of quality and safety. We want to make sure you have:

- The right kind of care
- Easy access to quality medical and behavioral health care
- Help with any chronic conditions or illnesses
- Support when you need it most
- High satisfaction with your doctors and with us

For more information about our Quality Management program visit our website at **AetnaBetterHealth.com/ WestVirginia**. If you have a problem, please call Member Services at **1-888-348-2922** (TTY: **711**).

ANNUAL COMMUNITY REPORT

A copy of the Aetna Better Health Annual Community Report is available to you. If you would like a copy, call us at **1-888-348-2922** (TTY: **711**).

CONTACT US

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call. You can also visit our website, **AetnaBetterHealth.com/WestVirginia**, for other information.

Member Services Department
Hours of Operation: Monday – Friday, 8:30 AM – 5 PM
Address: 500 Virginia Street East, Suite 400, Charleston, WV 25301
Toll-free: **1-888-348-2922**
TTY: **711**
Online: **AetnaBetterHealth.com/WestVirginia**

You can call or visit us online to:

- Ask questions about services and benefits, eligibility, claims, prior authorization requests, or utilization management (more information on utilization management procedures is available upon request)
- Change your primary care provider (PCP) or get help choosing a provider
- File a complaint
- Replace a lost member ID card
- Get help with referrals
- Let us know if you are pregnant
- Let us know if you give birth to a new baby
- Ask about any change that might affect you or your family's benefits
- Let us know about any changes to personal information
- Request interpreter services or help for people with disabilities

If you do not understand or speak English, we can help. Please call Member Services toll-free at **1-888-348-2922** (TTY: **711**). We can answer questions about your benefits in your language. We have free interpreter services and can help you find a health care practitioner who can communicate with you in any language.

For people with disabilities, we can help. Aetna Better Health offers services so that you can communicate effectively with us and your practitioner or provider. We have access to free sign language interpreter services and a TTY phone number: **1-888-348-2922** (TTY: **711**). We can offer this handbook and all written materials in many formats, such as large print, at no cost to you. Please call Member Services toll-free at **1-888-348-2922** to ask for materials in another format.

For other important phone numbers, please see the list in the back of this handbook.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your rights to privacy. We will never give out your medical information or social security number without your written permission, unless required by law. To learn more about your rights to privacy, please call Member Services at **1-888-348-2922** or visit our website at **AetnaBetterHealth.com/WestVirginia**.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act, you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East
Charleston, WV 25305
304-558-4331

DEFINITIONS

Appeal: A way for you to request the review of Aetna Better Health's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Complaint: An expression of dissatisfaction, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health or our practitioners or providers. For example, you might complain about the quality of your care. In this handbook "grievance" and "complaint" mean the same thing.

Co-payment: A fixed amount you pay each time you get a covered service or supply. For example, if you use the emergency room when it is not an emergency, you might pay $8.

Durable Medical Equipment (DME): Certain items your practitioner or provider orders for everyday or extended use. Examples of these items are wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm. An emergency medical condition would make you think that without medical attention, it might: place your health (or a pregnant woman's unborn child's health) in serious jeopardy; or lead to death, serious dysfunction of a body part or organ, or serious impairment of bodily functions. Examples of an emergency medical condition include severe pain, difficulty breathing, or uncontrolled bleeding.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you receive in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are: given by a qualified provider and needed to evaluate or stabilize an emergency medical condition.

Excluded Services: Healthcare services that Aetna Better Health does not pay for or cover.

Grievance: A complaint you make, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health or our practitioners or

providers. For example, you might complain about the quality of your care. In this handbook “grievance” and “complaint” mean the same thing.

Habilitation Services and Devices: Healthcare services and devices that help you keep, learn, or improve skills and functioning for daily living. Examples include occupational theory, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Insurance : A contract that requires Aetna Better Health to pay some or all of your healthcare costs in exchange for a premium.

Home Health Care: Healthcare services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies, and other services.

Hospice Services: Services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization : Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Medically Necessary: Items or services furnished or to be furnished to a patient for diagnosing, evaluating, treating or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Health care services and supplies that are reasonable and necessary to diagnose or treat an illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development. Determination of medical necessity is based on specific criteria.

Network: A group of providers who has contracted with Aetna Better Health to give care to members. The list of Aetna Better Health practitioners and providers can be found in your Provider Directory. It will be updated whenever there are changes.

Non-participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has not signed a contract agreeing to provide services to Aetna Better Health members.

Physician Services: Healthcare services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain healthcare services needed by plan members. You are a member of our health plan, Aetna Better Health.

Prior Authorization: Approval from Aetna Better Health that may be required before you get certain services or treatments in order for them to be covered. To get prior authorization, make sure to ask Member Services. If the care is medically necessary, then it will be covered.

Participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has signed a contract agreeing to provide services to Aetna Better Health members. They are listed in the Provider Directory.

Practitioner: A licensed or certified professional who provides medical or behavioral health care services, such as a doctor, nurse practitioner, or psychologist.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs and medications. Aetna Better Health does not provide prescription drug coverage, but the State of West Virginia does.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating practitioner you have chosen to be your personal doctor. Your PCP works with you to coordinate your healthcare, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Provider: An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Rehabilitation Services and Devices: Healthcare services and devices that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. Examples include occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Tertiary Services: Highly specialized medical services administered in a specialized medical facility.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgent care from out-of-network practitioners/providers when network practitioners/providers are unavailable, or you cannot get to them. Examples of when to get urgent care a sprained ankle, a bad splinter, or the flu.

YOUR RIGHTS

As a member of Aetna Better Health, you have rights around your health care. You have the right to:

- Get information about Aetna Better Health, our services, our practitioners and providers, and your rights and responsibilities.
- Be treated with respect and dignity and have your privacy protected.
- Get interpretation services if you do not speak English or have a hearing impairment.
- Have materials presented in a manner or language that you understand, at no cost to you.
- Not be discriminated against by Aetna Better Health.
- Access all services that Aetna Better Health must provide.
- Choose a practitioner or provider in our network.
- Take part in decisions about your health care.
- Accept or refuse medical or surgical treatment and choose a different provider.

- Learn about other treatment options and different courses of care no matter how much they cost and/or if Aetna Better Health will pay for it.
- Have your doctor tell you how he or she plans to treat you.
- Your medical records.
- Change or correct your medical records if needed.
- Be sure your medical records are kept private.
- Tell us how we can improve our policies and procedures, including the member rights and responsibilities policy.
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation.
- Get covered services, no matter what your cultural or ethnic background is or how well you understand English.
- Get covered services regardless of any physical or mental disability, or if you are homeless.
- Refer yourself to in-network and out-of-network family planning providers.
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services.
- Get emergency post-stabilization services.
- Get emergency health care services at any hospital or other setting.
- Receive information about advance directives, which tell how to have medical decisions made for you if you are not able to make them for yourself.
- Receive information about practitioner incentive plans upon request.
- Have your parent or a representative make treatment decisions when you can't.
- Submit a complaint or appeal about Aetna Better Health or the services it provides.
- A quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services.
- A state fair hearing after a decision has been made about your appeal.
- A copy of this member handbook.
- Disenroll from your health plan.
- Get accessible services.

YOUR RESPONSIBILITIES

As a member of Aetna Better Health, you have the responsibility to:

- Read your Member Handbook. It tells you about our services and how to file a grievance or appeal.
- Work with your PCP to manage and improve your health.
- Ask your PCP any questions you may have and call your PCP any time you need health care.
- Give all information about your health to Aetna Better Health and your doctor. Tell your doctor if you do not understand your health problems. You and your doctor should make plans together about your care.
- Show your ID card to each doctor before getting health services.
- Protect your member ID card. Do not lose or share it with others.
- Use the emergency room (ER) for true emergencies only.
- Make and keep appointments with doctors. If you need to cancel and appointment, it must be done at least twenty-four (24) hours before your scheduled visit.
- Follow what you and your practitioner agree to do.
- Follow your practitioner's recommendations about appointments and medications.
- Go back to your PCP or ask for a second opinion if you do not get better.
- Call Member Services at **1-888-348-2922** (TTY: **711**) whenever anything is unclear to you or you have questions.
- Contact DHHR Change Report Center at **1-877-716-1212** to report family size, employment, and/or address changes.
- Treat doctors, staff, and people providing services to you with respect.
- Tell Aetna Better Health if you have other health insurance, including Medicare.
- Give your doctor a copy of your living will and/or advance directive.

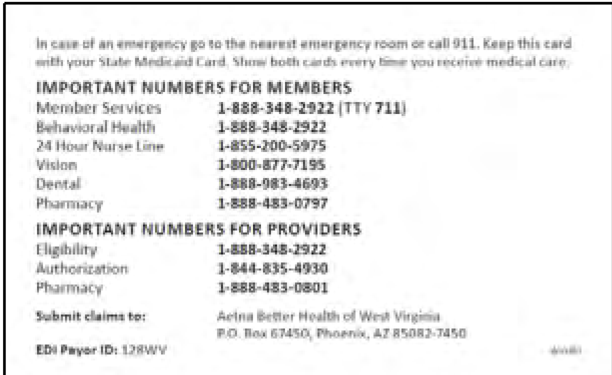
STEPSTO YOUR GETTING CARE

YOUR MEMBER ID CARD

After you join Aetna Better Health, we will send you your member ID card in the mail. Each member of your family who has joined Aetna Better Health will receive his or her own card. If you have not received your member ID card after five (5) days, please call Member Services at **1-888-348-2922** (TTY: **711**).

It is important to always keep your member ID card with you. You will need it any time you get care. Your card is your proof that you are a member of Aetna Better Health. You should also keep your Medicaid Benefit card. You need it to get care that is not covered by Aetna Better Health.

Your card should look like this:



You will find some useful information on your card like your Medicaid ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at **1-888-348-2922** (TTY: **711**) if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You have a baby or add a new member to your family
- You move
- Someone in your family dies

Please call your county DHHR immediately at **1-877-716-1212** if you move to another state or to another country.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Each member of Aetna Better Health chooses a primary care provider (PCP) from the Provider Directory. A PCP is a specific clinician responsible for coordinating your health care needs. The provider directory is available on our website at **AetnaBetterHealth.com/WestVirginia**. It is a list of all doctors, hospitals, dental and specialty care practitioners and other providers who work with Aetna Better Health. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the directory, we will choose one for you.

If you have a chronic illness, then you may be able to select a specialist as your PCP. Please call Member Services at **1-888-348-2922** (TTY: **711**) to find out If you already have a PCP and believe you need a specialist, you or your practitioner should call Member Services. Women can also receive women's health care services from an obstetrical/ gynecological practitioner (OB/GYN) without a referral from their PCP.

Upon request, a description of how physicians are paid is available to Aetna Better Health members.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all of your routine health care needs. All new members should try to schedule an appointment within 45 calendar days. You can schedule your appointments by calling the PCP's office phone number. Your PCP's name and office phone number will be listed on your member ID card. You can call 24 hours a day, seven days a week. On the day of your visit, remember to bring your member ID card and your Medicaid ID card. Please show up on time and call to cancel an appointment if you cannot make it.

Aetna Better Health requires that all routinely used sites, such as PCP offices and frequently used specialists, must be located within 30 minutes travel time of a member. Basic hospital services must be within 45 minutes travel time (urban) or 60 minutes travel time (rural).

Aetna Better Health will ensure hours of operation are convenient and do not discriminate against members.

Aetna Better Health requires that emergency cases will be seen or referred immediately. Urgent cases must be seen within 48 hours. Routine cases must be seen within 21 days.

CHANGING YOUR PCP

If you need to, you can change your PCP for any reason at any time. Let us know right away by calling Member Services at **1-888-348-2922** (TTY: **711**) or by going to **AetnaBetterHealth.com/WestVirginia**. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history.

Sometimes PCPs leave our network. If we find out your PCP is leaving, we will let you know by mail within 15 calendar days. We will try to give you 30 calendar days notice before your PCP leaves. We can assign you a new PCP or you can pick a new one yourself. If we need to assign you a new PCP for another reason, we will let you know.

SECUREMEMBER WEB PORTAL

Our updated secure member website is your go-to resource to manage your plan—and your health. It will help you use your benefits and services so you can get and stay healthy. You can:

- Access health plan details—change your doctor, find forms or request member ID cards.
- Get personalized health information—answer questions about your health. Get the tips and tools you'll need to meet your health goals like quitting smoking and weight management.
- Get instant access to claims details—see the status of a claim from start to finish.
- Find support—get in touch with a nurse. Or learn more about chronic condition management and wellness programs that will help you stay on track with goals.

Set up your account by visiting **AetnaBetterHealth.com/WestVirginia**. Click on the "Member Portal" then select "Register or Log In". You'll need your member ID and a current email address to create an account.

To sign up over the phone call Member Services at **1-888-348-2922** (TTY: **711**).

WHERE TO GETMEDICAL CARE

Please read below to understand what type of care to get in different situations.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need.

- Well-care Visits – A well care visit is when you or your child sees your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health, too. You can learn more about well-care visits under the section titled "More Information about Your Coverage".
- After Hours Care – You can reach your PCP even if it is after normal business hours. Just leave a voicemail with your name and phone number. Your PCP or another PCP on call for your PCP will call you back.
- We cover care given by licensed Aetna Better Health of West Virginia practitioners. You may receive care in the practitioner's office, a clinic, or other places needed to treat an illness, injury or disease.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs prompt care but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- The flu

You can also get urgent care if you are traveling and are too far from your PCP's office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do. If you think you might need urgent care when you are away from your home or after hours, you can also call the 24-Hour Nurse Line at **1-855-200-5975** (TTY: **711**). They can help you decide what kind of treatment you need.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think he or she needs to be treated right away. Some examples of an emergency are:

- Severe bleeding that does not stop
- A heart attack
- Severe chest pain
- Seizures
- Rape

You should not go to the emergency room (ER) for things like:

- Colds
- Minor cuts and bruises
- Sprained muscles.

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or Aetna Better Health. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or Aetna Better Health at **1-888-348-2922** (TTY: **711**). Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure Aetna Better Health is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call Aetna Better Health. If you are able, call your PCP to let him or her know that you have a

medical emergency. You will need to schedule follow-up services (called post-stabilization) with your PCP.

For more information about emergency transportation and post-stabilization services, please see the Mountain Health Trust and West Virginia Health Bridge Covered Benefits table.

HOSPITAL CARE

Inpatient Hospital Care

When you do not have an emergency, we must preauthorize your stay before you go to the hospital. You must go to a hospital that is an Aetna Better Health of West Virginia provider. You will be under the care of your PCP or other practitioner to whom your PCP has sent you.

We help manage all hospital stays. We look at the care you get while you are in the hospital. The care is covered as long as there is a medical need for the care. If all or part of the hospital stay is not medically needed, your practitioner will be told that coverage will end, and you will not be responsible for payment.

Outpatient Hospital Care

Outpatient hospital care includes:

- Care to prevent sickness.
- Tests to find sickness.
- Care to help you heal.

You should tell your PCP when you receive outpatient hospital care. We must preauthorize this care. You can get the care at hospital outpatient departments, clinics, health centers or practitioners' offices that are in the Aetna Better Health of West Virginia Provider Directory.

CARE AWAY FROM HOME

Aetna Better Health’s service area is the entire State of West Virginia. If you are traveling or out of the service area, you are only covered for emergency services. Routine care out of the service area or out of the country isn’t covered by Medicaid. If you are out of the service area and need health care services, call your PCP. He or she will tell you what to do. (You can also call us to check if you are out of the service area.)

If you are not in West Virginia and you think you or your child's life is in danger, go to the closest ER. Show your Aetna Better Health of West Virginia ID card, your Medicaid ID card, and any other insurance ID cards you have to the ER staff. If you or your child get services in the ER and are admitted to the hospital, have staff call us at the number on the back of your ID card.

YOUR BENEFITS

You can get many services through Aetna Better Health's Medicaid managed care program in addition to those that come with regular Medicaid. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP. This means that you do not need approval from your PCP. To get these services, look in our Provider Directory for the list of providers/practitioners who offer these services. You can schedule the appointment yourself. If you have any questions, Aetna Better Health can help. Just call Member Services at **1-888-348-2922** (TTY: **711**). Member Services can explain how to access your services.

COVEREDSERVICES

Your covered services must be medically necessary. You should get these services from providers/practitioners in the Aetna Better Health network. Your PCP should provide covered services or refer you to another practitioner or provider to do so. The services included fall under medical, behavioral, dental, and vision. Benefit packages differ, depending on whether you are covered under Mountain Health Trust or West Virginia Health Bridge. You can see any differences in the table below. You can get the services listed in the Mountain Health Trust and West Virginia Health Bridge Covered Benefits table by using your Aetna Better Health member ID card.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits
Medical • Primary Care Office Visits and Referrals to Specialists • Physician Services – Certain services may require prior authorization or have service limits. May be delivered through telehealth. • Laboratory and X-ray Services – Includes lab services related to substance abuse treatment. Services must be ordered by a physician, and certain procedures have service limits. • Clinics – Includes general clinics, birthing centers, and health department

clinics. Vaccinations are included for children.

Specialty

- Podiatry – Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered.
- Physical Therapy – MHT 20 visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy). WVHB - 30 visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Occupational Therapy – MHT 20 visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy). WVHB - 30 visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Speech Therapy – Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (not covered for adults twenty-one (21) years or older). Some procedures have service limits or require prior approval.
- Handicapped and Children with Special Health Care Needs Services – Includes coordinated services and limited medical services, equipment and supplier (for children only).
- Chiropractor Services – Includes radiological exams and corrections to subluxation. Certain procedures have service limits.

Emergency

- Post-stabilization Services – Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- Emergency Transportation – Includes ambulance and air ambulance. Out of state requires prior authorization. To call for Emergency Transportation, dial 911.

Preventive Care and Disease Management

- EPSDT – Includes health care services for any medical or psychological condition discovered during screening (for children only).
- Tobacco Cessation – Includes therapy and counseling and Quitline services. Guidance and risk-reduction counseling covered for children.
- Sexually Transmitted Disease Services – Includes screening for a sexually transmitted disease from your PCP or a specialist in our

network.

Maternity

- Right From The Start – Includes prenatal care and care coordination. No prior authorization required.
- Family Planning – Includes all family planning providers and services. Sterilizations, hysterectomies, pregnancy terminations, and infertility treatments are not covered. No referral needed for out-of-network providers.
- Maternity Care – Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Other

- Federally Qualified Health Centers – Includes physician, physician assistant, nurse practitioner, and nurse midwife services.
- Prosthetics – Customized special equipment is considered. Certain procedures have services limits or require prior authorization.
- Durable Medical Equipment – Covered in nursing facilities and ICF/MRs. Customized special equipment is considered. Certain procedures have services limits or require prior authorization
- Ambulatory Surgical Care – Includes services and equipment for surgical procedures. Physician services; lab and x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs; and durable medical equipment not covered.
- Organ and Tissue Transplants – corneal transplants only

Nursing

- Nurse Practitioner Services – Some procedures have service limits.
- Private Duty Nursing – Includes 24-hour nursing care (not covered for adults twenty-one (21) years or older). Prior approval may be required.

Rehabilitation

- Pulmonary Rehabilitation – Includes procedures to increase strength of respiratory muscle and functions.
- Cardiac Rehabilitation - Includes supervised exercise sessions with electrocardiograph monitoring.
- Inpatient Rehabilitation – Includes inpatient rehabilitation services and general medical outpatient services that meet the certification requirements. Not covered for adults under Mountain Health Trust.

Hospital • Inpatient – Includes all inpatient services (including bariatric and corneal transplants). Adults in institutions for mental diseases and some behavioral health inpatient stays are not included. • Outpatient – Includes preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
Home Health Care – Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Some suppliers have service limits.
Hospice – Includes nursing care, physician services, medical social services, short-term care, durable medical equipment, drugs, biologicals, home health aide, and homemaker. Requires physician certification. For adults, rights are waived to other Medicaid services related to the terminal illness.
Dental – Includes emergency, non-emergency, and orthodontic services for children. Includes treatment of fractures, biopsy, tumors, and emergency extractions for adults. TMJ is not covered for adults.
Behavioral Health • Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility – Includes services for children with mental illness and substance use disorder. Limits frequency and amount of services. • Inpatient – includes behavioral health and substance use disorder hospital stays • Inpatient Psychiatric – Includes treatment through an individual plan of care. Pre-admission and continued authorization is required. Certification required. Not covered under West Virginia Health Bridge. • Outpatient – Includes services for individuals with mental illness and substance use disorder. Limits frequency and amount of services. Only assertive community treatment (ACT) providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Children's residential treatment is not covered. Psychological Services – Evaluation and treatment, including individual, family, and group therapies. May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions.
Vision – Includes eye exams, lenses, frames, and repairs for children. Includes medical treatment, one pair of glasses after cataract surgery, and contact

lenses for adults with conditions such as aphakia and keratoconus. Does not cover prescription sunglasses or designer frames.

Be sure to use your regular Medicaid card for services that are not covered by Aetna Better Health.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.
Early Intervention Services for Children Three and Under
Nursing Facility Services – Includes nursing, social services, and therapy
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited one per unit, per month basis. Requires physician order and nursing plan of care.
ICF/MR Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for members with intellectual disabilities. Requires physician or psychiatrist certification.
Prescription Drugs – Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor and Hepatitis-C may be covered under fee-for-service Medicaid. Drugs dispensed by a physician at no cost are not covered. The prescription drug benefit is administered by the State Medicaid program. For questions about getting your medicines please call DXC Technologies at **1-888-483-0797** between 7 AM - 7 PM Monday through Friday.
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/research or for end-stage diseases. Must be used to manage disease.

School-based Services – Service limitations are listed in the fee for service Medicaid provider manual.
Transportation – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: **1-844-549-8353**
Substance Use Disorder – Physician-supervised medication and counseling services provided to those with severe opioid use disorder

In addition to your benefits, Aetna Better Health offers value-added services. When eligible members complete the healthy behaviors in the table below, they will receive a reward. We offer these services to encourage health education and to promote health. Co-payments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services. Please note that value-added services sometimes change. Call Member Services at **1-888-348-2922** (TTY: **711**) for details.

Value -Added Services and Rewards	
Pregnancy	**Reward**
6 Prenatal appointments	Cribette
1 Post-partum appointment within **7-84** days of having your baby	$50 gift card
Enroll in Neonatal Abstinence (NAS) Program	Cribette or Baby Wrap Carrier
Complete the NAS Program	Educational Toy
Preventive Dental Program	Up to 2 check-ups during pregnancy
Walking Program	**Reward**
Receive a pedometer and log for tracking your steps	$25 gift card for completing an 8-week program
Diabetes	**Reward**
Enroll in diabetic education program and complete A1C testing*	$25 gift card
Yearly diabetic eye exam	
Diabetic dental program*	Routine teeth cleaning

National Diabetes Management Program	
Good Health Practices	**Reward**
Wellness event participation (Locations and services vary. Contact Member Services at **1-888-348-2922** for details.)	$25 gift card
Yearly well child exam for ages 12-18	
Yearly child dental check-up for ages 2-3	
Timely behavioral health follow-up appointment (within 7 days)	
Healthy Activities	**Reward**
Health related summer camps for children	Camp scholarships

*Available in certain counties

MORE INFORMATION ABOUT YOUR COVERAGE

Please read below for more details about your coverage. If you have any questions, please call Member Services at **1-888-348-2922** (TTY: **711**).

WELL-CHILD VISITS

Well-child visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit covers all medically necessary and preventive health care services for members up to age 21. Both sick and well care services are provided by your PCP at no cost.

Some screenings that children can get include:

- Physical exams
- Laboratory tests
- Vision testing
- Immunizations
- Hearing test
- Dental services
- Behavioral health screenings
- Health education
- Health and development history

Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early, before they become more serious. Call your PCP or Member Services to schedule a well-child visit. Transportation and scheduling help is also available upon request at no cost.

Aetna Better Health has trained professionals on staff to help move from child to adult care. We can help you to get the right care for your child's special needs. Please call **1-888-348-2922** (TTY: **711**) and ask to speak to a care management staff member.

POPULATION HEALTH MANAGEMENT

Aetna Better Health has many programs to help members get healthy and stay as healthy as possible. Whether you have a medical problem or are just trying to live a healthy life, we have a program for you. These programs help you take good care of yourself. We will automatically put you into the program if you are eligible. Call us if you do not want to be part of a program. For questions about these programs, call us at **1-888-348-2922** (TTY: **711**).

Program	Who Is Eligible
Healthy Pregnancies/Healthy Babies	Pregnant members and moms up to 6 weeks after giving birth
Healthy Adults and Children	All members
Flu Vaccination	All members over 6 months of age
Living with Diabetes	Members with Diabetes
Neonatal Abstinence (NAS)	Pregnant women who have substance use disorder (drug addiction) and Babies born with NAS
Appropriate Use of Acute Care Settings	Members who are in the hospital or have recently been discharged
Opioid Management	Members who use certain drugs
Chronic Condition Management	Members with at least one chronic condition: Asthma, Diabetes, Heart Failure, COPD (Lung Disease), Coronary Artery Disease (CAD), Depression
Managing Diabetes and Heart Disease (Multiple Chronic Conditions)	Members with both Diabetes and Heart Disease
Emergency Room (ER) Utilization Management	Members who frequently use the ER
Integrated Care Management (ICM)	Members who need help managing their care

INTEGRATED CARE MANAGEMENT

Some members have special health care needs and medical conditions. Our Integrated Care Management (ICM) Program can help make sure you understand your condition and treatment plan. We have nurses, social workers, and support staff who work with many health care practitioners, agencies and organizations to get you the services and the care that you need. We will help you get the best care in the most efficient manner. Our Case Managers help coordinate care in the following ways:

- Work one-on-one with you to create a plan based on your goals.
- Review your plan to help make sure you do not have gaps in care.
- Consult with your doctors.
- Help you make specialist and primary care doctor appointments.
- Verify that the right medicines and treatments are in place.
- Help make sure you receive preventive care.
- Work to ensure you and your family have the support you need.
- Ask questions to make sure your home is safe.
- Provide patient and family education about programs and services available in the community and through your doctor.
- Make sure you have support for any behavioral health needs.
- Help you transition to other care when your benefits end, if necessary.

We want to help you get the care and services you need. To sign up, call us at **1-888-348-2922** (TTY: **711**) and ask to speak to a Case Manager. Your practitioner or caregiver can also call to sign you up for the program. You may leave the program at any time.

WORKFORCE WEST VIRGINIA

Workforce WV offers tools to help with job searches, unemployment, and training. Workforce WV has the largest database of job seekers and openings in the state. The education and training opportunities provide residents work skills needed by businesses. Visit their website at **http://workforcewv.org** . If you don't have a job due to a health issue, please contact us at **1-888-348-2922** (TTY: **711**).

WEST VIRGINIA WIC

Aetna Better Health wants to make sure you receive all the help available to you. West Virginia Women, Infants, and Children (WIC) is an organization that provides nutritional services to you and your family. The mission of the West Virginia WIC program is to improve the health of women, infants and children in West Virginia by providing quality nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.

The West Virginia WIC program may be able to help you and your family to get better nutrition. To reach the office of the West Virginia WIC program call **304-558-0030** or go to their website at **ons.wvdhhr.org** .

HEALTH HOME

The Health Home Program coordinates physical and behavioral health (both mental and substance disorder), long term and social services, and supports for members with chronic health conditions. If you would like assistance with enrolling in a health home, please contact us at **1-888-348-2922** (TTY: **711**).

UTILIZATION MANAGEMENT

We want to ensure that our members are getting the services or benefits they need to get or stay healthy. This is called “utilization management” (UM). Our UM staff use clinical criteria, guidelines and written policies to make UM decisions. They check that requested services are:

- Needed to get you healthy or keep you healthy
- Covered by Aetna Better Health of West Virginia

You or your practitioner or provider can get a copy of the guidelines we use to approve or deny services. You can call Member Services at **1-888-348-2922** (TTY: **711**) Monday - Friday from 8:30 AM to 5 PM with questions about our UM program. Member Services may transfer your call to the UM department for a staff member to help you. After normal business hours, you may leave a message. We’ll call you the next business day. When calling back, the representative will tell you that he or she is calling from Aetna Better Health of West Virginia and will give you their name and title.

We're here to help you with any UM issues:

- For help if you have vision and/or hearing problems, call TTY: **711**
- For help with language or translation services, call Member Services at **1-888-348-2922**.

We understand members want to feel confident they are receiving the health care and services that are best for them. We have policies our practitioners and providers follow to ensure you receive the right health care. We do not use incentives to encourage barriers to care and/or service, or to reward inappropriate restrictions of care. This is called an affirmative statement. We want to let you know that:

- Utilization Management (UM) decisions are made by looking at your benefits and choosing the most appropriate care and service.
- We don't reward doctors or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services you get.

We want to make sure that each member receives the right health care. If you need help understanding this information, call us at **1-888-348-2922** (TTY: **711)**.

MEDICATIONS

Your prescription medicine is covered under fee-for-service (traditional) Medicaid. If you have questions about your prescription medicine, please contact DXC Technologies at **1-888-483-0797**.

If medically necessary, Aetna Better Health covers:

- Medicine you get as part of a hospital stay
- Injectable medicine you get at the doctor's office

Your doctor will work with us to get you the right medicine for your condition. If you have questions about these kinds of medicines, talk to your doctor.

DENTAL SERVICES

Dental care is important to your overall health. Aetna Better Health uses a dental benefit manager, SkyGen USA, to provide dental services to Mountain Health Trust members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by twelve months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members under age 21 can also access the Fluoride Varnish Program, offered by practitioners certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your practitioner. Children are covered for non-emergency and emergency dental services.

For adults 21 years and older, emergency dental services are covered. These services may be provided by a dentist, orthodontist, or oral surgeon. Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

If you need to speak with SkyGen USA regarding the children's dental benefit, please call **1-888-983-4693**. For questions about adult emergency dental services call us at **1-888-348-2922** (TTY: **711**).

BEHAVIORAL HEALTH SERVICES

Aetna Better Health provides inpatient and outpatient services to members. This benefit includes mental health services, substance use disorder (alcohol and drugs) services, care management, rehabilitation and clinic services, and psychiatric residential treatment services.

You do not need a referral for behavioral health services. Your PCP or Member Services can help you get these services from behavioral health practitioners/providers. You can call **1-888-348-2922** (TTY:**711**).

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

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 and others:

- 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 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
- 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-network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at **1-888-348-2922** (TTY: **711**).

NEW TECHNOLOGY FOR MEDICAL PROCEDURES

We are always looking at new medical procedures and methods. We want to be sure members get safe, high-quality care. We have a team of doctors who review new health care technologies. They decide if they should become covered services. (We don't cover things that are investigational or still under research.)

To decide if a new technology will become a covered service, we will:

- Study the purpose of it
- Review medical literature
- Look at the impact and benefits
- Develop rules on how and when to use the technology

GETTING YOUR BENEFITS

SPECIALTY CARE

Sometimes you or your child may need care from a specialist. Specialists treat certain diseases and special types of conditions, including behavioral health or substance use concerns. Your PCP can recommend a specialist or behavioral health care provider to you. You don't need a formal referral from your PCP as long as the specialist is in our provider network.

Female members have direct access to an Aetna Better Health of West Virginia health specialist for preventive care. This includes covered services such as breast exams, mammograms, pap tests and prenatal care. You do not need an OK from your PCP. You must go to an Aetna Better Health practitioner in order for your service to be covered, except for emergency services or family planning services.

Let your PCP know if you visit a specialist, so he or she can support your care.

If you need help finding a specialist, please call us at **1-888-348-2922** (TTY: **711**) or visit **AetnaBetterHealth.com/WestVirginia/find -provider** .

SERVICE AUTHORIZATIONS

If you need to see a practitioner/provider who is not on our list, your PCP must ask Aetna Better Health for approval. Asking for an out-of-network referral is called a service authorization request. It is important to remember that your PCP must ask us for approval before you see an out-of-network practitioner/provider. You or your PCP can call Member Services at **1-888-348-2922** (TTY: **711**). If you are approved to

see a practitioner or provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization, you can appeal the decision.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your practitioner or provider must ask our Prior Authorization Team. If we do not approve a prior authorization, you can appeal the decision.

We give prior authorizations to Aetna Better Health practitioners or providers when you need health care, drugs or supplies that are medically needed. Your practitioner or provider needs to call us at least two (2) working days before the scheduled care. However, earlier notification helps the review process. We may ask to see written notes showing that the care is medically needed before it is preauthorized. Our Prior Authorization team is available from 8:30 AM - 5 PM (ET) Monday through Friday. If you have questions, call Member Services at **1-888-348-2922** (TTY: **711)**. After normal business hours, you may leave a message, and someone will return your call the next business day. If someone from our UM team calls you, they will give you their name and title and say they are calling from Aetna Better Health. You can also access TTY services or language assistance to talk about UM issues. Our UM program helps make sure you get the right services at the right place.

Prior authorization is required before the date you get care for the services listed below:

- Home health care (except behavioral health)
- Rehabilitative Services: Physical, Occupational, or Speech Therapy
- Chiropractic care
- Durable medical equipment (DME)
- Polysomnograms (Sleep Apnea Studies)
- Genetic testing
- Pain management services
- Computerized Tomography (CT scan)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Positive Emission Tomography (PET Scan)
- Inpatient hospital care
- Outpatient surgery

- Intensive outpatient behavioral health services
- Partial hospitalization
- Psychiatric residential treatment facility care
- Services from a non-participating provider (except emergency services and family planning)

This list is not intended to be all inclusive. If you have any questions, call Member Services at **1-888-348-2922** (TTY: **711**).

OUT-OF-NETWORK SERVICES

If we are unable to provide certain covered services, you may get out-of-network services.

You can go to a practitioner or provider outside the Aetna Better Health network only if: (1) the care is needed; and (2) there are no Aetna Better Health practitioners or providers who can give you the care needed. We have the right to say where the service can be given when no Aetna Better Health provider can give you the care needed. The care must be preauthorized before your visit. Your PCP or the practitioner that wants to give you the care should ask for this preauthorization. If we have approved care outside our network, the cost will be no greater than it would be if you received the services within our network. Services will be provided in an acceptable and timely manner. If you have questions, call Member Services at **1-888-348-2922** (TTY: **711).**

COST SHARING

Cost sharing, or a co-payment, is the money you need to pay at the time of service. Whenever you see your PCP or a practitioner/provider you were referred to in our network, you are not responsible for any costs except the co-payment. The amount of the co-payment will change depending on the service and the Federal Poverty Level. Please see the table below for more details.

Co-payments will be collected for:

- Inpatient and outpatient services
- Physician office visits, including nurse practitioner visits
- Non-emergency use of an emergency room
- Caretaker relatives age 21 and up
- Transitional Medicaid members age 21 and up
- Any other members that are not specifically exempt

Service	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	$0	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

Co-payments will not be collected for:

- Family planning services
- Emergency services
- Behavioral health services
- Members under age 21
- Pregnant women (including 60 days after pregnancy)
- American Indians and Alaska Natives
- Members getting hospice care
- Members in nursing homes
- Other members or services not under the State Plan authority
- Members who have met their household maximum limit for cost-sharing per calendar quarter
- Members with primary insurance other than Medicaid

For more information on co-payment amounts, please call Member Services at **1-888-348-2922** (TTY: **711**). If you get a bill from your doctor for a covered health care service, call us.

ACCESS AND AVAILABILITY GUIDE

Aetna Better Health offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a practitioner in different situations.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 Calendar Days
Urgent Care	Within 48 Hours
Initial Prenatal Care	Within 14 Days of Known Pregnancy
Emergency Care	Immediately or referred to ER
Specialty Care – new patient/initial visit	Within 90 calendar days
Specialty Care – follow-up visit	Within 30 calendar days
Initial Behavioral Health visit	Within 10 business days
Urgent Behavioral Health visit	Within 48 hours
Care for a non life-threatening behavioral health emergency	Within 6 hours
Follow-up care with a Behavioral Health practitioner	Within 60 calendar days

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:
PCP	30 Minutes
Specialist You See Often	30 Minutes
Hospital	45 Minutes (urban) or 60 minutes (rural)
Tertiary Services	45 minutes (urban) or 90 minutes (rural)
FQHCs/RHCs	60 minutes

LETTING US KNOW WHEN YOU'RE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, you can file a complaint or an appeal. A complaint may also be called a "grievance". Information on the number of complaints and appeals and their disposition is available upon request. You can also request a state fair hearing once you have gone through the process for complaints and appeals.

APPEALS

As a member of Aetna Better Health, you have the right to appeal a decision, including a non-coverage decision. You can file an appeal if you do not agree with our decision about your service authorization or prior authorization request. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter. You will have 60 calendar days from the date of the Notice of Action to file an appeal with Aetna Better Health. If you would like your benefits to continue while the appeal is pending, you or your practitioner/provider must file a request within 13 calendar days of the date of the Notice of Action letter.

You can file an appeal by calling Member Services at **1-888-348-2922** (TTY: **711**) or you can do so in writing. If you choose to write to us, you will need to include your address. With written consent, you can also have someone else, like your PCP, file an appeal on your behalf. Unless you request an expedited appeal resolution, you must follow up a verbal appeal with a written, signed appeal.

To file a written appeal, please mail it to:

Aetna Better Health
Attn: Appeals Coordinator
500 Virginia Street East, STE 400
Charleston, WV 25301

Aetna Better Health will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days. For appeals that need to be resolved more quickly, we will give you our decision within 72 hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome.

If you need help with an appeal, you can call Member Services toll-free at **1-888-348-2922** (TTY: **711**). We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

COMPLAINTS/GRIEVANCES

As a member of Aetna Better Health, you have the right to file a complaint (also called a grievance) at any time. You can file a complaint if you are unhappy with something about Aetna Better Health or one of our practitioners or providers. You can also file a complaint if you disagree with our decision about your appeal. To file

an informal complaint, call us at **1-888-348-2922** (TTY: **711**) to let us know that you are unhappy with Aetna Better Health or your health care services.

You can take also steps to file a formal (written) complaint or allow someone like your PCP to do so on your behalf. If someone files a complaint on your behalf, we will need your ok in writing. If you choose to write to us, you will need to include your address.

To file a written compliant, you will need to send us a letter that has:

- Your name
- Your mailing address
- The reason you are filing the complaint and what you want Aetna Better Health to do.

Please mail it to:

> Aetna Better Health
> Attn: Complaint Coordinator
> 500 Virginia Street East, STE 400
> Charleston, WV 25301

We will usually get our response to you within 30 days and no later than 90 days, from the date your complaint is received.

If you need help with a complaint, you can call Member Services toll-free at **1-888-348-2922** (TTY: **711**). We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

FAIR HEARINGS

As a member of Aetna Better Health, you have the right to request a state fair hearing. You can only request a state fair hearing after you have received notice that Aetna Better Health is upholding the decision to reduce, suspend, or stop your benefits. You must request the state fair hearing no later than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

> Once you get the form, please mail it back to:
> WV Bureau for Medical Services/Office of Medicaid Managed Care
> 350 Capitol Street, Room 251
> Charleston, WV 25301-3708

If you would like your benefits to continue while the hearing is going on, you or your practitioner or provider must file a request within 10 calendar days. You may have to pay the cost of services, depending on the outcome. Parties to the state fair hearing can include the State, Aetna Better Health, your representative, or the representative of a deceased member. The State will hear your case and decide within 90 days of your request for a state fair hearing.

Please call Member Services at **1-888-348-2922** (TTY: **711**) if you have questions about requesting a state fair hearing. You can also call the Department of Health and Human Resources at **304-558-0684**.

REPORTING FRAUD

If you suspect fraud, waste, or abuse by an Aetna Better Health member, practitioner, or provider, please report it to our special investigative unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call **1-844-405-2016**. You may also complete the Fraud, Waste, and Abuse Reporting form on our website or by mailing it to us.

AetnaBetterHealth.com/WestVirginia/fraud
Aetna Better Health
500 Virginia Street East, STE 400
Charleston, WV 25301

OUR POLICIES

ADVANCE DIRECTIVES

Under Federal and State law, you have the right to make decisions about your medical care, including an advance directive. An advance directive is legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advance directive allows you to plan in advance and participate in decision-making around your health. It is a way to let your doctors know what kind of treatment you do or do not want. You can also allow someone you trust to make treatment decisions for you. This would allow that person to make choices about your care and treatment. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an

advance directive requires filling out forms and stating your wishes in writing. It will become a part of your medical records. Remember, you can change your advance directive at any time.

Your doctor and Member Services can help you to fill out or answer questions about advance directives.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of Aetna Better Health, you have the right to disenroll at any time. You may re-enroll in another health plan if you choose. The enrollment broker can help you. Just call **1-800-449-8466**.

Sometimes members are disenrolled from the health plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid managed care
- You move outside of our service area
- You are placed in an inpatient facility, nursing facility, State institution, or intermediate care facility for the mentally retarded for more than 30 calendar days
- You were incorrectly enrolled in Aetna Better Health
- You die

If this happens, your services may stop suddenly. The enrollment broker and Member Services can answer any questions you may have about disenrollment. If you move out of the country or out of state, call the West Virginia Bureau for Medical Services at **304-558-1700**.

APPROPRIATE TREATMENTOF MINORS

Aetna Better Health follows the guidance of West Virginia Code §§ 16-4-10 “Minors” and 16-29-1 “Copies of Healthcare Records to be Furnished to Patients.” Anyone over 16 who has been deemed emancipated in a court of law, or who is over 16 and legally married, will be treated, and have all the privileges, rights and duties of an adult.

Oral interpreters for minors are available in the case of an emergency.

THIRD PARTY LIABILITY

If you have insurance other than Medicaid, please call Member Services to let us know. Please call and let us know if another insurance company has been involved with your:

- Worker's compensation claim
- Personal injury
- Medical malpractice law suit
- Car accident

You must use any other health insurance you have first before using Medicaid.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our policies and services. To let us know, please call Member Services at **1-888-348-2922** (TTY: **711**).

We also invite you to join our Member Advisory Committee (MAC). The MAC meets to review plan facts, share ideas, and talk about changes or new programs. You can also earn rewards for participating. To join call **1-888-349-2922** (TTY: **711**).

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 calendar days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

IMPORTANT CONTACT INFORMATION		
Entity	Phone Number	Street Address
Aetna Better Health Member Services	Toll-Free: 1-888-348-2922	500 Virginia Street East STE 400 Charleston, WV 25301
County DHHR	1-877-716-1212	
West Virginia Bureau for Medical Services	304-558-1700	Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301

Aetna Better Health Medical Management	1-888-348-2922	500 Virginia Street East STE 400 Charleston, WV 25301
Enrollment Broker	1-800-449-8466	Maximus
Emergency	911	
SkyGen USA Dental (under 21)	1-888-983-4693	
VSP (Vision)	1-800-877-7195	
Aetna Better Health Behavioral Health	1-888-348-2922	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Better Health Grievances/ Appeals	1-888-348-2922	500 Virginia Street East STE 400 Charleston, WV 25301
State Fair Hearing	304-558-1700	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301
Aetna Better Health Fraud, Waste, and Abuse	1-844-405-2016	500 Virginia Street East STE 400 Charleston, WV 25301
Non-Emergent Transportation	1-844-549-8353	
Prescription Drugs	1-888-483-0797	DXC
Aetna Dental (over 21)	1-888-348-2922	
Aetna 24-Hour Nurse Line	1-855-200-5975	

AETNA BETTER HEALTH® OF WEST VIRGINIA

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard
Phoenix, AZ 85040
Telephone: **1-888-234-7358 (TTY 711)**
Email: MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

WV-16-09-13

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104** (الهاتف النصي والبكم: **711**).

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または **1-800-385-4104** (TTY: **711**)までご連絡ください。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**).

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به طور رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں ۔ اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں۔

WV-16-09-13

AetnaBetterHealth.com/WestVirginia

Welcome

Aetna Better Health® of West Virginia

2020-2021 Member Handbook

Mountain Health Trust – Medicaid

Exhibit
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AetnaBetterHealth.com/WestVirginia

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Aetna Better Health® of West Virginia

Helpful Information

Aetna Better Health® of West Virginia

Member Services
1-888-348-2922 (TTY: 711)

Website
AetnaBetterHealth.com/WestVirginia

Hours of operation
8:30 AM to 5 PM

SKYGEN Dental
1-888-983-4693

Non-Emergent transportation - Logisticare
1-844-549-8353

Prescription Drugs - Gainwell Technologies
1-888-483-0797

HELP IN YOUR LANGUAGE

If you do not speak English, you can call us at **1-888-348-2922 (TTY: 711)** We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: Si usted no habla inglés, llámenos a l **1-888-348-2922** y **711** Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

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WELCOME

Welcome to Aetna Better Health's Medicaid managed care program! We are glad that you have enrolled with us. This handbook will provide you with the information you need to know about your health care plan, also known as a managed care plan. Please read this handbook from cover to cover to understand the way your plan works. This handbook will help you get the most from Aetna Better Health. It will answer many of the questions that come up about your benefits and the services offered by Aetna Better Health. You can also ask us any questions you may have by calling us at **1-888-348-2922**. If you are speech or hearing impaired, please dial **711**. If you would like a printed copy of this handbook, please call us and one will be mailed to you within five (5) business days of your request.

ABOUT OUR PLAN

Aetna Better Health has a contract with the West Virginia Department of Health and Human Resources (DHHR). Under managed care, we are able to select a group of health care practitioners and providers to form a provider network. Usually provider networks are made up of doctors and specialists, hospitals, and other health care facilities. Our practitioners and providers help to meet the health care needs of people with Medicaid. The Provider Directory lists all of our network providers you can use to get services statewide. It can be found online at our website, **AetnaBetterHealth.com/WestVirginia**. If you would like a printed copy of the Provider Directory or information about a practitioner's education, such as medical school and residency, cultural competency, or board certification, please call **1-888-348-2922 (TTY: 711)**.

It is important to us that you receive quality health care and customer service. Your satisfaction matters to us. The Quality Management (QM) program ensures our services meet high standards of quality and safety. We want to make sure you have:

- The right kind of care
- Easy access to quality medical and behavioral health care
- Help with any chronic conditions or illnesses
- Support when you need it most
- High satisfaction with your doctors and with us

For more information about our Quality Management program visit our website at **AetnaBetterHealth.com/WestVirginia**. If you have a problem, please call Member Services at **1-888-348-2922 (TTY: 711)**.

CONTACT US

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call. You can also visit our website, **AetnaBetterHealth.com/WestVirginia**, for other information.

Member Services Department
Hours of Operation: Monday – Friday, 8:30 AM – 5 PM
Address: 500 Virginia Street East, Suite 400, Charleston, WV 25301
Toll-free: **1-888-348-2922 (TTY: 711)**
Online: **AetnaBetterHealth.com/WestVirginia**

You can call or visit us online to:

- Ask questions about services and benefits, eligibility, claims, prior authorization requests, or utilization management (more information on utilization management procedures is available upon request)
- Change your primary care provider (PCP) or get help choosing a provider
- File a complaint
- Replace a lost member ID card
- Get help with referrals
- Let us know if you are pregnant
- Let us know if you give birth to a new baby
- Ask about any change that might affect you or your family's benefits
- Let us know about any changes to personal information
- Request interpreter services or help for people with disabilities

If you do not understand or speak English, we can help. Please call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can answer questions aboutyour benefits in your language. We have free interpreter services and can help you find a health care practitioner who can communicate with you in any language.

If you have a disability, we can help. Aetna Better Health offers services so that you can communicate effectively with us and your practitioner or provider. We have access to free sign language interpreter services and a TTY phone number: **1-888-348-2922 (TTY: 711)**. We can offer this handbook and all written materials in many formats, such as large print, at no cost to you. Please call Member Services toll-free at **1-888-348-2922** to ask for materials in another format.

For other important phone numbers, please see the list in the back of this handbook.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your rights to privacy. We will never give out your medical information or social security number without your written permission, unless required by law. To learn more about your rights to privacy, please call Member Services at **1-888-348-2922** or visit our website at **AetnaBetterHealth.com/WestVirginia**.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act, you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East
Charleston, WV 25305
304-558-4331

DEFINITIONS

Appeal: A way for you to request the review of Aetna Better Health's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Complaint: An expression of dissatisfaction, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health or our practitioners or providers. For example, you might complain about the quality of your care. In this handbook "grievance" and "complaint" mean the same thing.

Co-payment: A fixed amount you pay each time you get a covered service or supply. For example, if you use the emergency room when it is not an emergency, you might pay $8.

Durable Medical Equipment (DME): Certain items your practitioner or provider orders for everyday or extended use. Examples of these items are wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm. An emergency medical condition would make you think that without medical attention, it might: place your health (or a pregnant woman's unborn child's health) in serious jeopardy; or lead to death, serious dysfunction of a body part or organ, or serious impairment of bodily functions. Examples of an emergency medical condition include severe pain, difficulty breathing, or uncontrolled bleeding.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you receive in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are: given by a qualified provider and needed to evaluate or stabilize an emergency medical condition.

Excluded Services: Health care services that Aetna Better Health does not pay for or cover.

Fee-For-Service: A fee-for-service benefit is covered by the West Virginia Medicaid program and not by Aetna Better Health.

Grievance: A complaint you make, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health or our practitioners or providers. For example, you might complain about the quality of your care. In this handbook "grievance" and "complaint" mean the same thing.

Habilitation Services and Devices: Health care services and devices that help you keep, learn, or improve skills and functioning for daily living. Examples include occupational theory, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Insurance: A contract that requires Aetna Better Health to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies, and other services.

Hospice Services: Services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Medically Necessary: Items or services furnished or to be furnished to a patient for diagnosing, evaluating, treating or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Health care services and supplies that are reasonable and necessary to diagnose or treat an illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development. Determination of medical necessity is based on specific criteria.

Network: A group of providers who has contracted with Aetna Better Health to give care to members. The list of Aetna Better Health practitioners and providers can be found in your Provider Directory. It will be updated whenever there are changes.

Non-participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has not signed a contract agreeing to provide services to Aetna Better Health members.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, Aetna Better Health.

Prior Authorization: Approval from Aetna Better Health that may be required before you get certain services or treatments in order for them to be covered. To get prior authorization, make sure to ask Member Services. If the care is medically necessary, then it will be covered.

Participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has signed a contract agreeing to provide services to Aetna Better Health members. They are listed in the Provider Directory.

Practitioner: A licensed or certified professional who provides medical or behavioral health care services, such as a doctor, nurse practitioner, or psychologist.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs and medications. Aetna Better Health does not provide prescription drug coverage, but the State of West Virginia does.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating practitioner you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Provider: An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Rehabilitation Services and Devices: Health care services and devices that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. Examples include occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Tertiary Services: Highly specialized medical services administered in a specialized medical facility.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgent care from out-of-network practitioners/providers when network practitioners/providers are unavailable, or you cannot get to them. Examples of when to get urgent care a sprained ankle, a bad splinter, or the flu.

YOUR RIGHTS

As a member of Aetna Better Health, you have rights around your health care. You have the right to:

- Get information about Aetna Better Health, our services, our practitioners and providers, and your rights and responsibilities.
- Be treated with respect and dignity and have your privacy protected.
- Get interpretation services if you do not speak English or have a hearing impairment.
- Not be discriminated against by Aetna Better Health.
- Access all services that Aetna Better Health must provide.
- Choose a practitioner or provider in our network.
- Take part in decisions about your health care.
- Accept or refuse medical or surgical treatment and choose a different provider.
- Learn about other treatment options and different courses of care no matter how much they cost and/or if Aetna Better Health will pay for it.
- Ask for and get your medical records.
- Change or correct your medical records if needed.
- Be sure your medical records are kept private.
- Tell us how we can improve our policies and procedures, including the member rights and responsibilities policy.
- Be free from abuse, neglect, financial exploitation, or any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation.
- Get covered services, no matter what your cultural or ethnic background is or how well you understand English.
- Get covered services regardless of any physical or mental disability, or if you are homeless.
- Refer yourself to in-network and out-of-network family planning providers.
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services.
- Get emergency post-stabilization services.
- Get emergency health care services at any hospital or other setting.
- Receive information about advance directives, which tell how to have medical decisions made for you if you are not able to make them for yourself.
- Have your parent or a representative make treatment decisions when you can't.
- Submit a complaint or appeal about Aetna Better Health or the care it

provides.

- A quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services.
- A state fair hearing after a decision has been made about your appeal.
- A copy of this member handbook.
- Disenroll from your health plan.
- Get accessible services and receive reasonable disability accommodations.
- Obtain advocacy on your behalf.
- A second opinion.

YOUR RESPONSIBILITIES

As a member of Aetna Better Health, you have the responsibility to:

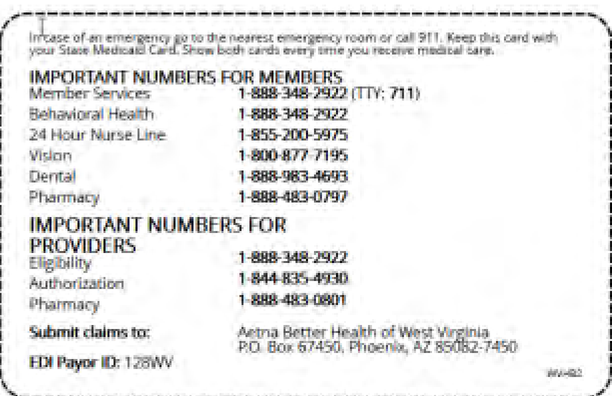
- Read through and follow the instructions in your Member Handbook.
- Work with your PCP to manage and improve your health.
- Ask your PCP any questions you may have and call your PCP any time you need health care.
- Give all information about your health to Aetna Better Health and your doctor. Tell your doctor if you do not understand your health problems. Work together with your doctor to make plans about your care.
- Show your ID card to each doctor before getting health services.
- Protect your member ID card. Do not lose or share it with others.
- Use the emergency room (ER) for true emergencies only.
- Keep your appointments.
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know. Follow what you and your practitioner agree to do.
- Follow your practitioner's recommendations about appointments and medications.
- Go back to your PCP or ask for a second opinion if you do not get better.
- Call Member Services at **1-888-348-2922 (TTY: 711)** whenever anything is unclear to you or you have questions.
- Contact DHHR Change Report Center at **1-877-716-1212** to report family size, employment, and/or address changes.
- Treat doctors, staff, and people providing services to you with respect.
- Tell Aetna Better Health if you have other health insurance, including Medicare.

YOUR MEMBER ID CARD

After you join Aetna Better Health, we will send you your member ID card in the mail. Each member of your family who has joined Aetna Better Health will receive his or her own card. If you have not received your member ID card after five (5) days, please call Member Services at **1-888-348-2922 (TTY: 711)**.

It is important to always keep your member ID card with you. You will need it any time you get care. Your card is your proof that you are a member of Aetna Better Health. You should also keep your Medicaid Benefit card with you. You need it to get care that is not covered by Aetna Better Health.

Your member ID card should look like this:



You will find some useful information on your card like your Medicaid ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at **1-888-348-2922 (TTY: 711)** if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You have a baby or add a new member to your family
- You move
- Someone in your family dies

Please call your county DHHR immediately at **1-877-716-1212** if you move to another state or to another country.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Each member of Aetna Better Health chooses a primary care provider (PCP) from the Provider Directory. A PCP is a specific clinician responsible for coordinating your health care needs. The provider directory is available on our website at **AetnaBetterHealth.com/WestVirginia**. It is a list of all doctors, hospitals, dental and specialty care practitioners and other providers who work with Aetna Better Health. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the directory, we will choose one for you.

If you have a chronic illness, then you may be able to select a specialist as your PCP. Please call Member Services at **1-888-348-2922 (TTY: 711)** to find out If you already have a PCP and believe you need a specialist, you or your practitioner should call Member Services. Women can also receive women's health care services from an obstetrical/ gynecological practitioner (OB/GYN) without a referral from their PCP.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all of your routine health care needs. All new members should try to schedule an appointment within 45 calendar days. You can schedule your appointments by calling the PCP's office phone number. Your PCP's name and office phone number will be listed on your member ID card. You can call 24 hours a day, seven days a week. On the day of your visit, remember to bring your member ID card and your Medicaid ID card. Please show up on time and call to cancel an appointment if you cannot make it.

Aetna Better Health requires that all routinely used sites, such as PCP offices and frequently used specialists, must be located within 30 minutes travel time of a member. Basic hospital services must be within 45 minutes travel time (urban) or 90 minutes travel time (rural).

Aetna Better Health will ensure hours of operation are convenient and do not

discriminate against members.

Aetna Better Health requires that emergency cases will be seen or referred immediately. Urgent cases must be seen within 48 hours. Routine cases must be seen within 21 days.

CHANGING YOUR PCP

If you need to, you can change your PCP for any reason at any time. Let us know right away by calling Member Services at **1-888-348-2922 (TTY: 711)** or by going to **AetnaBetterHealth.com/WestVirginia**. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history.

Sometimes PCPs leave our network. If we find out your PCP is leaving, we will let you know by mail within 15 calendar days. We will try to give you 30 calendar days' notice before your PCP leaves. We can assign you a new PCP or you can pick a new one yourself. If we need to assign you a new PCP for another reason, we will let you know.

SECURE MEMBER WEB PORTAL

Our updated secure member website is your go-to resource to manage your plan—and your health. It will help you use your benefits and services so you can get and stay healthy. You can:

- Access health plan details—change your doctor, find forms or request member ID cards.
- Get personalized health information—answer questions about your health. Get the tips and tools you'll need to meet your health goals like quitting smoking and weight management.
- Get instant access to claims details—see the status of a claim from start to finish.
- Find support—get in touch with a nurse. Or learn more about chronic condition management and wellness programs that will help you stay on track with goals.

Set up your account by visiting **AetnaBetterHealth.com/WestVirginia**. Click on the "Member Portal" then select "Register or Log In". You'll need your member ID and a current email address to create an account.

To sign up over the phone call Member Services at **1-888-348-2922 (TTY: 711)**.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care to get in different situations.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need.

- Well-care Visits – A well care visit is when you or your child sees your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health, too. You can learn more about well-care visits under the section titled "More Information about Your Health Plan".
- After Hours Care – You can reach your PCP even if it is after normal business hours. Just leave a voicemail with your name and phone number. Your PCP or another PCP on call for your PCP will call you back.
- We cover care given by licensed Aetna Better Health of West Virginia practitioners. You may receive care in the practitioner's office, a clinic, or other places needed to treat an illness, injury or disease.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs prompt care but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- The flu

You can also get urgent care if you are traveling and are too far from your PCP's office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do. If you think you might need urgent care when you are away from your home or after hours, you can also call the 24-Hour Nurse Line at **1-855-200-5975 (TTY: 711)**. They can help you decide what kind of treatment you need.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think he or she needs to be treated right away. Some examples of an emergency are:

- Severe bleeding that does not stop
- A heart attack
- Severe chest pain
- Seizures
- Rape
- Attempted suicide

You should not go to the emergency room (ER) for things like:

- Colds
- Minor cuts and bruises
- Sprained muscles.

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or Aetna Better Health. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or Aetna Better Health at
1-888-348-2922 (TTY: 711).

Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure Aetna Better Health is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call Aetna Better Health. If you are able, call your PCP to let him or her know that you have a medical emergency. You will need to schedule follow-up services (called post-stabilization) with your PCP.

For more information about emergency transportation and post-stabilization services, please see the Mountain Health Trust and West Virginia Health Bridge Covered Benefits table.

HOSPITAL CARE

Inpatient Hospital Care

When you do not have an emergency, we must preauthorize your stay before you go to the hospital. You must go to a hospital that is an Aetna Better Health of West Virginia provider. You will be under the care of your PCP or other practitioner to whom your PCP has sent you.

We help manage all hospital stays. We look at the care you get while you are in the hospital. The care is covered as long as there is a medical need for the care. If all or part of the hospital stay is not medically needed, your provider will be told that coverage will end, and you will not be responsible for payment.

Outpatient Hospital Care

Outpatient hospital care is care in a hospital that does not require an overnight stay. It may include tests to find sickness or care to help you heal. If you get an x-ray or have physical therapy in a hospital, that is outpatient hospital care.

You should tell your PCP when you receive outpatient hospital care.

CARE AWAY FROM HOME

Aetna Better Health's service area is the entire State of West Virginia. If you are traveling or out of the service area, you are only covered for emergency services. Routine care out of the service area or out of the country isn't covered by Medicaid. If you are out of the service area and need health care services, call your PCP. He or she will tell you what to do. (You can also call us to check if you are out of the service area.)

If you are not in West Virginia and you think you or your child's life is in danger, go to the closest ER. Show your Aetna Better Health of West Virginia ID card, your Medicaid ID card, and any other insurance ID cards you have to the ER staff. If you or your child gets services in the ER and are admitted to the hospital, have staff call us at the number on the back of your ID card.

YOUR BENEFITS

You can get many services through Aetna Better Health's Medicaid managed care program in addition to those that come with regular Medicaid. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP. This means that you do not need approval from your PCP. To get these services, look in our Provider Directory for the list of providers/ practitioners who offer these services. You can schedule the appointment yourself. If you have any questions, Aetna Better Health can help. Just call Member Services at **1-888-348-2922 (TTY: 711)**. Member Services can explain how to access your services.

COVERED SERVICES

Covered services fall under medical, behavioral, dental, and vision. Benefit packages differ, depending on whether you are covered under Mountain Health Trust (MHT) or West Virginia Health Bridge (WVHB). You can see any differences in the table below. Your covered services must be medically necessary. You should get these services from providers/practitioners in the Aetna Better Health network. Your PCP should provide covered services or refer you to another practitioner or provider to do so. You can get the services listed in the Mountain Health Trust and West Virginia Health Bridge Covered Benefits table by using your Aetna Better Health member ID card.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits
Medical • PCP and Specialist Office Visits in the Aetna Better Health provider network. • Clinic Services – Outpatient clinics including general clinics, birthing centers, and health department clinics. • Federally Qualified Health Centers – Includes physician, physician assistant, nurse practitioner, and nurse midwife services. • Laboratory and X-ray Services – Includes lab services related to substance abuse treatment. Services must be ordered by a physician, and certain procedures have service limits. • Physician Services – Inpatient or outpatient medical or surgical services provided by a doctor or dentist. Certain services may require prior authorization or have service limits. May be delivered through telehealth. • Vaccinations are included for children.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Behavioral Health

- Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility – Includes services for children (under age 21) with mental illness and substance use disorder. Limits on frequency and amount of services.
- Drug Screening – if ordered by treating practitioner and deemed medically necessary. Some limits apply.
- Inpatient Hospital – includes behavioral health and substance use disorder hospital stays.
- Inpatient Psychiatric – Includes treatment through an individual plan of care for members under age 21. Pre-admission and continued authorization is required. Certification required. Not covered under West Virginia Health Bridge.
- Outpatient Services – Includes services for individuals with mental illness and substance use disorder. Limits on frequency and amount of services. Assertive community treatment (ACT) is covered for members 18 years and older. Only ACT providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services.
- Psychological Services – Evaluation and treatment, including individual, family, and group therapies. May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions.
- Substance Use Disorder (SUD) Services - Targeted case management and physician-supervised medication and counseling services.

Emergency

- Emergency Transportation – Includes ambulance and air ambulance. Out of state requires prior authorization. To call for Emergency Transportation, dial **911**.
- Post-stabilization Services – Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits
Home Health Care Services– Includes services given at member's residence. This does not include a hospital nursing facility, ICF/IID, or state institutions. Some suppliers have service limits.
Hospice – Includes nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker. Requires physician certification. For adults, rights are waived to other Medicaid services related to the terminal illness.
Hospital • Inpatient – Includes all inpatient services, including bariatric surgery, corneal transplants and long-term acute care (LTAC). Some exclusions apply. • Outpatient – Includes preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
Maternity • Maternity Care – Includes prenatal, inpatient hospital stays during delivery, and post-partum care. • Right From The Start Services – Includes prenatal care services and care coordination. No prior authorization required.
Nursing Services • Nurse Practitioners' Services – Some procedures may have service limits. • Private Duty Nursing – Includes 24-hour nursing care if medically necessary. (not covered for adults twenty-one (21) years or older). Prior approval may be required.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Preventive Care and Disease Management

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Based on the periodicity schedule. Includes health care services for any medical or psychological condition discovered during screening (limited to members under age 21).
- Family Planning – Includes all family planning providers, services and supplies. No referral needed for out-of-network providers. Sterilization is not covered for members under age 21. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered.
- Tobacco Cessation – Includes therapy, counseling and Quitline services. Guidance and risk-reduction counseling covered for children.
- Sexually Transmitted Disease Services – Includes screening for a sexually transmitted disease from your PCP, a specialist in our network, or an out-of-network family planning practitioner.

Other

- Ambulatory Surgical Center Services – Includes services, equipment and use of the facility for surgical procedures.
- Children with Special Health Care Needs Services – Includes coordination of services and limited medical services, equipment and supplies (limited to children under age 21 with certain medical conditions).
- Chiropractor Services – Includes radiological exams and corrections to subluxation. Certain procedures have service limits.
- Corneal transplants Durable Medical Equipment – Medically necessary devices and medical equipment prescribed by a physician. May have services limits or require prior authorization.
- Orthotic and Prosthetic Devices – May require prior approval and have service limits. Customized special equipment is considered.
- Podiatry – Includes treatment of acute conditions, some surgeries, reduction of fractures and other injuries, and orthotics. Treatment of children limited to acute conditions. Routine foot care is not covered.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Rehabilitation Services

- Inpatient Rehabilitation – Includes inpatient rehabilitation services and general medical outpatient services that meet the certification requirements, for members up to age 64.
- Occupational Therapy (OT) – Habilitative and rehabilitative services
    - MHT: 20 visits per year (combined for PT and OT)
    - WVHB: 30 visits per year (combined for PT and OT)
- Physical Therapy (PT) – Habilitative and rehabilitative services
    - MHT: 20 visits per year (combined for PT and OT)
    - WVHB: 30 visits per year (combined for PT and OT)
- Speech Therapy – Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (not covered for adults twenty-one (21) years or older). Some procedures have service limits or require prior approval.

Specialty Rehabilitation Services

- Pulmonary Rehabilitation – Includes procedures to increase strength of respiratory muscle and functions.
- Cardiac Rehabilitation - Includes supervised exercise sessions with electrocardiograph monitoring.

Dental – Includes emergency, non-emergency, and orthodontic services for children (under age 21). Includes treatment of fractures, biopsy, tumor removal, and emergency extractions for adults. TMJ is not covered for adults. Preventive and non-emergency dental coverage for adults beginning 1/01/2021.

Vision – Includes eye exams, lenses, frames, and needed repairs for children (under age 21). Includes medical treatment and one pair of glasses after cataract surgery for adults, and contact lenses for adults and children with certain conditions. Does not cover prescription sunglasses or designer frames.

BENEFITS COVERED UNDER MEDICAID FEE-FOR-SERVICE

Be sure to use your regular Medicaid card for services that are not covered by Aetna Better Health. These services fall under fee-for-service Medicaid.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.
Early Intervention Services - Early intervention services provided to children three (3) years and under through the Birth to Three program.
ICF/IID Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for members with intellectual disabilities. Requires physician or psychiatrist certification.
Nursing Facility Services – Includes nursing, social services, and therapies.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited one per unit, per month basis. Requires physician order and nursing plan of care.
Prescription Drugs – Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor and Hepatitis-C may be covered under fee-for-service Medicaid. The prescription drug benefit is administered by the State Medicaid program. For questions about getting your medicines please call Gainwell Technologies at **1-888-483-0797** between 7 AM - 7 PM Monday through Friday.

Benefits Under Fee-for-Service Medicaid
School-based Services – Service limitations are listed in the fee for service Medicaid provider manual.
Transportation – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: **1-844-549-8353.**
Substance Use Disorder – Physician-supervised medication and counseling services provided to those with severe opioid use disorder.

VALUE-ADDED SERVICES

In addition to your benefits, Aetna Better Health offers value-added services. When eligible members complete the healthy behaviors in the table below, they will receive a reward. We offer these services to encourage health education and to promote health. Co-payments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services. Please note that value-added services sometimes change. Call Member Services at **1-888-348-2922 (TTY: 711)** for details.

Value-Added Services and Rewards	
Pregnancy	**Reward**
6 Prenatal appointments	Cribette
1 Post-partum appointment within **7-84** days of having your baby	$50 gift card
Enroll in Moms and Babies Program upon delivery	Cribette or Baby Wrap Carrier
Enroll in Neonatal Abstinence (NAS) Program	Cribette or Baby Wrap Carrier
Complete the NAS Program	Educational Toy
Preventive Dental Program	Up to 2 check-ups during pregnancy

Asthma	Reward
Asthma Care Program	One-on-one asthma education and a Peak Flow Meter
Diabetes	**Reward**
Enroll in diabetic education program and complete A1C testing* *Available in certain counties	$25 gift card
Yearly diabetic eye exam	
Diabetes	**Reward**
Diabetic dental program* *Available in certain counties	Routine teeth cleaning
Certified Diabetes Management Program	
Good Health Practices	**Reward**
Wellness event participation (Locations and services vary. Contact Member Services at **1-888-348-2922** for details.)	
Yearly well child exam for ages 12-18	$25 gift card
Yearly child dental check-up for ages 2-3	
Adolescent immunizations	$25 gift card
Timely behavioral health follow-up appointment (within 7 days)	
Annual flu shot (adults only)	Fishing/hunting license
Healthy Activities	**Reward**
Ted E Bear Cub Club (through age 13)	Quarterly rewards
Keep Kids Safe	Medication Lock Box
Health related summer camps for children	Camp scholarships
Walking Program completion (adults only)	$25 gift card

COMMUNITY SERVICES

WEST VIRGINIA WIC

Aetna Better Health wants to make sure you receive all the help available to you. West Virginia Women, Infants, and Children (WIC) is an organization that provides nutritional services to you and your family. The mission of the West Virginia WIC program is to improve the health of women, infants and children in West Virginia by providing quality nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.

The West Virginia WIC program may be able to help you and your family to get better nutrition. To reach the office of the West Virginia WIC program call **304-558-0030** or go to their website at **ons.wvdhhr.org**.

WORKFORCE WEST VIRGINIA

Workforce WV offers tools to help with job searches, unemployment, and training. Workforce WV has the largest database of job seekers and openings in the state. The education and training opportunities provide residents work skills needed by businesses. Visit their website at **http://workforcewv.org**. If your child doesn't have a job due to a health issue, please contact us at **1-888-348-2922 (TTY: 711)**.

MORE INFORMATION ABOUT YOUR HEALTH PLAN

Please read below for more details about your Aetna Better Health benefits and services. If you have any questions, please call Member Services at **1-888-348-2922 (TTY: 711)**.

WELL-CHILD VISITS

Well-child visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit covers all medically necessary and preventive health care services for members up to age 21. Both sick and well care services are provided by your PCP at no cost.

Some screenings that children can get include:

- Physical exams
- Laboratory tests
- Vision testing
- Immunizations
- Hearing test
- Dental services

- Behavioral health screenings
- Health education
- Health and development history

Immunizations are important to keep your child healthy. See Appendix A in this handbook for the recommended immunization schedule. Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early, before they become more serious. Call your PCP or Member Services to schedule a well-child visit. Transportation and scheduling help are also available upon request at no cost.

Aetna Better Health has trained professionals on staff to help members move from child to adult care. We can help you to get the right care for your child's special needs.

Please call **1-888-348-2922 (TTY: 711)** and ask to speak to a care management staff member.

POPULATION HEALTH MANAGEMENT

Aetna Better Health has many programs to help members get healthy and stay as healthy as possible. Whether you have a medical problem or are just trying to live a healthy life, we have a program for you. We will automatically put you into the program if you are eligible. Call us if you do not want to be part of a program. For questions about these programs, call us at **1-888-348-2922 (TTY: 711)**.

Program	Who Is Eligible
Healthy Pregnancies/Healthy Babies	Pregnant members and moms up to 6 weeks after giving birth
Healthy Adults and Children	All members
Flu Vaccination	All members over 6 months of age
Living with Diabetes	Members with Diabetes
Neonatal Abstinence (NAS)	Pregnant women who have substance use disorder (drug addiction) and Babies born with NAS
Appropriate Use of Acute Care Settings	Members who are in the hospital or have recently been discharged
Opioid Management	Members who use certain drugs
Chronic Condition Management	Members with at least one chronic condition: Asthma, Diabetes, Heart Failure, COPD (Lung Disease), Coronary Artery Disease (CAD), Depression
Managing Diabetes and Heart Disease (Multiple Chronic Conditions)	Members with both Diabetes and Heart Disease
Emergency Room (ER) Utilization Management	Members who frequently use the ER

Program	Who Is Eligible
Integrated Care Management (ICM)	Members who need help managing their care

INTEGRATED CARE MANAGEMENT

Some members have special health care needs and medical conditions. Our Integrated Care Management (ICM) Program can help make sure you understand your condition and treatment plan. We have nurses, social workers, and support staff who work with many health care practitioners, agencies and organizations to get you the services and the care that you need. We will help you get the best care in the most efficient manner. Our Case Managers help coordinate care in the following ways:

- Work one-on-one with you to create a plan based on your goals.
- Review your plan to help make sure you do not have gaps in care.
- Consult with your doctors.
- Help you make specialist and primary care doctor appointments.
- Verify that the right medicines and treatments are in place.
- Help make sure you receive preventive care.
- Work to ensure you and your family have the support you need.
- Ask questions to make sure your home is safe.
- Provide patient and family education about programs and services available in the community and through your doctor.
- Make sure you have support for any behavioral health needs.
- Help you transition to other care when your benefits end, if necessary.

We want to help you get the care and services you need. To sign up, call us at **1-888-348-2922 (TTY: 711)** and ask to speak to a Case Manager. Your practitioner or caregiver can also call to sign you up for the program. You may leave the program at any time.

HEALTH HOME

The Health Home Program coordinates physical and behavioral health (both mental and substance disorder), long term and social services, and supports for members with chronic health conditions. If you would like assistance with enrolling in a health home, please contact us at **1-888-348-2922 (TTY: 711)**.

UTILIZATION MANAGEMENT

We want to ensure that our members are getting the services or benefits they need to get or stay healthy. This is called "utilization management" (UM). Our UM staff use clinical criteria, guidelines and written policies to make UM decisions. They check that requested services are:

- Needed to get you healthy or keep you healthy
- Covered by Aetna Better Health of West Virginia

You or your practitioner or provider can get a copy of the guidelines we use to approve or deny services. You can call Member Services at **1-888-348-2922 (TTY: 711)** Monday - Friday from 8:30 AM to 5 PM with questions about our UM program. Member Services may transfer your call to the UM department for a staff member to help you. After normal business hours, you may leave a message. We'll call you the next business day. When calling back, the representative will tell you that he or she is calling from Aetna Better Health of West Virginia and will give you their name and title.

We're here to help you with any UM issues:

- For help if you have vision and/or hearing problems, call us at **1-888-348-2922 (TTY: 711)**.
- For help with language or translation services, call Member Services at **1-888-348-2922**.

We understand members want to feel confident they are receiving the health care and services that are best for them. We have policies our practitioners and providers follow to ensure you receive the right health care. We do not use incentives to encourage barriers to care and/or service, or to reward inappropriate restrictions of care. This is called an affirmative statement. We want to let you know that:

- Utilization Management (UM) decisions are made by looking at your benefits and choosing the most appropriate care and service.
- We don't reward doctors or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services you get.

We want to make sure that each member receives the right health care. If you need help understanding this information, call us at **1-888-348-2922 (TTY: 711)**.

MEDICATIONS

Your prescription medicine is covered under fee-for-service (traditional) Medicaid. If you have questions about your prescription medicine, please contact Gainwell Technologies at **1-888-483-0797**.

If medically necessary, Aetna Better Health covers:

- Medicine you get as part of a hospital stay
- Injectable medicine you get at the doctor's office

Your doctor will work with us to get you the right medicine for your condition. If you have questions about these kinds of medicines, talk to your doctor.

PREGNANCY AND MATERNITY SERVICES

Aetna Better Health provides coverage for prenatal care, inpatient hospital stays during delivery, and post-partum care.

DENTAL SERVICES

Dental care is important to your overall health. Aetna Better Health uses a dental benefit manager, SKYGEN USA, to provide dental services to Mountain Health Trust members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by twelve months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members under age 21 can also access the Fluoride Varnish Program, offered by practitioners certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your practitioner. Children are covered for non- emergency and emergency dental services.

For adults 21 years and older, emergency dental services are covered. These services may be provided by a dentist, orthodontist, or oral surgeon. Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

If you need to speak with SKYGEN USA regarding the children's dental benefit, please call **1-888-983-4693**.

Preventive and non-emergency dental coverage for adults will begin 01/01/2021. For questions about adult dental services call us at **1-888-348-2922 (TTY: 711)**.

BEHAVIORAL HEALTH SERVICES

Aetna Better Health provides inpatient and outpatient services to members. This benefit includes mental health services, substance use disorder (alcohol and drugs) services, care management, rehabilitation and clinic services, and psychiatric residential treatment services.

You do not need a referral for behavioral health services. Your PCP or Member Services can help you get these services from behavioral health practitioners / providers. You can call **1-888-348-2922 (TTY: 711)**.

Let your PCP know if you visit a behavioral health specialist, so he or she can support your care. If there is a mental health or substance use emergency, please call **911** right away.

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 practices, 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-network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at **1-888-348-2922 (TTY: 711)**.

NEW TECHNOLOGY FOR MEDICAL PROCEDURES

We are always looking at new medical procedures and methods. We want to be sure members get safe, high-quality care. We have a team of doctors who review new health care technologies. They decide if new technologies should become covered services. (We don't cover things that are investigational or still under research.)

To decide if a new technology will become a covered service, we will:

- Study the purpose of it
- Review medical literature
- Look at the impact and benefits
- Develop rules on how and when to use the technology

SPECIALTY CARE

Sometimes you or your child may need care from a specialist. Specialists treat certain diseases and special types of conditions, including behavioral health or substance use concerns. Your PCP can recommend a specialist or behavioral health care provider to you. You don't need a formal referral from your PCP as long as the specialist is in our provider network.

Female members have direct access to an Aetna Better Health women's health specialist for preventive care. This includes covered services such as breast exams, mammograms, pap tests and prenatal care. You do not need an OK from your PCP. You must go to an Aetna Better Health practitioner in order for your service to be covered, except for emergency services or family planning services. You can use any Medicaid provider for family planning services.

Let your PCP know if you visit a specialist, so he or she can support your care. If you need help finding a specialist, please call us at **1-888-348-2922 (TTY: 711)** or visit **AetnaBetterHealth.com/WestVirginia/find-provider**.

SERVICE AUTHORIZATIONS

If you need to see a practitioner / provider who is not on our list, your PCP must ask Aetna Better Health for approval. Asking for an out-of-network referral is called a service authorization request. It is important to remember that your PCP must ask us for approval before you see an out-of-network practitioner/provider. You or your PCP can call Member Services at **1-888-348-2922 (TTY: 711)**. If you are approved to see a practitioner or provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization, you can appeal the decision.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your practitioner or provider must ask our Prior Authorization Team. If we do not approve a prior authorization, you can appeal the decision.

We give prior authorizations to Aetna Better Health practitioners or providers when you need health care, drugs or supplies that are medically needed. Your practitioner or provider needs to call us at least two (2) working days before the scheduled care. However, earlier notification helps the review process. We may ask to see written notes showing that the care is medically needed before it is preauthorized.

Our Prior Authorization team is available from 8:30 AM - 5 PM (ET) Monday through Friday. If you have questions, call Member Services at **1-888-348-2922 (TTY: 711)**. After normal business hours, you may leave a message, and someone will return your call the next business day. If someone from our UM team calls you, they will give you their name and title and say they are calling from Aetna Better Health. You can also access TTY services or language assistance to talk about UM issues. Our UM program helps make sure you get the right services at the right place.

Prior authorization is required before the date you get care for the services listed below:

- Home health care (except behavioral health)
- Rehabilitative Services: Physical, Occupational, or Speech Therapy
- Chiropractic care
- Durable medical equipment (DME)
- Polysomnograms (Sleep Apnea Studies)
- Genetic testing
- Pain management services
- Computerized Tomography (CT scan)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Positive Emission Tomography (PET Scan)
- Inpatient hospital care
- Outpatient surgery
- Intensive outpatient behavioral health services
- Partial hospitalization
- Psychiatric residential treatment facility care
- Services from a non-participating provider (except emergency services and family planning)

This list is not intended to be all inclusive. If you have any questions, call Member Services at **1-888-348-2922 (TTY: 711)**.

OUT-OF-NETWORK SERVICES

If we are unable to provide certain covered services, you may get out-of-network services.

You can go to a practitioner or provider outside the Aetna Better Health network only if: (1) the care is needed; and (2) there are no Aetna Better Health practitioners or providers who can give you the care needed. We have the right to say where the service can be given when no Aetna Better Health provider can give you the care needed. The care must be preauthorized before your visit. Your PCP or the practitioner that wants to give you the care should ask for this preauthorization.
If we have approved care outside our network, the cost will be no greater than it would be if you received the services within our network. Services will be provided in an acceptable and timely manner. If you have questions, call Member Services at **1-888-348-2922 (TTY: 711)**.

COST SHARING

Cost sharing, or a co-payment, is the money you need to pay at the time of service. Whenever you see your PCP or a practitioner/provider you were referred to in our network, you are not responsible for any costs except the co-payment. The amount of the co-payment will change depending on the service and the Federal Poverty Level. Please see the table below for more details.

Co-payments will be collected for:

- Inpatient and outpatient services
- Physician office visits, including nurse practitioner visits
- Non-emergency use of an emergency room
- Caretaker relatives age 21 and up
- Transitional Medicaid members age 21 and up
- Any other members that are not specifically exempt

Service	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	$0	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

Co-payments will not be collected for:

- Family planning services
- Emergency services
- Behavioral health services
- Members under age 21
- Pregnant women (including 60 days after pregnancy)
- American Indians and Alaska Natives
- Members getting hospice care
- Members in nursing homes
- Other members or services not under the State Plan authority
- Members who have met their household maximum limit for cost-sharing per calendar quarter
- Members with primary insurance other than Medicaid

For more information on co-payment amounts, please call Member Services at **1-888-348-2922 (TTY: 711)**. If you get a bill from your doctor for a covered health care service, call us.

ACCESS AND AVAILABILITY GUIDE

Aetna Better Health offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a practitioner in different situations.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 Calendar Days
Urgent Care	Within 48 Hours
Initial Prenatal Care	Within 14 Days of Known Pregnancy
Emergency Care	Immediately or referred to ER
Specialty Care – new patient/initial visit	Within 90 calendar days
Specialty Care – follow-up visit	Within 30 calendar days
Initial Behavioral Health visit	Within 10 business days
Urgent Behavioral Health visit	Within 48 hours
Care for a non-life-threatening behavioral health emergency	Within 6 hours
Follow-up care with a Behavioral Health practitioner (routine)	Within 60 calendar days

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:
PCP	30 Minutes
Specialist You See Often	30 Minutes
Hospital	45 Minutes (urban) or 90 minutes (rural)
Tertiary Services	45 minutes (urban) or 90 minutes (rural)
FQHCs/RHCs	60 minutes

LETTING US KNOW WHEN YOU'RE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, you can file a complaint or an appeal. A complaint may also be called a "grievance". Information on the number of complaints and appeals and their disposition is available upon request. You can also request a state fair hearing once you have gone through the process for complaints and appeals.

COMPLAINTS/GRIEVANCES

As a member of Aetna Better Health, you have the right to file a complaint (also called a grievance) at any time. You can file a complaint if you are unhappy with something about Aetna Better Health or one of our practitioners or providers. You can also file a complaint if you disagree with our decision about your appeal. To file an informal complaint, call us at **1-888-348-2922 (TTY: 711)** to let us know that you are unhappy with Aetna Better Health or your health care services.

You can take also steps to file a formal (written) complaint or allow someone like your PCP to do so on your behalf. If someone files a complaint on your behalf, we will need your ok in writing.

To file a written complaint, you will need to send us a letter that has:

- Your name
- Provider/practitioner name, if your complaint is about a service
- Date of service, if about a service
- Your mailing address
- The reason you are filing the complaint and what you want Aetna Better Health to do
- Any information or additional documents that could support your case
  Please mail it to:
  Aetna Better Health
  Attn: Complaint Coordinator
  500 Virginia Street East, STE 400
  Charleston, WV 25301

We will acknowledge receipt of your complaint in writing within 3 calendar days from when we receive it. We will get our response to you within 30 days from the date your complaint is received. If it is in your best interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days.

If you need help with a complaint, you can call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

APPEALS

As a member of Aetna Better Health, you have the right to appeal a decision, including a non-coverage decision. You can file an appeal if you do not agree with our decision about your service authorization or prior authorization request. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter. You will have 60 calendar days from the date of the Notice of Action to file an appeal with Aetna Better Health. If you would like your benefits to continue while the appeal is pending, you or your practitioner/provider must file a request within 13 calendar days of the date of the Notice of Action letter.

You can file an appeal by calling Member Services at **1-888-348-2922 (TTY: 711)** or you can do so in writing. If you choose to write to us, you will need to include your address. With written consent, you can also have someone else, like your PCP, file an appeal on your behalf. Unless you request an expedited appeal resolution, you must follow up a verbal appeal with a written, signed appeal.

To file a written appeal, please mail it to:

Aetna Better Health
Attn: Appeals Coordinator
500 Virginia Street East, STE 400
Charleston, WV 25301

Aetna Better Health will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days. For appeals that need to be resolved more quickly, we will give you our decision within 72 hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome.

If you need help with an appeal, you can call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

FAIR HEARINGS

As a member of Aetna Better Health, you have the right to request a state fair hearing. The state fair hearing process is different from the Aetna Better Health complaint and appeal process. You can only request a state fair hearing after you have received notice that Aetna Better Health is upholding the decision to reduce, suspend, or stop your benefits. You must request the state fair hearing no later

than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

Once you get the form, please mail it back to:

WV Bureau for Medical Services/Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

If you would like your benefits to continue while the hearing is going on, you or your practitioner or provider must file a request within 13 calendar days of the date on the Notice of Action letter. You may have to pay the cost of services, depending on the outcome. Parties to the state fair hearing can include the State, Aetna Better Health, your representative, or the representative of a deceased member. The State will hear your case and decide within 90 days of your request for a state fair hearing.

Please call Member Services at **1-888-348-2922 (TTY: 711)** if you have questions about requesting a state fair hearing. You can also call the Department of Health and Human Resources at **304-558-0684**.

COMPLAINTS TO THE BUREAU FOR MEDICAL SERVICES

At any time, you can file a complaint to West Virginia's Bureau for Medical Services:

Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
304- 558-1700

BMS can overturn any Aetna Better Health decision if it will be bad for your child's health or violates their policy.

REPORTING FRAUD

If you suspect fraud, waste, or abuse by an Aetna Better Health member, practitioner, or provider, please report it to our special investigative unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call **1-844-405-2016**. You may also complete the Fraud, Waste, and Abuse Reporting form on our website at **AetnaBetterHealth.com/WestVirginia/fraud** or by mailing it to us:

Aetna Better Health
500 Virginia Street East, STE 400
Charleston, WV 25301

OUR POLICIES

YOUR MEDICAL RECORDS

You have the right to ask for your medical records and get them within 30 calendar days from when you ask for them. You can also ask to have your medical records changed or corrected. Aetna Better Health will take action on your request to have your medical records changed no later than sixty (60) calendar days from when you ask us. Your medical records will always be kept private.

YOUR RIGHT TO INFORMATION ABOUT YOUR HEALTH PLAN

You may request the following information at any time:

- A description of how physicians are paid, including any incentives
- How many complaints and appeals we receive and how we resolve them
- Information on the structure and operation of Aetna Better Health
- A copy of the Aetna Better Health community report.

To request this information, call member services at **1-888-348-2922 (TTY: 711)**.

ADVANCE DIRECTIVES

Under Federal and State law, members age 18 and older have the right to make decisions about your medical care, including an advance directive. An advance directive is legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advance directive allows you to plan in advance and participate in decision-making about your health. It is a way to let your doctors know what kind of treatment you do or do not want. You can also allow someone you trust to make treatment decisions for you. This would allow that person to make choices about your care and treatment. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not

have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. You will need to sign and date your advance directive and have two witnesses sign it. You should keep a copy of your advance directive and be sure your doctor also has a copy. The advance directive will become part of your medical records. Remember, you can change your advance directive at any time.

Your doctor can help you complete an advance directive or answer questions you may have. For a copy of an advance directive form, call member services.

APPROPRIATE TREATMENT OF MINORS

Aetna Better Health follows the guidance of West Virginia Code §§ 16-4-10 "Minors" and 16-29-1 "Copies of Healthcare Records to be Furnished to Patients." Anyone over 16 who has been deemed emancipated in a court of law, or who is over 16 and legally married, will be treated, and have all the privileges, rights and duties of an adult.

Oral interpreters are provided to minors on an as-needed basis including emergencies.

THIRD PARTY LIABILITY

If you have insurance other than Medicaid, please call Member Services to let us know. Please call and let us know if another insurance company has been involved with your:

- Worker's compensation claim
- Personal injury
- Medical malpractice lawsuit
- Car accident

You must use any other health insurance you have first before using Medicaid.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our policies and services. To let us know, please call Member Services at **1-888-348-2922 (TTY: 711)**.

We also invite you to join our Member Advisory Committee (MAC). The MAC meets to review plan facts, share ideas, and talk about changes or new programs. You can also earn rewards for participating. To join call **1-888-349-2922 (TTY: 711)**.

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 calendar days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

REPORTING ABUSE & NEGLECT

If you need to report abuse and neglect of a child or adult, please call the DHHR Centralized Intake for Abuse and Neglect hotline at **1-800-352-6513**. The hotline is operated 24 hours a day, 7 days a week. If it is an emergency situation, call **911**.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of Aetna Better Health, you have the right to disenroll at any time. You may re-enroll in another health plan if you choose. The enrollment broker can help you. Just call **1-800-449-8466**.

Sometimes members are disenrolled from the health plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid managed care
- You move outside of our service area
- You are placed in an inpatient facility, nursing facility, State institution, or intermediate care facility for the mentally retarded for more than 30 calendar days
- You were incorrectly enrolled in Aetna Better Health
- You die

If this happens, your services may stop suddenly. The enrollment broker and Member Services can answer any questions you may have about disenrollment. If you move out of the country or out of state, call the West Virginia Bureau for Medical Services at **304-558-1700**.

IMPORTANT CONTACT INFORMATION		
Entity	**Phone Number**	**Street Address**
Aetna 24-Hour Nurse Line	**1-855-200-5975**	
Aetna Better Health Behavioral Health	**1-888-348-2922**	500 Virginia Street East; STE 400 Charleston, WV 25301
Aetna Better Health Fraud, Waste, and Abuse	**1-844-405-2016**	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Better Health Grievances/ Appeals	**1-888-348-2922**	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Better Health Medical Management	**1-888-348-2922**	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Better Health Member Services	Toll-Free: **1-888-348-2922**	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Dental (over 21)	**1-888-348-2922**	
County Department of Health & Human Resources (DHHR)	**1-877-716-1212**	
Enrollment Broker	**1-800-449-8466**	Maximus
Emergency	Call **911**	
Non-Emergent Transportation	**1-844-549-8353**	
Prescription Drugs	**1-888-483-0797**	Gainwell Technologies
SKYGEN USA Dental (under 21)	**1-888-983-4693**	
State Fair Hearing	**304-558-1700**	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301
VSP (Vision)	**1-800-877-7195**	

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2020 Recommended Immunizations for Children from Birth Through 6 Years Old

<table>
<tr><th>Birth</th><th>1 month</th><th>2 months</th><th>4 months</th><th>6 months</th><th>12 months</th><th>15 months</th><th>18 months</th><th>19–23 months</th><th>2–3 years</th><th>4–6 years</th></tr>
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Is your family growing? To protect your new baby against whooping cough, get a Tdap vaccine. The recommended time is the 27th through 36th week of pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during shown age range.

NOTE:
If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the first dose. All children and adolescents over 24 months of age who have not been vaccinated should also receive 2 doses of HepA vaccine.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he or she may need.

See back page for more information on vaccine-preventable diseases and the vaccines that prevent them.

For more information, call toll-free **1-800-CDC-INFO** (1-800-232-4636) or visit **www.cdc.gov/vaccines/parents**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Case 3:20-cv-00740 Document 252-1 Filed 05/31/22 Page 806 of 921 PageID #: 3336

INFORMATION FOR PARENTS

2020 Recommended Immunizations for Children 7–18 Years

Talk to your child's doctor or nurse about the vaccines recommended for their age.

	Flu Influenza	**Tdap** Tetanus, diphtheria, pertussis	**HPV** Human papillomavirus	**Meningococcal**		**Pneumo coccal**	**Hepa titis B**	**Hepatitis A**	**Polio**	**MMR** Measles, mumps, rubella	**Chickenpox** Varicella
				MenACWY	**MenB**						
7-8 Years											
9-10 Years											
11-12 Years											
13-15 Years											
16-18 Years											
More information:	Everyone 6 months and older should get a flu vaccine every year.	All 11- through 12-year olds should get one shot of Tdap.	All 11- through 12-year olds should get a 2-shot series of HPV vaccine. A 3-shot series is needed for those with weakened immune systems and those who start the series at 15 years or older.	All 11- through 12-year olds should get one shot of meningococcal conjugate (MenACWY). A booster shot is recommended at age 16.	Teens 16–18 years old **may** be vaccinated with a serogroup B meningococcal (MenB) vaccine.						

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/hcp/acip-recs/.

This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address:	Attn: Civil Rights Coordinator 4500 East Cotton Center Boulevard Phoenix, AZ 85040
Telephone:	**1-888-234-7358 (TTY 711)**
Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104** (للصم والبكم: **711**).

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または **1-800-385-4104** (TTY: **711**)までご連絡ください。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**).

NEPALI: ध्यान दनिुहोस्: दतिपयाईं नेपयाली भयाषया बोलनुहुन्छ भने तपयाईंकया लयागगिन:शुलक रूपमया भयाषया सेवयाहरू उपलब्ध छन्। तपयाईंको आइडीकयाडको पछयाडि रहको **1-800-385-4104** (TTY: **711**) मया फोन गिनुडहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں۔

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Member Services **1-888-348-2922 (TTY 711)**

AetnaBetterHealth.com/WestVirginia

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86.05.360.1-WV December 2020

Aetna Better Health® of West Virginia

Welcome

Aetna Better Health® of West Virginia

2021-2022 Member Handbook

Mountain Health Trust – Medicaid

Exhibit
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AetnaBetterHealth.com/WestVirginia

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Aetna Better Health® of West Virginia

Helpful Information

Aetna Better Health® of West Virginia

Member Services
1-888-348-2922 (TTY: 711)

Website
AetnaBetterHealth.com/WestVirginia

Hours of operation
8:30 AM to 5 PM

SKYGEN Dental
1-888-983-4693

Non-Emergent transportation - ModivCare
1-844-549-8353

Prescription Drugs - Gainwell Technologies
1-888-483-0797

HELP IN YOUR LANGUAGE

If you do not speak English, you can call us at **1-888-348-2922 (TTY: 711)**. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: Si usted no habla inglés, llámenos al **1-888-348-2922** y **711**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

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WELCOME

Welcome to Aetna Better Health's Medicaid managed care program! We are glad that you have enrolled with us. This handbook will provide you with the information you need to know about your health care plan, also known as a managed care plan. Please read this handbook from cover to cover to understand the way your plan works. This handbook will help you get the most from Aetna Better Health. It will answer many of the questions that come up about your benefits and the services offered by Aetna Better Health. You can also ask us any questions you may have by calling us at **1-888-348-2922**. If you are speech or hearing impaired, please dial **711**. If you would like a printed copy of this handbook, please call us and one will be mailed to you within five (5) business days of your request.

ABOUT OUR PLAN

Aetna Better Health has a contract with the West Virginia Department of Health and Human Resources (DHHR). Under managed care, we are able to select a group of health care practitioners and providers to form a provider network. Usually provider networks are made up of doctors and specialists, hospitals, and other health care facilities. Our practitioners and providers help to meet the health care needs of people with Medicaid. The Provider Directory lists all of our network providers you can use to get services statewide. It can be found online at our website, **AetnaBetterHealth.com/WestVirginia**. If you would like a printed copy of the Provider Directory or information about a practitioner's education, such as medical school and residency, cultural competency, or board certification, please call **1-888-348-2922 (TTY: 711)**.

It is important to us that you receive quality health care and customer service. Your satisfaction matters to us. The Quality Management (QM) program ensures our services meet high standards of quality and safety. We want to make sure you have:

- The right kind of care
- Easy access to quality medical and behavioral health care
- Help with any chronic conditions or illnesses
- Support when you need it most
- High satisfaction with your doctors and with us

For more information about our Quality Management program visit our website at **AetnaBetterHealth.com/WestVirginia**. If you have a problem, please call Member Services at **1-888-348-2922 (TTY: 711)**.

CONTACT US

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call. You can also visit our website, **AetnaBetterHealth.com/WestVirginia**, for other information.

Member Services Department
Hours of Operation: Monday – Friday, 8:30 AM – 5 PM
Address: 500 Virginia Street East, Suite 400, Charleston, WV 25301
Toll-free: **1-888-348-2922 (TTY: 711)**
Online: **AetnaBetterHealth.com/WestVirginia**

You can call or visit us online to:

- Ask questions about services and benefits, eligibility, claims, prior authorization requests, utilization management, or case management
- Change your primary care provider (PCP) or get help choosing a provider
- File a complaint
- Replace a lost member ID card
- Get help finding a specialist
- Let us know if you are pregnant
- Let us know if you give birth to a new baby
- Ask about any change that might affect you or your family's benefits
- Let us know about any changes to personal information
- Request interpreter services or get help for people with disabilities

If you do not understand or speak English, we can help. Please call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can answer questions about your benefits in your language. We have free interpreter services and can help you find a health care practitioner who can communicate with you in any language.

If you have a disability, we can help. Aetna Better Health offers services so that you can communicate effectively with us and your practitioner or provider. We have access to free sign language interpreter services and a TTY phone number: **1-888-348-2922 (TTY: 711)**. We can offer this handbook and all written materials in many formats, such as large print, at no cost to you. Please call Member Services toll-free at **1-888-348-2922** to ask for materials in another format.

For other important phone numbers, please see the list in the back of this handbook.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your rights to privacy. We will never give out your medical information or social security number without your written permission, unless required by law. To learn more about your rights to privacy, please call Member Services at **1-888-348-2922** or visit our website at **AetnaBetterHealth.com/WestVirginia**.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act, you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East
Charleston, WV 25305
304-558-4331

DEFINITIONS

Appeal: A way for you to request the review of Aetna Better Health's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Complaint: An expression of dissatisfaction, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health or our practitioners or providers. For example, you might complain about the quality of your care. In this handbook "grievance" and "complaint" mean the same thing.

Co-payment: A fixed amount you pay each time you get a covered service or supply. For example, if you use the emergency room when it is not an emergency, you might pay $8.

Durable Medical Equipment (DME): Certain items your practitioner or provider orders for everyday or extended use. Examples of these items are wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm. An emergency medical condition would make you think that without medical attention, it might: place your health (or a pregnant woman's unborn child's health) in serious jeopardy; or lead to death, serious dysfunction of a body part or organ, or serious impairment of bodily functions. Examples of an emergency medical condition include severe pain, difficulty breathing, or uncontrolled bleeding.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you receive in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are given by a qualified provider and needed to evaluate or stabilize an emergency medical condition.

Excluded Services: Health care services that Aetna Better Health does not pay for or cover.

Fee-For-Service: A fee-for-service benefit is covered by the West Virginia Medicaid program and not by Aetna Better Health.

Grievance: A complaint you make, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health or our practitioners or providers. For example, you might complain about the quality of your care. In this handbook "grievance" and "complaint" mean the same thing.

Habilitation Services and Devices: Health care services and devices that help you keep, learn, or improve skills and functioning for daily living. Examples include occupational theory, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Insurance: A contract that requires Aetna Better Health to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies, and other services.

Hospice Services: Services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness andis expected to have six months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Medically Necessary: Items or services furnished or to be furnished to a patient for diagnosing, evaluating, treating or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Health care services and supplies that are reasonable and necessary to diagnose or treat an illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development. Determination of medical necessity is based on specific criteria.

Network: A group of providers who has contracted with Aetna Better Health to give care to members. The list of Aetna Better Health practitioners and providers can be found in your Provider Directory. It will be updated whenever there are changes.

Non-participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has not signed a contract agreeing to provide services to Aetna Better Health members.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, Aetna Better Health.

Prior Authorization: Approval from Aetna Better Health that may be required before you get certain services or treatments in order for them to be covered. To get prior authorization, make sure to ask Member Services. If the care is medically necessary, then it will be covered.

Participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has signed a contract agreeing to provide services to Aetna Better Health members. They are listed in the Provider Directory.

Practitioner: A licensed or certified professional who provides medical or behavioral health care services, such as a doctor, nurse practitioner, or psychologist.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs and medications. Aetna Better Health does not provide prescription drug coverage, but the State of West Virginia does.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating practitioner you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Provider: An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Rehabilitation Services and Devices: Health care services and devices that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. Examples include occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Tertiary Services: Highly specialized medical services administered in a specialized medical facility.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgent care from out-of-network practitioners/providers when network practitioners/providers are unavailable, or you cannot get to them. Examples of when to get urgent care include a sprained ankle, a bad splinter, or the flu.

YOUR RIGHTS

As a member of Aetna Better Health, you have rights around your health care. You have the right to:

- Get information about Aetna Better Health, our services, our practitioners and providers, and your rights and responsibilities.
- Be treated with respect and dignity and have your privacy protected.
- Get interpretation services if you do not speak English or have a hearing impairment.
- Not be discriminated against by Aetna Better Health.
- Access all services that Aetna Better Health must provide.
- Choose a practitioner or provider in our network.
- Take part in decisions about your health care.
- Accept or refuse medical or surgical treatment and choose a different provider.
- A second opinion.
- Learn about other treatment options and different courses of care no matter how much they cost and/or if Aetna Better Health will pay for it.
- Ask for and get your medical records.
- Change or correct your medical records if needed.
- Be sure your medical records are kept private.
- Tell us how we can improve our policies and procedures, including the member rights and responsibilities policy.
- Be free from abuse, neglect, financial exploitation, or any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation.
- Get covered services, no matter what your cultural or ethnic background is or how well you understand English.
- Get covered services regardless of any physical or mental disability, or if you are homeless.
- Get accessible services and receive reasonable disability accommodations.
- Refer yourself to in-network and out-of-network family planning providers.
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services.
- Get emergency post-stabilization services.
- Get emergency health care services at any hospital or other setting.
- Receive information about advance directives, which tell how to have medical decisions made for you if you are not able to make them for yourself.

- Have your parent or a representative make treatment decisions when you can't.
- Submit a complaint or appeal about Aetna Better Health or the care it provides.
- A quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services.
- A state fair hearing after a decision has been made about your appeal.
- A copy of this member handbook.
- Obtain advocacy on your behalf.
- Disenroll from your health plan.

YOUR RESPONSIBILITIES

As a member of Aetna Better Health, you have the responsibility to:

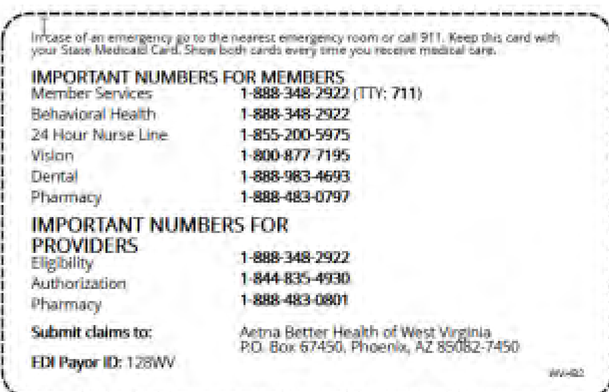
- Read through and follow the instructions in your Member Handbook.
- Work with your PCP to manage and improve your health.
- Ask your PCP any questions you may have and call your PCP any time you need health care.
- Give all information about your health to Aetna Better Health and your doctor. Tell your doctor if you do not understand your health problems. Work together with your doctor to make plans about your care.
- Show your ID card to each doctor before getting health services.
- Protect your member ID card. Do not lose or share it with others.
- Use the emergency room (ER) for true emergencies only.
- Keep your appointments.
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know. Follow what you and your practitioner agree to do.
- Follow your practitioner's recommendations about appointments and medications.
- Go back to your PCP or ask for a second opinion if you do not get better.
- Call Member Services at **1-888-348-2922 (TTY: 711)** whenever anything is unclear to you or you have questions.
- Contact DHHR Change Report Center at **1-877-716-1212** to report family size, employment, and/or address changes.
- Treat doctors, staff, and people providing services to you with respect.
- Tell Aetna Better Health if you have other health insurance, including Medicare.

YOUR MEMBER ID CARD

After you join Aetna Better Health, we will send you your member ID card in the mail. Each member of your family who has joined Aetna Better Health will receive his or her own card. If you have not received your member ID card after five (5) days, please call Member Services at **1-888-348-2922 (TTY: 711)**.

It is important to always keep your member ID card with you. You will need it any time you get care. Your card is your proof that you are a member of Aetna Better Health.

Your member ID card should look like this:



You will find some useful information on your card like your Medicaid ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at **1-888-348-2922 (TTY: 711)** if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You have a baby or add a new member to your family
- You move
- Someone in your family dies

Pregnant women and their newborn infants are eligible for Medicaid coverage for up to one year after delivery.

Please call your county DHHR immediately at **1-f ee-e1d-1212** if you move to another state or to another country.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Each member of Aetna Better Health chooses a primary care provider (PCP) from the Provider Directory. A PCP is a specific clinician responsible for coordinating your health care needs. The provider directory is available on our website at **AetnaBetterHealth.com/WestVirginia**. It is a list of all doctors, hospitals, dental and specialty care practitioners and other providers who work with Aetna Better Health. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the directory, we will choose one for you.

Your PCP's name and office phone number will be listed on your member ID card. If you would like to change your PCP, just give us a call.

If you have a chronic illness, then you may be able to select a specialist as your PCP. Please call Member Services at **1-888-348-2922 (TTY: 711)** to find out. If you already have a PCP and believe you need a specialist, you or your practitioner should call Member Services. Women can also receive women's health care services from an obstetrical/ gynecological practitioner (OB/GYN) without a referral from their PCP.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all your routine health care needs. All new members should try to schedule an appointment within 45 calendar days. You can schedule your appointments by calling the PCP's office phone number which is on your member ID card. You can call 24 hours a day, seven days a week. If you need help scheduling an appointment, please give us a call.

On the day of your visit, remember to bring your Aetna Better Health member ID card. Please show up on time or call to cancel an appointment if you cannot make it. We work with our provider offices to make sure you are seen as close to your appointment time as possible.

Aetna Better Health requires that members have access to all routinely used sites, such as PCP offices and frequently used specialists, within 30 minutes travel time of a member. See the Access and Availability Guide section in this handbook for more information. Aetna Better Health will ensure hours of operation are convenient and do not discriminate against members.

Aetna Better Health requires that emergency cases will be seen or referred immediately. Urgent cases must be seen within 48 hours. Routine cases must be seen within 21 days.

CHANGING YOUR PCP

If you need to, you can change your PCP for any reason at any time. Let us know right away by calling Member Services at **1-888-348-2922 (TTY: 711)** or by going to **AetnaBetterHealth.com/WestVirginia/members/portal**. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history.

Sometimes PCPs leave our network. If we find out your PCP is leaving, we will let you know by mail within 15 calendar days. We will try to give you 30 calendar days' notice before your PCP leaves. We can assign you a new PCP or you can pick a new one yourself. If we need to assign you a new PCP for another reason, we will let you know.

SECURE MEMBER WEB PORTAL

Our updated secure member website is your go-to resource to manage your plan—and your health. It will help you use your benefits and services so you can get and stay healthy. You can:

- Access health plan details—change your doctor, find forms or request member ID cards.
- Get personalized health information—answer questions about your health. Get the tips and tools you'll need to meet your health goals like quitting smoking and weight management.
- Get instant access to claims details—see the status of a claim from start to finish.
- Find support—get in touch with a nurse. Or learn more about chronic condition management and wellness programs that will help you stay on track with goals.

Set up your account by visiting **AetnaBetterHealth.com/WestVirginia**. Click on the "Member Portal" then select "Register or Log In". You'll need your member ID and a current email address to create an account.

To sign up over the phone call Member Services at **1-888-348-2922 (TTY: 711)**.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care to get in different situations.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need.

- Well-care Visits – A well care visit is when you or your child sees your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health, too. You can learn more about well-care visits under the section titled "More Information about Your Health Plan".
- After Hours Care – You can reach your PCP even if it is after normal business hours. Just leave a message with your name and phone number. Your PCP or another PCP on call for your PCP will call you back.
- We cover care given by licensed Aetna Better Health of West Virginia practitioners. You may receive care in the practitioner's office, a clinic, or other places needed to treat an illness, injury or disease.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs prompt care but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- The flu

You can also get urgent care if you are traveling and are too far from your PCP's office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do. If you think you might need urgent care when you are away from your home or after hours, you can also call the 24-Hour Nurse Line at **1-855-200-5975 (TTY: 711)**. They can help you decide what kind of treatment you need.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think he or she needs to be treated right away. Some examples of an emergency are:

- Severe bleeding that does not stop
- A heart attack
- Severe chest pain
- Seizures
- Rape
- Attempted suicide

You should not go to the emergency room (ER) for things like:

- Colds
- Minor cuts and bruises
- Sprained muscles.

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or Aetna Better Health. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or Aetna Better Health at **1-888-348-2922 (TTY: 711)**.

Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure Aetna Better Health is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call Aetna Better Health. If you are able, call your PCP to let him or her know that you have a medical emergency. You will need to schedule follow-up services (called post-stabilization) with your PCP.

For more information about emergency transportation and post-stabilization services, please see the Mountain Health Trust Covered Benefits table.

HOSPITAL CARE

Inpatient Hospital Care

If you do not have an emergency, we must preauthorize your stay before you go to the hospital. You must go to a hospital that is an Aetna Better Health of West Virginia provider. You will be under the care of your PCP or other practitioner recommended by your PCP.

We help manage all hospital stays. We look at the care you get while you are in the hospital. The care is covered as long as there is a medical need for the care. If all or part of the hospital stay is not medically needed, your provider will be told that coverage will end, and you will not be responsible for payment.

Outpatient Hospital Care

Outpatient hospital care is care in a hospital that does not require an overnight stay. It may include tests to find sickness or care to help you heal. If you get an x-ray or have physical therapy in a hospital, that is outpatient hospital care.

You should tell your PCP when you receive outpatient hospital care.

CARE AWAY FROM HOME

Aetna Better Health's service area is the entire State of West Virginia. If you are traveling or out of the service area, you are only covered for emergency services. Routine care out of the service area or out of the country isn't covered by Medicaid. If you are out of the service area and need health care services, call your PCP. He or she will tell you what to do. (You can also call us to check if you are out of the service area.)

If you are not in West Virginia and you think your or your child's life is in danger, go to the closest ER. Show your Aetna Better Health of West Virginia ID card and any other insurance ID cards you have to the ER staff. If you or your child gets services in the ER and are admitted to the hospital, have staff call us at the number on the back of your ID card.

YOUR BENEFITS

You can get many services through Aetna Better Health's Medicaid managed care program in addition to those that come with regular Medicaid. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP. This means that you do not need approval from your PCP. To get these services, look in our Provider Directory for the list of providers/practitioners who offer these services. You can schedule the appointment yourself. If you have any questions, Aetna Better Health can help. Just call Member Services at **1-888-348-2922 (TTY: 711)**. Member Services can explain how to access your services.

COVERED SERVICES

Covered services fall under medical, behavioral, dental, and vision. Your covered services must be medically necessary. You should get these services from providers/practitioners in the Aetna Better Health network. Your PCP should provide covered services or refer you to another practitioner or provider to do so. You can get the services listed in the Mountain Health Trust Covered Benefits table by using your Aetna Better Health member ID card. Members previously covered under West Virginia Health Bridge may not be eligible for all benefits.

Mountain Health Trust Covered Benefits
Medical • PCP and Specialist Office Visits in the Aetna Better Health provider network. • Clinic Services – Outpatient clinics including general clinics, birthing centers, and health department clinics. • Federally Qualified Health Centers – Includes physician, physician assistant, nurse practitioner, and nurse midwife services. • Laboratory and X-ray Services – Includes lab services related to substance abuse treatment. Services must be ordered by a physician, and certain procedures have service limits. • Physician Services – Inpatient or outpatient medical or surgical services provided by a doctor or dentist. Certain services may require prior authorization or have service limits. May be delivered through telehealth. • Vaccinations are included for children.
Behavioral Health • Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility – Includes services for children (under age 21) with mental illness and substance use disorder. Limits on frequency and amount of services. • Drug Screening – if ordered by treating practitioner and deemed medically necessary. Some limits apply. • Inpatient Hospital – includes behavioral health and substance use disorder hospital stays. • Inpatient Psychiatric (under age 21)– Includes treatment of psychiatric condition through an individual plan of care. Pre-admission and continued authorization is required. Certification required. • Inpatient Psychiatric (age 21-64) – Includes treatment of psychiatric condition through an individual plan of care furnished at an Institution for Mental Diseases (IMD). Limitations apply. • Outpatient Services – Includes services for individuals with mental illness and substance use disorder. Limits on frequency and amount of services. Assertive community treatment (ACT) is covered for members 18 years and older. Only ACT providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services. • Psychological Services – Evaluation and treatment, including individual, family, and group therapies. May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. • Substance Use Disorder (SUD) Services - Targeted care management, physician-supervised medication, and counseling services to treat members with SUD. Some exclusions apply.

Mountain Health Trust Covered Benefits
Emergency • Emergency Transportation – Includes ambulance and air ambulance. Out of state requires prior authorization. To call for Emergency Transportation, dial **911**. • Post-stabilization Services – Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
Home Health Care Services– Includes services given at member's residence. This does not include a hospital nursing facility, ICF/IID, or state institutions. Some suppliers have service limits.
Hospice – Includes nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker. Requires physician certification. For members over age 21, rights are waived to other Medicaid services related to the terminal illness.
Hospital • Inpatient – Includes all inpatient services, including bariatric surgery, corneal transplants and long-term acute care (LTAC). Some exclusions apply. • Outpatient – Includes preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
Maternity • Maternity Care – Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Right from the Start Services – Includes enhanced prenatal care services and care coordination for pregnant women through 60 days after giving birth and their newborn infants up to 1 year of age. No prior authorization required.
Nursing Services • Nurse Practitioners' Services – Some procedures may have service limits. • Private Duty Nursing – Includes 24-hour nursing care if medically necessary Limited to children under twenty-one (21) years of age. Prior approval may be required.

Mountain Health Trust Covered Benefits
Preventive Care and Disease Management • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Based on the periodicity schedule. Includes health care services for any medical or psychological condition discovered during screening (limited to members under age 21). • Family Planning – Includes all family planning providers, services and supplies. No referral needed for out-of-network providers. Sterilization is not covered for members under age 21. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered. • Tobacco Cessation – Includes therapy, counseling and Quitline services. Guidance and risk-reduction counseling covered for children. • Sexually Transmitted Disease Services – Includes screening for a sexually transmitted disease from your PCP, a specialist in our network, or an out-of-network family planning practitioner.
Other • Ambulatory Surgical Center Services – Includes services, equipment and use of the facility for surgical procedures. • Children with Special Health Care Needs Services – Includes coordination of services and limited medical services, equipment and supplies (limited to children under age 21 with certain medical conditions). • Chiropractor Services – Includes radiological exams and corrections to subluxation. Certain procedures have service limits. • Durable Medical Equipment – Medically necessary devices and medical equipment prescribed by a physician. May have services limits or require prior authorization. • Orthotic and Prosthetic Devices – May require prior approval and have service limits. Customized special equipment is considered. • Podiatry – Includes treatment of acute conditions, some surgeries, reduction of fractures and other injuries, and orthotics. Treatment of children limited to acute conditions. Routine foot care is not covered.

Mountain Health Trust Covered Benefits
Rehabilitation Services • Inpatient Rehabilitation – Includes inpatient rehabilitation services and general medical outpatient services that meet the certification requirements, for members up to age 64. • Occupational Therapy (OT) – Habilitative and rehabilitative services: 20 visits per year (combined for PT and OT) • Physical Therapy (PT) – Habilitative and rehabilitative services: 20 visits per year (combined for PT and OT) • Speech Therapy – Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (not covered for adults twenty-one (21) years or older). Some procedures have service limits or require prior approval.
Specialty Rehabilitation Services • Pulmonary Rehabilitation – Includes procedures to increase strength of respiratory muscle and functions. • Cardiac Rehabilitation - Includes supervised exercise sessions with electrocardiograph monitoring.
Dental • Children (under age 21) – Includes preventive, emergency, non-emergency, diagnostic, surgical, restorative treatment, and orthodontic services. • Adults (21 and over) – Includes preventative, diagnostic, and restorative services and emergency procedures to treat fractures, reduce pain, or eliminate infection. Non-emergency dental services are limited to $1,000 per calendar year. Cosmetic services are not covered.
Vision – Includes eye exams, lenses, frames, and needed repairs for children (under age 21). Includes medical treatment and one pair of glasses after cataract surgery for adults, and contact lenses for adults and children with certain conditions. Does not cover prescription sunglasses or designer frames.

BENEFITS COVERED UNDER MEDICAID FEE-FOR-SERVICE

The following services fall under fee-for-service Medicaid.

Benefits Covered Under Fee-for-Service Medicaid
Abortion – Includes drugs or devices to prevent implantation of fertilized ovum and medical procedures for termination of ectopic pregnancy. Physician certification required.
Early Intervention Services - Early intervention services provided to children three (3) years and under through the Birth to Three program.
ICF/IID Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for members with intellectual disabilities. Requires physician or psychologist certification.
Nursing Facility Services – Includes nursing, social services, and therapies.
Organ Transplant Services - covered when considered generally safe, effective, and medically necessary, and when no alternative medical treatment as recognized by the medical community is available. Corneal transplants are covered under managed care, not fee-for-service.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on a per unit, per month basis. Requires physician order and nursing plan of care.
Prescription Drugs – Includes prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor and Hepatitis-C may be covered under fee-for-service Medicaid. The prescription drug benefit is administered by the State Medicaid program. For questions about getting your medicines please call Gainwell Technologies at **1-f f f -bf a-0ege** between 7 AM - 7 PM Monday through Friday.
School-based Services – Services provided in a school-based setting. Limitations are listed in the fee for service Medicaid provider manual.

Benefits Covered Under Fee-for-Service Medicaid
Substance Use Disorder – Physician-supervised daily or several times weekly medication-assisted treatment and counseling services provided to those with severe opioid use disorder.
Transportation (non-emergency) – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by BMS or county DHHR staff. To get transportation, call: **1-844-549-8353**.
Tubal Ligation - provided to individuals of childbearing age to permanently prevent pregnancy.

VALUE-ADDED SERVICES

In addition to your benefits, Aetna Better Health offers value-added services. When eligible members complete the healthy behaviors in the table below, they will receive a reward. We offer these services to encourage health education and to promote health. Co-payments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services. Please note that value-added services sometimes change. Call Member Services at **1-888-348-2922 (TTY: 711)** for details.

Value-Added Services and Rewards	
Pregnancy	**Reward**
Attend 6 Prenatal appointments	Cribette
Attend 1 Post-partum appointment within **7-84** days of having your baby	$50 gift card
Enroll in Moms and Babies Program	Cribette or Baby Wrap Carrier upon delivery
Complete the Mom's and Babies Program	Educational Toy on baby's first birthday
Preventive Dental Program	Up to 2 check-ups during pregnancy
Asthma	**Reward**
Asthma Care Program	One-on-one asthma education and a Peak Flow Meter
Congestive Heart Failure	
Congestive Heart Failure Program	Wellness tools and bathroom scale

Value-Added Services and Rewards	
Diabetes	**Reward**
Enroll in diabetic education program and complete A1C testing* *Available in certain counties	$25 gift card
Yearly diabetic eye exam	$25 gift card
Certified Diabetes Management Program	
Good Health Practices	**Reward**
Wellness event participation (Locations and services vary. Contact Member Services at **1-888-348-2922** for details.)	$25 gift card
Yearly well child exam for ages 12-18	$25 gift card
Yearly child dental check-up for ages 2-3	$25 gift card
Adolescent immunizations	$25 gift card
Timely behavioral health follow-up appointment (within 7 days)	$25 gift card
Annual flu shot (adults only)	Fishing/hunting license
Healthy Activities	**Reward**
Ted E Bear Cub Club (under age 13)	Quarterly rewards
Keep Kids Safe	Medication Lock Box
Health related summer camps for children	Camp scholarships
ATV Safety Course completion	$25 gift card
Walking Program completion (adults only)	$25 gift card

In addition to rewarding you for healthy behaviors, Aetna Better Health offers members a free cell phone with free minutes for text and voice, unlimited calls to Member Services, and free wellness and appointment reminder texts. Call member services at **1-888-348-2922 (TTY: 711)** for more information.

COMMUNITY SERVICES

Good health and well-being is about more than just having good medical care. There are many services in West Virginia that can help you meet your needs. Whether you need help with a housing problem or childcare or getting healthy food or help with a substance use problem our care management team can help. Call us at **1-888-348-2922 (TTY: 711)** or visit our website for a list of resources. Go to **AetnaBetterHealth.com/WestVirginia/Members** and click on the Community Resources tab.

WEST VIRGINIA WIC

Aetna Better Health wants to make sure you receive all the help available to you. West Virginia Women, Infants, and Children (WIC) is an organization that provides nutritional services to you and your family. The mission of the West Virginia WIC program is to improve the health of women, infants and children in West Virginia by providing quality nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.

The West Virginia WIC program may help you and your family get healthy foods and have better nutrition. To reach the office of the West Virginia WIC program call **304-558-0030** or go to their website at **ons.wvdhhr.org**.

WORKFORCE WEST VIRGINIA

Workforce WV offers tools to help with job searches, unemployment, and training. Workforce WV has the largest database of job seekers and openings in the state. The education and training opportunities provide residents work skills needed by businesses. Visit their website at **http://workforcewv.org**. If you or someone in your family doesn't have a job due to a health issue, please contact us at **1-888-348-2922 (TTY: 711)**.

MORE INFORMATION ABOUT YOUR HEALTH PLAN

Please read below for more details about your Aetna Better Health benefits and services. If you have any questions, please call Member Services at **1-888-348-2922 (TTY: 711)**.

WELL-CHILD VISITS

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a child preventive health component of Medicaid. HealthCheck is the name for West Virginia's EPSDT Program. The HealthCheck Program promotes regular preventive medical care and the diagnosis and treatment of any health problem found during a screening.

Well-child visits are important to make sure children are healthy and stay healthy. HealthCheck covers all medically necessary and preventive health care services for members up to age 21. Covered screening services are medical, mental health, vision, hearing, and dental. Both sick and well care services are provided by your PCP at no cost.

HealthCheck Screening Schedule for Well-child visits	
Stage	**Ages for Well-child visits**
Infancy	Birth, 3-5 days old, by 1 month, 2 months, 4 months, 6 months and 9 months
Early Childhood	12 months, 15 months, 18 months, 24 months, 30 months, 3 years and 4 years
Middle Childhood and Adolescence	Every year from age 5 to age 21

Some screenings that children can get include:

- Physical exams
- Laboratory tests
- Vision testing
- Immunizations
- Hearing test
- Dental services
- Behavioral health screenings
- Health education
- Health and development history

Immunizations are important to keep your child healthy. See Appendix A in this handbook for the recommended immunization schedule. Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early, before they become more serious. Call your PCP or Member Services to schedule a well-child visit. Transportation and scheduling help are also available upon request at no cost.

Aetna Better Health has trained professionals on staff to help members move from child to adult care. We can help you to get the right care for your child's special needs.

Please call **1-888-348-2922 (TTY: 711)** and ask to speak to a care management staff member.

POPULATION HEALTH MANAGEMENT

Aetna Better Health has many programs to help members get healthy and stay as healthy as possible. Whether you have a medical problem or are just trying to live a healthy life, we have a program for you. We will automatically put you into the program if you are eligible. Call us if you do not want to be part of a program. For questions about these programs, call us at **1-f f f -abf -2g22 (TTY: 711)**.

Program	Who Is Eligible
Healthy Pregnancies/Healthy Babies	Pregnant members and moms up to 6 weeks after giving birth
Healthy Adults and Children	All members
Flu Vaccination	All members over 6 months of age
Living with Diabetes	Members with Diabetes
Moms and Babies	Pregnant women who have substance use disorder (drug addiction) and Babies born with Neonatal Abstinence Syndrome (NAS)
Appropriate Use of Acute Care Settings	Members who are in the hospital or have recently been discharged
Opioid Management	Members who use certain drugs
Chronic Condition Management	Members with at least one chronic condition: Asthma, Diabetes, Heart Failure, COPD (Lung Disease), Coronary Artery Disease (CAD), Depression
Managing Diabetes and Heart Disease (Multiple Chronic Conditions)	Members with both Diabetes and Heart Disease
Emergency Room (ER) Utilization Management	Members who frequently use the ER
Integrated Care Management (ICM)	Members who need help managing their care
Child and Family Welfare Program	Assists and supports members in the child and family welfare system

INTEGRATED CARE MANAGEMENT

Some members have special health care needs and medical conditions. Our Integrated Care Management (ICM) Program can help make sure you understand your condition and treatment plan. We have nurses, social workers, and support staff who work with many health care practitioners, agencies and organizations to get you the services and the care that you need. We will help you get the best care in the most efficient manner. Our Case Managers help coordinate care in the following ways:

- Work one-on-one with you to create a plan based on your goals.
- Review your plan to help make sure you do not have gaps in care.
- Consult with your doctors.

- Help you make specialist and primary care doctor appointments.
- Verify that the right medicines and treatments are in place.
- Help make sure you receive preventive care.
- Work to ensure you and your family have the support you need.
- Ask questions to make sure your home is safe.
- Provide patient and family education about programs and services available in the community and through your doctor.
- Make sure you have support for any behavioral health needs.
- Help you transition to other care when your benefits end, if necessary.

We want to help you get the care and services you need. To sign up, call us at **1-888-348-2922 (TTY: 711)** and ask to speak to a Case Manager. Your practitioner or caregiver can also call to sign you up for the program. You may leave the program at any time.

HEALTH HOME

The Health Home Program coordinates physical and behavioral health (both mental and substance disorders), long term and social services, and supports for members with chronic health conditions. If you would like assistance with enrolling in a health home, please contact us at **1-888-348-2922 (TTY: 711)**.

UTILIZATION MANAGEMENT

We want to ensure that our members are getting the services or benefits they need to get or stay healthy. This is called "utilization management" (UM). Our UM staff use clinical criteria, guidelines and written policies to make UM decisions. They check that requested services are:

- Needed to get you healthy or keep you healthy
- Covered by Aetna Better Health of West Virginia

You or your practitioner or provider can get a copy of the guidelines we use to approve or deny services. You can call Member Services at **1-888-348-2922 (TTY: 711)** Monday - Friday from 8:30 AM to 5 PM with questions about our UM program. Member Services may transfer your call to the UM department for a staff member to help you. After normal business hours, you may leave a message. We'll call you the next business day. When calling back, the representative will tell you that he or she is calling from Aetna Better Health of West Virginia and will give you their name and title.

We're here to help you with any UM issues:

- For help if you have vision and/or hearing problems, call us at **1-888-348-2922 (TTY: 711)**.
- For help with language or translation services, call Member Services at **1-888-348-2922**.

We understand members want to feel confident they are receiving the health care and services that are best for them. We have policies our practitioners and providers follow to ensure you receive the right health care. We do not use incentives to encourage barriers to care and/or service, or to reward inappropriate restrictions of care. This is called an affirmative statement. We want to let you know that:

- Utilization Management (UM) decisions are made by looking at your benefits and choosing the most appropriate care and service.
- We don't reward doctors or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services you get.

We want to make sure that each member receives the right health care. If you need help understanding this information, call us at **1-888-348-2922 (TTY: 711)**.

MEDICATIONS

Your prescription medicine is covered under fee-for-service (traditional) Medicaid. If you have questions about your prescription medicine, please contact Gainwell Technologies at **1-888-483-0797**.

If medically necessary, Aetna Better Health covers:

- Medicine you get as part of a hospital stay
- Injectable medicine you get at the doctor's office

Your doctor will work with us to get you the right medicine for your condition. If you have questions about these kinds of medicines, talk to your doctor.

PREGNANCY AND MATERNITY SERVICES

Aetna Better Health provides coverage for prenatal care, inpatient hospital stays during delivery, and post-partum care. Our Healthy Pregnancies/Healthy Babies program can offer you support throughout your pregnancy and after delivery. Call **1-888-483-0797** and ask to speak to Care Management for more information on the program.

DENTAL SERVICES

Dental care is important to your overall health. Aetna Better Health uses a dental benefit manager, SKYGEN USA, to provide dental services to Mountain Health Trust members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by twelve months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members under age 21 can also access the Fluoride Varnish Program, offered by practitioners certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your practitioner. Children are covered for non- emergency and emergency dental services.

For adults 21 years and older, diagnostic, preventive, restorative and emergency dental services are covered. Non-emergency dental services are limited to $1,000 per calendar year (other limitations apply). Dental services may be provided by a dentist, orthodontist, or oral surgeon. Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

If you need to speak with SKYGEN USA regarding the dental benefit, please call **1-888-983-4693**.

BEHAVIORAL HEALTH SERVICES

Aetna Better Health provides inpatient and outpatient services to members. This benefit includes mental health services, substance use disorder (alcohol and drugs) services, care management, rehabilitation and clinic services, and psychiatric residential treatment services.

You do not need a referral for behavioral health services. Your PCP or Member Services can help you get these services from behavioral health practitioners / providers. You can call **1-888-348-2922 (TTY: 711)**.

Let your PCP know if you visit a behavioral health specialist, so he or she can support your care. If there is a mental health or substance use emergency, please call **911** right away.

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-

network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at **1-888-348-2922 (TTY: 711)**.

NEW TECHNOLOGY FOR MEDICAL PROCEDURES

We are always looking at new medical procedures and methods. We want to be sure members get safe, high-quality care. We have a team of doctors who review new health care technologies. They decide if new technologies should become covered services. (We don't cover things that are investigational or still under research.)

To decide if a new technology will become a covered service, we will:

- Study the purpose of it
- Review medical literature
- Look at the impact and benefits
- Develop rules on how and when to use the technology

GETTING YOUR BENEFITS

SPECIALTY CARE

Sometimes you or your child may need care from a specialist. Specialists treat certain diseases and special types of conditions, including behavioral health or substance use concerns. Your PCP can recommend a specialist or behavioral health care provider to you. You don't need a formal referral from your PCP as long as the specialist is in our provider network.

Female members have direct access to an Aetna Better Health women's health specialist for preventive care. This includes covered services such as breast exams, mammograms, pap tests and prenatal care. You do not need an OK from your PCP. You must go to an Aetna Better Health practitioner in order for your service to be covered, except for emergency services or family planning services. You can use any Medicaid provider for family planning services.

Let your PCP know if you visit a specialist, so he or she can support your care. If you need help finding a specialist, please call us at **1-888-348-2922 (TTY: 711)** or visit **AetnaBetterHealth.com/WestVirginia/find-provider**.

SERVICE AUTHORIZATIONS

If you need to see a practitioner / provider who is not on our list, your PCP must ask Aetna Better Health for approval. Asking for an out-of-network referral is called a service authorization request. It is important to remember that your PCP must ask us for approval before you see an out-of-network practitioner/provider. You or your PCP can call Member Services at **1-888-348-2922 (TTY: 711)**. If you are approved to see a practitioner or provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization, you can appeal the decision.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your practitioner or provider must ask our Prior Authorization Team. If we do not approve a prior authorization, you can appeal the decision.

We give prior authorizations to Aetna Better Health practitioners or providers when you need health care, drugs or supplies that are medically needed. Your practitioner or provider needs to call us at least two (2) working days before the scheduled care. However, earlier notification helps the review process. We may ask to see written notes showing that the care is medically needed before it is preauthorized.

Our Prior Authorization team is available from 8:30 AM - 5 PM (ET) Monday through Friday. If you have questions, call Member Services at **1-888-348-2922 (TTY: 711)**. After normal business hours, you may leave a message, and someone will return your call the next business day. If someone from our UM team calls you, they will give you their name and title and say they are calling from Aetna Better Health. You can also access TTY services or language assistance to talk about UM issues. Our UM program helps make sure you get the right services at the right place.

Prior authorization is required before the date you get care for the services listed below:

- Home health care (except behavioral health)
- Rehabilitative Services: Physical, Occupational, or Speech Therapy
- Chiropractic care
- Durable medical equipment (DME)
- Polysomnograms (Sleep Apnea Studies)
- Genetic testing
- Pain management services
- Computerized Tomography (CT scan)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)

- Positive Emission Tomography (PET Scan)
- Inpatient hospital care
- Outpatient surgery
- Intensive outpatient behavioral health services
- Partial hospitalization
- Psychiatric residential treatment facility care
- Services from a non-participating provider (except emergency services and family planning)

This list is not intended to be all inclusive. If you have any questions, call Member Services at **1-888-348-2922 (TTY: 711)**.

OUT-OF-NETWORK SERVICES

If we are unable to provide certain covered services, you may get out-of-network services.

You can go to a practitioner or provider outside the Aetna Better Health network only if: (1) the care is needed; and (2) there are no Aetna Better Health practitioners or providers who can give you the care you need. We have the right to say where the service can be given when no Aetna Better Health provider can give you the care needed. The care must be preauthorized before your visit. Your PCP or the practitioner that wants to give you the care should ask for this preauthorization. If we have approved care outside our network, the cost will be no greater than it would be if you received the services within our network. Services will be provided in an acceptable and timely manner. If you have questions, call Member Services at **1-f f f -abf -2g22 (TTY: 711)**.

COST SHARING

Cost sharing, or a co-payment, is the money you need to pay at the time of service. Whenever you see your PCP or a practitioner/provider you were referred to in our network, you are not responsible for any costs except the co-payment. The amount of the co-payment will change depending on the service and the Federal Poverty Level. Please see the table below for more details.

Co-payments will be collected for:

- Inpatient and outpatient services
- Physician office visits, including nurse practitioner visits
- Non-emergency use of an emergency room
- Caretaker relatives age 21 and up
- Transitional Medicaid members age 21 and up
- Any other members that are not specifically exempt

Service	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	$0	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

Co-payments will not be collected for:

- Family planning services
- Emergency services
- Behavioral health services
- Members under age 21
- Pregnant women (including one year after delivery)
- American Indians and Alaska Natives
- Members getting hospice care
- Members in nursing homes
- Other members or services not under the State Plan authority
- Members who have met their household maximum limit for cost-sharing per calendar quarter
- Members with primary insurance other than Medicaid

For more information on co-payment amounts, please call Member Services at **1-f f f -abf -2g22 (TTY: 711)**. If you get a bill from your doctor for a covered health care service, call us.

ACCESS AND AVAILABILITY GUIDE

Aetna Better Health offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a practitioner in different situations.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 Calendar Days
Urgent Care	Within 48 Hours
Initial Prenatal Care	Within 14 Days of Known Pregnancy
Emergency Care	Immediately or referred to ER
Specialty Care – new patient/initial visit	Within 90 calendar days
Specialty Care – follow-up visit	Within 30 calendar days
Initial Behavioral Health visit	Within 10 business days
Urgent Behavioral Health visit	Within 48 hours
Care for a non-life-threatening behavioral health emergency	Within 6 hours
Follow-up care with a Behavioral Health practitioner (routine)	Within 60 calendar days

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:
PCP	30 Minutes
Specialist You See Often	30 Minutes
Hospital	45 Minutes (urban) or 90 minutes (rural)
Tertiary Services	45 minutes (urban) or 90 minutes (rural)
FQHCs/RHCs	60 minutes

LETTING US KNOW WHEN YOU'RE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, you can file a complaint or an appeal. A complaint may also be called a "grievance". You can also request a state fair hearing once you have gone through the process for complaints and appeals. Information on the number of complaints and appeals and their disposition is available upon request.

COMPLAINTS/GRIEVANCES

As a member of Aetna Better Health, you have the right to file a complaint (also called a grievance) at any time. You can file a complaint if you are unhappy with something about Aetna Better Health or one of our practitioners or providers. You can also file a complaint if you disagree with our decision about your appeal. To file an informal complaint, call us at **1-888-348-2922 (TTY: 711)** to let us know that you are unhappy with Aetna Better Health or your health care services.

You can take also steps to file a formal (written) complaint or allow someone like your PCP to do so on your behalf. If someone files a complaint on your behalf, we will need your ok in writing.

To file a written complaint, you will need to send us a letter that has:

- Your name
- Provider/practitioner name, if your complaint is about a service
- Date of service, if about a service
- Your mailing address
- The reason you are filing the complaint and what you want Aetna Better Health to do
- Any information or additional documents that could support your case

Please mail it to:
Aetna Better Health of West Virginia
P.O. Box 81139
5801 Postal Rd.
Cleveland, OH 44181

We will acknowledge receipt of your complaint in writing within 3 calendar days from when we receive it. We will get our response to you within 30 days from the date your complaint is received. If it is in your best interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days.

If you need help with a complaint, you can call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

APPEALS

As a member of Aetna Better Health, you have the right to appeal a decision, including a non-coverage decision. You can file an appeal if you do not agree with our decision about your service authorization or prior authorization request. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter. You will have 60 calendar days from the date of the Notice of Action to file an appeal with Aetna Better Health. Appeals can be filed verbally or in writing. If you would like your benefits to continue while the appeal is pending, you or your practitioner/provider must file a request within 13 calendar days of the date of the Notice of Action letter. If our appeal decision is not in your favor, you may have to pay for services you received while the appeal was pending.

You can file an appeal by calling Member Services at **1-f f f -abf -2g22 (TTY: 711)** or you can do so in writing. If you choose to write to us, you will need to include your address. With written consent, you can also have someone else, like your PCP, file an appeal on your behalf.

To file a written appeal, please mail it to:

Aetna Better Health of West Virginia
Box 81139
5801 Postal Rd.
Cleveland, OH 44181

Aetna Better Health will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days. For appeals that need to be resolved more quickly, we will give you our decision within 72 hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome.

If you need help with an appeal, you can call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

FAIR HEARINGS

As a member of Aetna Better Health, you have the right to request a state fair hearing. The state fair hearing process is different from the Aetna Better Health complaint and appeal process. You can only request a state fair hearing after you have received notice that Aetna Better Health is upholding the decision to reduce, suspend, or stop your benefits. You must request the state fair hearing no later than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

Once you get the form, please mail it back to:

WV Bureau for Medical Services/Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

If you would like your benefits to continue while the hearing is going on, you or your practitioner or provider must file a request within 13 calendar days of the date on the Notice of Action letter. You may have to pay the cost of services, depending on the outcome. Parties to the state fair hearing can include the State, Aetna Better Health, your representative, or the representative of a deceased member. The State will hear your case and decide within 90 days of your request for a state fair hearing.

Please call Member Services at **1-888-348-2922 (TTY: 711)** if you have questions about requesting a state fair hearing. You can also call the Department of Health and Human Resources at **304-558-0684**.

COMPLAINTS TO THE BUREAU FOR MEDICAL SERVICES

At any time, you can file a complaint to West Virginia's Bureau for Medical Services:

Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
304- 558-1700

BMS can overturn any Aetna Better Health decision if it will be bad for your child's health or violates their policy.

REPORTING FRAUD

If you suspect fraud, waste, or abuse by an Aetna Better Health member, practitioner, or provider, please report it to our special investigative unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call **1-844-405-2016**. You may also complete the Fraud, Waste, and Abuse Reporting form on our website at **AetnaBetterHealth.com/WestVirginia/fraud** or by mailing it to us:

Aetna Better Health
500 Virginia Street East, STE 400
Charleston, WV 25301

YOUR MEDICAL RECORDS

You have the right to ask for your medical records and get them within 30 calendar days from when you ask for them. You can also ask to have your medical records changed or corrected. Aetna Better Health will take action on your request to have your medical records changed no later than sixty (60) calendar days from when you ask us. Your medical records will always be kept private.

YOUR RIGHT TO INFORMATION ABOUT YOUR HEALTH PLAN

You may request the following information at any time:

- A description of how physicians are paid, including any incentives
- How many complaints and appeals we receive and how we resolve them
- Information on the structure and operation of Aetna Better Health
- A copy of the Aetna Better Health community report.

To request this information, call member services at **1-888-348-2922 (TTY: 711)**.

ADVANCE DIRECTIVES

Under Federal and State law, members age 18 and older have the right to make decisions about their medical care, including an advance directive. An advance directive is legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advance directive allows you to plan in advance and participate in decision-making about your health. It is a way to let your doctors know what kind of treatment you do or do not want. You can also allow someone you trust to make treatment decisions for you. This would allow that person to make choices about your care and treatment. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. You will need to sign and date your advance directive and have two witnesses sign it. You should keep a copy of your advance directive and be sure your doctor also has a copy. The advance directive will become part of your medical records. Remember, you can change your advance directive at any time.

Your doctor can help you complete an advance directive or answer questions you may have. For a copy of an advance directive form, call member services.

APPROPRIATE TREATMENT OF MINORS

Aetna Better Health follows the guidance of West Virginia Code §§ 16-4-10 “Minors” and 16-29-1 “Copies of Healthcare Records to be Furnished to Patients.” Anyone over 16 who has been deemed emancipated in a court of law, or who is over 16 and legally married, will be treated, and have all the privileges, rights and duties of an adult.

Oral interpreters are provided to minors on an as-needed basis including emergencies.

THIRD PARTY LIABILITY

If you have insurance other than Medicaid, please call Member Services to let us know. Please also call and let us know if another insurance company has been involved with your:

- Worker’s compensation claim
- Personal injury
- Medical malpractice lawsuit
- Car accident

You must use any other health insurance you have first before using Medicaid.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our policies and services. To let us know, please call Member Services at **1-888-348-2922 (TTY: 711)**.

We also invite you to join our Member Advisory Committee (MAC). The MAC meets to review plan facts, share ideas, and talk about changes or new programs. You can also earn rewards for participating. To join call **1-888-349-2922 (TTY: 711)**.

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 calendar days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

REPORTING ABUSE & NEGLECT

If you need to report abuse and neglect of a child or adult, please call the DHHR Centralized Intake for Abuse and Neglect hotline at **1-800-352-6513**. The hotline is operated 24 hours a day, 7 days a week. If it is an emergency situation, call **911**.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of Aetna Better Health, you have the right to disenroll at any time. You may re-enroll in another health plan if you choose. The enrollment broker can help you. Just call **1-800-449-8466**.

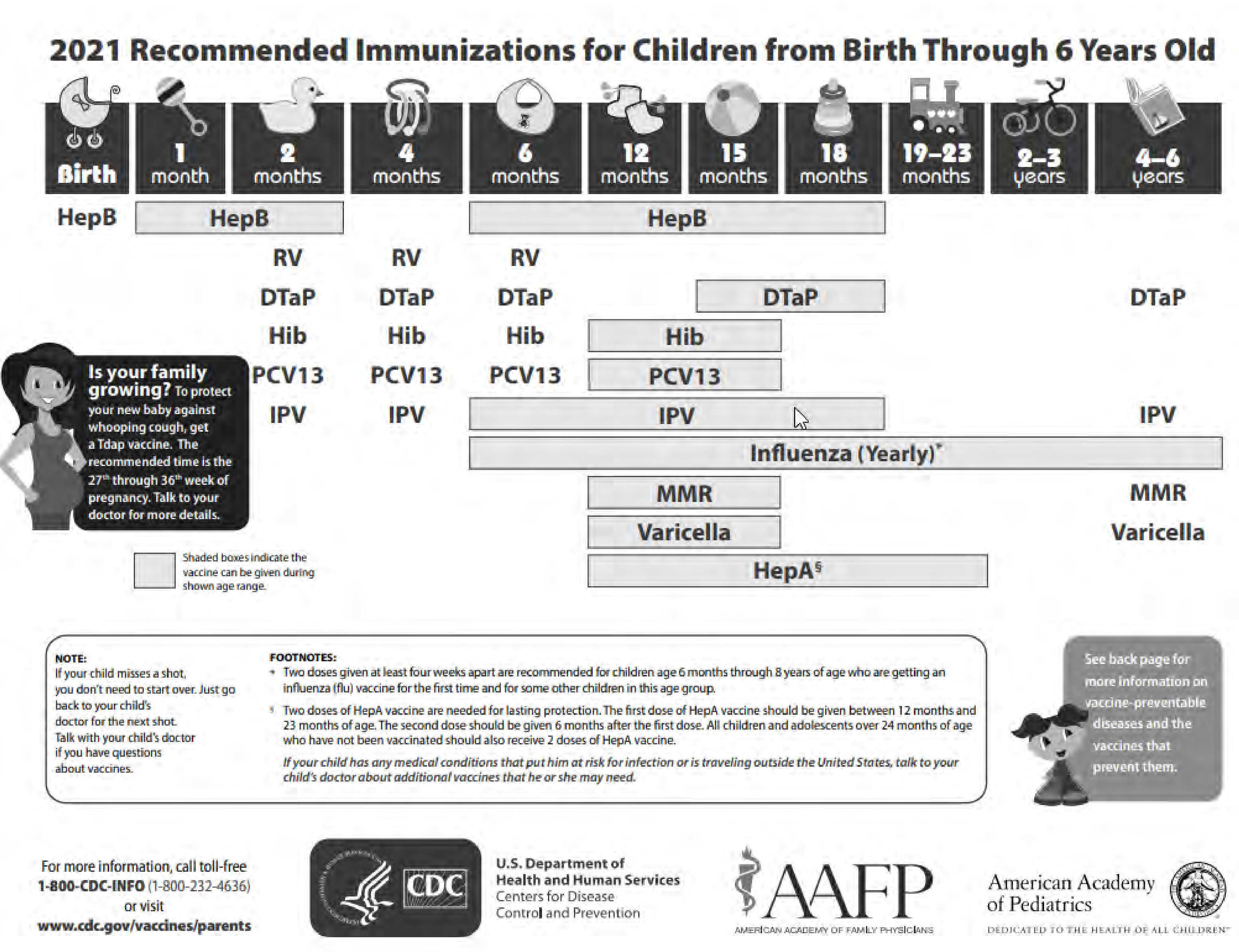
Sometimes members are disenrolled from the health plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid managed care
- You move outside of our service area
- You are placed in an inpatient facility, nursing facility, State institution, or intermediate care facility for the mentally retarded for more than 30 calendar days
- You were incorrectly enrolled in Aetna Better Health
- You die

If this happens, your services may stop suddenly. The enrollment broker and Member Services can answer any questions you may have about disenrollment. If you move out of the country or out of state, call the West Virginia Bureau for Medical Services at **304-558-1700**.

IMPORTANT CONTACT INFORMATION		
Entity	**Phone Number**	**Street Address**
Aetna 24-Hour Nurse Line	**1-855-200-5975**	
Aetna Better Health Behavioral Health	**1-888-348-2922**	500 Virginia Street East; STE 400 Charleston, WV 25301
Aetna Better Health Fraud, Waste, and Abuse	**1-f bb-b0c-201d**	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Better Health Grievances/ Appeals	**1-888-348-2922**	Aetna Better Health of West Virginia Box 81139 5801 Postal Rd. Cleveland, OH 44181
Aetna Better Health Medical Management	**1-888-348-2922**	500 Virginia Street East STE 400 Charleston, WV 25301
Aetna Better Health Member Services	Toll-Free: **1-888-348-2922**	500 Virginia Street East STE 400 Charleston, WV 25301
County Department of Health & Human Resources (DHHR)	**1-877-716-1212**	
Enrollment Broker	**1-800-449-8466**	Maximus
Emergency	Call **911**	
Non-Emergent Transportation	**1-844-549-8353**	
Prescription Drugs	**1-888-483-0797**	Gainwell Technologies
SKYGEN USA Dental	**1-888-983-4693**	
State Fair Hearing	**304-558-1700**	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301
VSP (Vision)	**1-800-877-7195**	

APPENDIX A: IMMUNIZATION CHARTS



Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV13 vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated February 2021 • CS322257-A

INFORMATION FOR PARENTS

2021 Recommended Immunizations for Children 7–18 Years Old

Talk to your child's doctor or nurse about the vaccines recommended for their age. COVID-19 vaccination is recommended for some adolescents.

	Flu Influenza	**Tdap** Tetanus, diphtheria, pertussis	**HPV** Human papillomavirus	**Meningococcal**		**Pneumococcal**	**Hepatitis B**	**Hepatitis A**	**Polio**	**MMR** Measles, mumps, rubella	**Chickenpox** Varicella
				MenACWY	**MenB**						
7-8 Years											
9-10 Years											
11-12 Years											
13-15 Years											
16-18 Years											
More information:	Everyone 6 months and older should get a flu vaccine every year.	All 11- through 12-year olds should get one shot of Tdap.	All 11- through 12-year olds should get a 2-shot series of HPV vaccine. A 3-shot series is needed for those with weakened immune systems and those who start the series at 15 years or older.	All 11- through 12-year olds should get one shot of meningococcal conjugate (MenACWY). A booster shot is recommended at age 16.	Teens 16–18 years old **may** be vaccinated with a serogroup B meningococcal (MenB) vaccine.						

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/hcp/acip-recs/.

This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	Tdap* and Td** vaccines protect against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Human Papillomavirus	HPV vaccine protects against human papillomavirus.	Direct skin contact	May be no symptoms, genital warts	Cervical, vaginal, vulvar, penile, anal, oropharyngeal cancers
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR*** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Meningococcal Disease	MenACWY and MenB vaccines protect against meningococcal disease.	Air, direct contact	Sudden onset of fever, headache, and stiff neck, dark purple rash	Loss of limb, deafness, nervous system disorders, developmental disabilities, seizure disorder, stroke, death
Mumps	MMR*** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	Tdap* vaccine protects against pertussis.	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Pneumococcal Disease	Pneumococcal vaccine protects against pneumococcal disease.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Polio	Polio vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Rubella	MMR*** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	Tdap* and Td ** vaccines protect against tetanus.	Exposure through cuts on skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

*Tdap combines protection against diphtheria, tetanus, and pertussis.
**Td combines protection against diphtheria and tetanus.
***MMR combines protection against measles, mumps, and rubella.

If you have any questions about your child's vaccines, talk to your child's doctor or nurse.

Last updated on February 2021 • CS322257-B

AETNA BETTER HEALTH® OF WEST VIRGINIA

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Attn: Civil Rights Coordinator 4500
East Cotton Center Boulevard
Phoenix, AZ 85040
Telephone: **1-888-234-7358 (TTY 711)**
Email: MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019,
1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html .

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104**)للصم والبكم: **711**(.

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

JAPANESE: 注意事項日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または **1-800-385-4104** (TTY: **711**) までご連絡ください。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**).

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली बोलनुहुन्छ भने तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नमबर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. باشماره درج شده در پشت کارت شناسایی یا باشماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**)

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں ۔ اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کر

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, individually and on behalf of all others similarly situated, *et al.*, *Plaintiffs,* v. WILLIAM CROUCH, *et al.*, *Defendants.*	CIVIL ACTION NO. 3:20-cv-00740 HON. ROBERT C. CHAMBERS

PLAINTIFFS' SECOND AMENDED NOTICE OF 30(b)(6) DEPOSITION

PLEASE TAKE NOTICE THAT pursuant to Rule 30(b)(6) of the Federal Rules of Civil Procedure, Plaintiffs, individually and on behalf of the proposed classes, will take the deposition of Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services through its corporate representatives most knowledgeable about the topics listed herein at the following dates and times, and continuing thereafter until completed:

1. **Sarah Young**, March 11, 2022, beginning at 9 a.m. E.T.
2. **Secretary Crouch**, March 17, 2022, beginning at 11:30 a.m. E.T. to 4 p.m. E.T.
3. **Secretary Crouch**, March 18, 2022, beginning 12:30 p.m. E.T. until completion
4. **Commissioner Beane**, as a Rule 30(b)(6) designee and in her individual capacity, March 29, 2022, beginning at 9:00 a.m. E.T.
5. **Dr. Becker**, March 30, 2022, beginning at 8:00 a.m. E.T. to 4:00 p.m. E.T.
6. **Frederick Lewis**, April 4, 2022, beginning at 9:00 a.m. E.T.

7. **Brandon Lewis**, April 5, 2022, beginning at 10:00 a.m. E.T.

8. **Jennifer Myers**, April 8, 2022, beginning at 9:00 a.m. E.T.

9. **Becky Manning**, April 12, 2022, beginning at 10:00 a.m. E.T.

10. **Brian Thompson,** April 13, 2022, beginning at 9:00 a.m. E.T.

If needed, and to the extent any of the designees above are not able to provide the seven hours of testimony on the record provided for under Federal Rules on the dates specified above, Plaintiffs reserve their right to continue the deposition on another date until it is completed.

The depositions will be taken remotely via video teleconference offered by Veritext. The depositions of each designee will continue from day to day until concluded. The depositions will be taken under oath before a certified shorthand reporter or other officer authorized to administer oaths. The deposition will be recorded by stenographic means, and on videotape. The deposition shall be used for discovery purposes and may be used as evidence in this action, including at trial.

The definitions contained in Plaintiffs' First Set of Requests for the Production of Documents apply to this deposition notice. The relevant time period is January 1, 2016 to the present unless otherwise noted below.

Pursuant to Rule 30(b)(6), Deponents provided by Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services shall be knowledgeable officers, directors, managing agents, or other persons who consent to testify on their behalf concerning the above-captioned matter regarding the following:

1. Your authority to and/or role in establishing eligibility standards for Medicaid providers, determining benefits, and reimbursing providers.

2. Your receipt of federal and/or state funds, including funds from the U.S.

Department of Health and Human Services, and all representations made to the federal and/or state government in the course of securing such funds.

3. Your choice to participate in the Medicaid program.

4. The development, creation, and/or use of the Medicaid Plan.

5. Your efforts to administer the Medicaid Program in West Virginia and/or affirm Your compliance with the Medicaid Act and the Patient Protection and Affordable Care Act.

6. Your relationship with each of the following, including any written or unwritten agreements, policies, practices, and/or procedures, and/or communications as they relate to the provision of healthcare coverage to West Virginia Medicaid participants: Mountain Health Trust, UniCare Health Plan of West Virginia, Inc., The Health Plan, Aetna Better Health of West Virginia, and the Rational Drug Therapy Program.

7. Your role in determining and/or offering healthcare coverage to West Virginia Medicaid participants, including Your authority, responsibility, and duties as they relate to determining and/or offering healthcare coverage to West Virginia Medicaid participants.

8. Healthcare coverage and/or denials through Medicaid for transgender West Virginians generally and Christopher Fain and Shauntae Anderson specifically.

9. The decision to stop excluding hormone therapy from coverage in 2017 and/or Your experience covering and/or denying coverage for hormone therapy before and after 2017.

10. Your policies, practices, and procedures related to the Exclusion, including

but not limited to how the Exclusion is developed, approved, and maintained.

11. Any government interests that you contend support the Exclusion, and their factual bases.

12. Any research, consideration, and/or analysis by or on behalf of You regarding providing access to gender-confirming care for West Virginia Medicaid participants.

13. Any research, consideration, and/or analysis by or on behalf of You regarding the legality of the Exclusion.

14. As to healthcare coverage for West Virginia Medicaid participants, Your data and documents systems, including but not limited to hardware configuration, software configuration, network configuration, internet structure, and document and data retention systems.

15. As to healthcare coverage for West Virginia Medicaid participants, Your organizational structure including its units, divisions, and departments.

16. The number of Medicaid participants who are transgender and/or have sought any form of care for the treatment of gender dysphoria.

17. All lawsuits, counterclaims, arbitrations, complaints, or judicial or quasi-judicial actions brought or threatened against You related to the denial of gender-confirming care.

18. All interrogatory requests, requests for admission, and requests for production of documents directed to Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services, and any discovery responses, responsive documents, filings, or productions by or on behalf of Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services.

Dated: March 1, 2022

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document on March 1, 2022 with the Clerk of the Court using the CM/ECF system, which will send notification of filing, and a copy of the same, to the following CM/ECF participants:

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Dated: March 1, 2022

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Section 1557 of the Affordable Care Act

Selected Highlights of the Final Regulation Impacting State Medicaid, CHIP, and Basic Health Program Agencies

State Operations Technical Assistance Call

July 19, 2016

SECTION 1557 OF THE ACA

- Section 1557 ***prohibits discrimination based on race, color, national origin, sex, age or disability*** in health programs and activities that receive Federal funds.

- Section 1557 builds on long-standing Federal civil rights laws
  - Title VI of the Civil Rights Act of 1964
  - Title IX of the Education Amendments of 1972
  - Section 504 of the Rehabilitation Act of 1973
  - Age Discrimination Act of 1975

SECTION 1557 OF THE ACA

- Section 1557 is integral to achieving the ACA's goals of expanding access to health insurance coverage and health care and reducing health disparities.

- Section 1557 assists populations that have been most vulnerable to discrimination in health care and health coverage, including:
  - Women
  - Members of the LGBT community
  - Individuals with disabilities
  - Individuals with limited English proficiency

SECTION 1557 REGULATION

- Section 1557 was effective upon the enactment of the Affordable Care Act (March 2010) and OCR has been enforcing it since then.

- OCR's final regulation implementing Section 1557 was published in the Federal Register on May 18, 2016 (Nondiscrimination in Health Programs and Activities, Final Rule (81 FR 31376)).

WHAT IS NEW ABOUT SECTION 1557 OF THE AFFORDABLE CARE ACT AND THE REGULATION

- First Federal civil rights law and regulation to focus exclusively on non-discrimination in health programs and activities.

- First Federal civil rights law and regulation to prohibit sex discrimination broadly in health coverage and care; the regulation details sex non-discrimination requirements.

- The law and regulation apply civil rights obligations to the Marketplaces and all of the health plans of issuers participating in the Marketplaces, thereby expanding the scope of civil rights protections in health plans.

- While it incorporates existing civil rights obligations, the regulation also clarifies requirements for accessibility by persons with limited English proficiency (LEP) and persons with disabilities.

WHO MUST COMPLY WITH SECTION 1557

- All health programs and activities that receive Federal financial assistance from HHS
- All health programs and activities administered by ACA Title I entities (State-based and Federally-facilitated Health Insurance Marketplaces).
- All health programs and activities administered by HHS (e.g., Centers for Medicare & Medicaid Services, National Institutes of Health, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration).

DEFINITION OF HEALTH PROGRAM OR ACTIVITY

- Health program or activity is broadly defined in § 92.4 in the regulation and includes:
  - The provision or administration of health related services, including behavioral health services
  - Stage agencies, including Medicaid, CHIP, Basic Health Programs
  - Medicare programs
  - Hospitals
  - Nursing facilities, intermediate care facilities for persons with intellectual/developmental disabilities, community residential facilities
  - Health-related insurance
  - Wellness programs
  - Health research and education programs
- Includes all of the operations of an entity principally engaged in health services or health coverage.

ENFORCEMENT OF SECTION 1557 REGULATION

- Imports existing civil rights enforcement procedures for OCR enforcement. §§ 92.301 to 92.303
- Provides for a private right of action against federally assisted programs and State-based Marketplaces. § 92.302(d)
- Provides for enforcement tools for failure to provide information during OCR investigations. § 92.302(c)
- Provides for compensatory damages. § 92.301(b)

WHAT STATE MEDICAID, CHIP, AND BASIC HEALTH AGENCIES MUST DO BY WHEN

- Effective **July 18, 2016:**
  - Designate an employee to serve as the compliance coordinator - § 92.7(a)
    - Responsible for coordinating compliance
    - Responsible for investigating complaints
  - Adopt a grievance procedure - § 92.7(b)
    - Must afford due process and prompt and equitable resolution of grievances
    - Appendix C to the final regulation is a sample

WHAT STATE MEDICAID, CHIP, AND BASIC HEALTH AGENCIES MUST DO BY WHEN - NOTICE

- Effective **October 17, 2016:**
- Post a nondiscrimination notice - § 92.8(a), (b)(1)
  - Seven elements required in the notice - § 92.8(a)(1)-(7)
  - Agency may combine content of notice with other notices - § 92.8(h)
- Post taglines in at least the top 15 languages in the relevant State or States - § 92.8(d)(1)
  - Taglines are a gateway to language assistance services
  - A language in the top 15 must be posted, regardless of the percentage of individuals with LEP who speak the language
  - This obligation should not be confused with translating documents

NOTICE (CONTINUED)

- Posting requirements for notice and taglines - § 92.8(f)(1)(i)-(iii)
  - In significant publications and significant communications (except those that are small-size)
  - In conspicuous physical locations where the agency interacts with the public
  - On the agency's website, accessible from the home page
- In **small-size** significant publications and significant communications, must post:
  - A nondiscrimination statement - § 92.8(b)(2), (g)(1)
  - At least 2 taglines - § 92.8(d)(2), (g)(2)
- Appendices to the final regulation include sample notice of nondiscrimination, nondiscrimination statement, and taglines that State Medicaid agencies can use.

MORE INFORMATION ON THE NOTICE REQUIREMENT

- Preamble discussion on § 92.8 (not binding but explanatory for covered entities, including State Medicaid agencies)
  - Flexibility to implement requirements as long as the actions do not compromise intent to clearly inform individuals of their Section 1557 rights
  - Provision of notice and taglines is effective if the content is sufficiently conspicuous and visible that an individual could reasonably be expected to see and be able to read the information

SPOTLIGHT ON TAGLINES

- "[P]ost taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States" - §92.8(d)(1)
- (For small-size documents, at least the top 2 languages) - § 92.8(d)(2)
- What does this mean?
- "languages spoken by individuals with LEP"
  - Spoken by individuals who are LEP versus by the public at-large
- "of the relevant State or States"
  - Spoken in State (or U.S. Territory) where individuals live who entity serves
  - Entities serving multiple States can aggregate LEP populations to derive top 15
- "at least the top 15 languages" (or "at least the top 2 languages")
  - Prevalence (most language speakers of a language)

REASONABLE STEPS TO PROVIDE LEP INDIVIDUALS MEANINGFUL ACCESS

- A State Medicaid agency must take reasonable steps to provide meaningful access for individuals with LEP. Evaluation of compliance is a flexible, fact-dependent standard. § 92.201(a)-(b)
- Development and implementation of a language access plan is encouraged - § 92.201(b)(2)
  - Plans help covered entities, including State Medicaid agencies, to be prepared to take reasonable steps to provide meaningful access to each individual with LEP who may require assistance.
  - A plan is one factor, among other relevant factors, that OCR will consider in determining compliance.
- OCR will also evaluate, and give substantial weight to, the nature and importance of the health program or activity (including the communication at issue) - § 92.201(b)(1)

HIGHLIGHTS OF MEANINGFUL ACCESS PROVISION AND RELATED DEFINITIONS

- Individuals providing oral language assistance or written translation must be qualified. §§ 92.4, 92.201(d)-(e)
  - Includes bilingual/multilingual staff
  - Oral interpreters
  - Translators
- Regulation codifies restrictions on the use of family members, friends, and children to interpret or facilitate communication. § 92.201(d)-(e)
- If video remote interpreting is used, the services must meet certain quality standards. § 92.201(f)

DISABILITY REQUIREMENTS UNDER SECTION 1557 REGULATION

- Covered entities must make reasonable changes to policies, practices and procedures where necessary to provide equal access for individuals with disabilities. § 92.205
- Covered entities must ensure effective communication with persons with disabilities. § 92.205
- Requires entities to give "primary consideration" to individual's choice of auxiliary aids and services. § 92.202(a)
- Codifies application of appropriate auxiliary aids and services, including sign language interpreters, to entities with fewer than 15 employees. § 92.202(b)
- An individual providing qualified interpretation for an individual with a disability, e.g. sign language interpreter, must be qualified. § 92.4

DISABILITY REQUIREMENTS (CONTINUED)

- Covered entities must ensure newly constructed and altered facilities are physically accessible to individuals with disabilities. § 92.203
- The regulation includes a safe harbor for construction that was done in compliance with standards applicable at the time. § 92.203
- Covered entities must make all health programs and activities provided through electronic and information technology accessible to individuals with disabilities. § 92.204
- Covered entities must ensure non-discrimination in marketing and benefit design of health plans (which includes drug-tiering). § 92.207

SEX DISCRIMINATION PROVISIONS IN SECTION 1557 REGULATION § 92.206

Sex discrimination prohibited under Section 1557 includes discrimination based on:

- An individual's sex
- Pregnancy, childbirth and related medical conditions
- Gender identity
- Sex stereotyping

SEX DISCRIMINATION DEFINITIONS IN SECTION 1557 REGULATION: § 92.4

Definition of “on the basis of sex”

- Includes but is not limited to, discrimination on the basis of sex stereotyping and gender identity

Definition of “gender Identity”

- Means an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and may be different from one’s sex assigned atbirth

Definition of “sex stereotypes”

- Includes expectations that individuals will act in conformity with gender expressions associated with being male or female, such as appropriate roles of a certain sex.

SEX DISCRIMINATION REQUIREMENTS IN SECTION 1557 REGULATION: § 92.206

- Under Section 1557, covered entities, including State Medicaid agencies, must:
  - Provide equal access to health care and insurance coverage regardless of an individual's sex, including gender identity and sex stereotypes.
  - Treat individuals consistent with their gender identity, including with respect to access to facilities.
- But cannot:
  - Deny or limit sex-specific health services based solely on the fact that the gender recorded for the individual does not align with the sex that usually receives those types of sex-specific services.

SEX DISCRIMINATION REQUIREMENTS – GENDER CODING § 92.207

- Record coding that flags a gender mismatch for certain sex-specific services, by itself, is not prohibited if it does not result in a delay or denial of services.
- Requiring transgender individuals to repeatedly go through an appeals process to correct gender coding issues in order to obtain coverage for certain services may be discriminatory.
- Covered entities should utilize interim methods to correct gender coding mismatch issues.
- Covered entities are free to develop methods for processing claims for sex-specific services by transgender individuals as long as process is not overly burdensome and provides timely access to care.

SEX DISCRIMINATION REQUIREMENTS – GENDER TRANSITION RELATED CARE

- Bright line test: Categorical exclusions for all health care services related to gender transition are per se discriminatory. § 92.207(b)(4)

- Denial for specific health services related to gender transition will be evaluated based on the application of longstanding nondiscrimination principles to the facts of the particular plan.
 § 92.207(b)(5)

- The regulation does not affirmatively require issuers to cover any particular procedure or treatment for gender transition-related care.

- Issuers must have neutral standards and administer them in a nondiscriminatory manner.

- The regulation does not restrict an issuer from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.
 § 92.207(d)

SEX DISCRIMINATION REQUIREMENTS: SEX-SPECIFICPROGRAMS AND ACTIVITIES § 92.101(b)(3)(iv)

- Sex-specific programs and activities are permitted only if the covered entity can demonstrate an exceedingly persuasive justification, that is, that the program is substantially related to achievement of an important health-related or scientific objective.

- Justification that relies on generalizations or stereotypes would not be sufficient.

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www.hhs.gov/ocr

HHS.gov Office for Civil Rights U.S. Department of Health & Human Services

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- Section 1557 Nondiscrimination
- Health Information Privacy

Section 1557

Civil Rights Provision of the Affordable Care Act

On OCR's website….

- Read about civil rights and HIPAA laws
- Download factsheets
- Access sample policies and resources in English and other languages
- File a complaint
- Contact us!

SPECIFIC RESOURCES AVAILABLE ON OCR'S WEBSITE

- Sample grievance procedure
- Sample notice and nondiscrimination statement translated into 64 languages as a resource -- translations are not required to be posted
- Sample tagline translated into 64 languages
- Staff training materials
- Summary and fact sheets about Section 1557 translated into multiple languages

U.S. Department of Health and Human Services
Office for Civil Rights

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1557@hhs.gov

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Toll Free: (800) 368-1019

TDD toll-free: (800) 537-7697

March 2, 2022

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office for Civil Rights

HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy

The Department of Health & Human Services (HHS) stands with transgender and gender nonconforming youth and their families—and the significant majority of expert medical associations—in unequivocally stating that gender affirming care for minors, when medically appropriate and necessary, improves their physical and mental health. Attempts to restrict, challenge, or falsely characterize this potentially lifesaving care as abuse is dangerous. Such attempts block parents from making critical health care decisions for their children, create a chilling effect on health care providers who are necessary to provide care for these youth, and ultimately negatively impact the health and well-being of transgender and gender nonconforming youth. The HHS Office for Civil Rights (OCR) will continue working to ensure that transgender and gender nonconforming youth are able to access health care free from the burden of discrimination. HHS understands that many families and health care providers are facing fear and concerns about attempts to portray gender affirming care as abuse. To help these families and providers navigate those concerns, HHS is providing additional information on federal civil rights protections and federal health privacy laws that apply to gender affirming care.

As a law enforcement agency, OCR is investigating and, where appropriate, enforcing Section 1557 of the Affordable Care Act[1] cases involving discrimination on the basis of sexual orientation and gender identity in accordance with all applicable law. This means that if people believe they have been discriminated against in a health program or activity that receives financial assistance from HHS, they can file a complaint.

Federal Civil Rights Laws:

Parents or caregivers who believe their child has been denied health care, including gender affirming care, on the basis of that child's gender identity, may file a complaint with OCR.

Health care providers who believe that they are or have been unlawfully restricted from providing health care to a patient on the basis of that patient's gender identity may file a complaint with OCR.

OCR enforces federal civil rights laws that prohibit discriminatory restrictions on access to health care. Among these laws is Section 1557, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in covered health programs or activities. OCR

[1] 42 U.S.C. 18116; *see also* 45 C.F.R. part 92.

Exhibit
PL0010
SY

also enforces Section 504 of the Rehabilitation Act,[2] which prohibits discrimination on the basis of disability in any program or activity receiving federal financial assistance.

Section 1557 protects the right of individuals to access the health programs and activities of recipients of federal financial assistance without facing discrimination on the basis of sex, which includes discrimination on the basis of gender identity. Categorically refusing to provide treatment to an individual based on their gender identity is prohibited discrimination. Similarly, federally-funded covered entities restricting an individual's ability to receive medically necessary care, including gender-affirming care, from their health care provider solely on the basis of their sex assigned at birth or gender identity likely violates Section 1557. For example, if a parent and their child visit a doctor for a consultation regarding or to receive gender affirming care, and the doctor or other staff at the facility reports the parent to state authorities for seeking such care, that reporting may constitute violation of Section 1557 if the doctor or facility receives federal financial assistance. Restricting a health care provider's ability to provide or prescribe such care may also violate Section 1557.

Section 504 protects qualified individuals with disabilities from discrimination in programs and activities receiving federal financial assistance. Title II of the Americans with Disabilities Act[3] (ADA) protects qualified individuals with disabilities from discrimination in state and local government programs. Gender dysphoria may, in some cases, qualify as a disability under these laws. Restrictions that prevent otherwise qualified individuals from receiving medically necessary care on the basis of their gender dysphoria, gender dysphoria diagnosis, or perception of gender dysphoria may, therefore, also violate Section 504 and Title II of the ADA.

If you believe that you or another party has been discriminated against on the basis of gender identity or disability in seeking to access gender affirming health care, visit the OCR complaint portal to file a complaint online. To read more about Section 1557 and other laws that OCR enforces, please visit our website at https:www.hhs.gov/ocr.

Federal Health Care Privacy Laws - Health Insurance Portability and Accountability Act of 1996 (HIPAA):

HIPAA, the cornerstone patient privacy law, limits the circumstances under which health care providers and other entities may disclose protected health information, such as gender affirming physical or mental health care administered by a licensed provider.

Providers who may be concerned about their obligations to disclose information concerning gender affirming care should seek additional legal guidance regarding their legal responsibilities and other laws.

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[2] 29 U.S.C. 794; *see also* 45 C.F.R. part 84.

[3] 42 U.S.C. 12132.

OCR enforces the HIPAA Privacy, Security and Breach Notification Rules,[4] which establish requirements with respect to the use, disclosure, and protection of protected health information (PHI) by covered entities and business associates;[5] provide health information privacy and security protections; and establish rights for individuals with respect to their PHI.[6]

OCR reminds covered entities (health plans, health care providers, health care clearinghouses) and business associates that the HIPAA Privacy Rule permits, **but does not require,** covered entities and business associates to disclose PHI about an individual, without the individual's authorization,[7] when such disclosure is required by another law and the disclosure complies with the requirements of the other law.[8] This "required by law" exception to the authorization requirement is limited to "a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law."[9] Where a disclosure is required by law, the disclosure is limited to the relevant requirements of such law.[10] Disclosures of PHI that do not meet the "required by law definition" or exceed what is required by such law do not qualify as permissible disclosures under this exception.

HIPAA prohibits disclosure of gender affirming care that is PHI without an individuals' consent[11] except in limited circumstances.

If you believe that your (or someone else's) health privacy rights have been violated, visit the OCR complaint portal to file a complaint online.

DISCLAIMER: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or the Departments' policies.

To obtain this information in an alternate format, contact the HHS Office for Civil Rights at (800) 368-1019, TDD toll-free: (800) 537-7697, or by emailing OCRMail@hhs.gov. Language assistance services for OCR matters are available and provided free of charge.

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[4] 45 C.F.R. Parts 160 and 164, Subparts A, C, D, and E.
[5] *See* 45 C.F.R. 160.103 ("covered entity" and 'business associate" definitions).
[6] *See* 45 C.F.R. 160.103 ("protected health information" and "individually identifiable health information" definitions).
[7] *See* 45 C.F.R. 164.508(c) (HIPAA authorization required elements).
[8] 45 C.F.R. 164.512(a)(1).
[9] 45 C.F.R. 164.103 ("required by law" definition). Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.
[10] 45 C.F.R. 164.512(a)(1).
[11] For purposes of this guidance, "consent" refers to a valid HIPAA authorization. *See 45 C.F.R. 164.508.*

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.,**

Defendants.

DEFENDANTS' RESPONSE TO PLAINTIFF'S SECOND SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

INTERROGATORIES

8. Identify all conditions, diagnostic codes, or instances where coverage for hysterectomy and/or oophorectomy surgical procedures is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:

a. Diagnostic code(s);

b. Procedure code(s);

c. Medical necessity criteria.

RESPONSE: Objection, this Interrogatory seeks information regarding procedures for which Plaintiff Fain is not seeking relief. Therefore, this request is not relevant, is not proportional to the matters in issue, and is outside the scope of permissible discovery. Without waiving this objection, multiple factors go into the review of any particular request, including past medical history, surgical history, and diagnosis. In addition, we have requested documents which are used as part of the review process and these will be supplemented upon receipt.

9. Identify all conditions, diagnostic codes, or instances where coverage for vaginoplasty procedures is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:

    a. Diagnostic code(s);

    b. Procedure code(s);

    c. Medical necessity criteria.

RESPONSE: Objection, this Interrogatory seeks information regarding procedures for which Plaintiff Fain is not seeking relief. Therefore, this request is not relevant, is not proportional to the matters in issue, and is outside the scope of permissible discovery. Without waiving this objection, multiple factors go into the review of any particular request, including past medical history, surgical history, and diagnosis.

10. Identify all conditions, diagnostic codes, or instances where coverage for orchiectomy, penectomy, and/or phalloplasty procedures is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:

    a. Diagnostic code(s);

    b. Procedure code(s);

    c. Medical necessity criteria.

RESPONSE: Objection, this Interrogatory seeks information regarding procedures for which Plaintiff Fain is not seeking relief. Therefore, this request is not relevant, is not proportional to the matters in issue, and is outside the scope of permissible discovery. Without waiving this objection, multiple factors go into the review of any particular request, including past medical history, surgical history, and diagnosis.

11. Taking necessary steps to comply with applicable privacy laws, for each year since 2016 through the present identify the number of Health Plan participants who have submitted one or more claims with a diagnosis code for Gender Dysphoria or Gender Incongruence. This includes, but is not limited to, the following diagnosis: F64.0, Transsexualism (ICD-10-CM); F64.2, Gender identity disorder of childhood (ICD-10-CM); F64.8, Other gender identity disorders (ICD-10-CM); F64.9, Gender identity disorder, unspecified(ICD-10-CM); HA60, Gender incongruence of adolescence or adulthood (ICD-11); and HA61, Gender incongruence of childhood (ICD-11).

    RESPONSE: Upon information and belief:

2016 30 members
2017 50 members
2018 243 members
2019 439 members
2020 602 members
2021 (through 9/30) 686 members.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF
HEALTH AND HUMAN RESOURCES,
BUREAU FOR MEDICAL SERVICES,
By counsel

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 25th day of October, 2021, a true and exact copy of **DEFENDANTS' RESPONSE TO PLAINTIFF'S SECOND SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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From: Karen Wilkinson[Karen.Wilkinson@kepro.com]
Sent: Thur 10/21/2021 5:06:09 PM (UTC)
Subject: RE: [External]now I need any criteria you have for:
SmartSheet IQ Penectomy.pdf
SmartSheet Phalloplasty.pdf
SmartSheet (1) Oricheitomy.pdf
SmartSheet Oophorectomy.pdf
SmartSheet (1) Vaginoplasty.pdf
SmartSheet (1) Hysterectomy.pdf

InterQual® 2021, Apr. 2021 Release, CP:Procedures
Gender Affirmation Surgery

-
- Show Codes
-

I/O Setting:
Bilateral Mastectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Clitoroplasty - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Hysterectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Intersex Surgery - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Metoidioplasty - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Ovariectomy/Salpingo-oophorectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Phalloplasty - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Scrotoplasty - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Urethroplasty - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
Vaginoplasty - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting.
All others - Outpatient
These criteria include the following procedures:

Bilateral Mastectomy
Breast Augmentation
Clitoroplasty
Gender Confirmation Surgery
Gender Reassignment Surgery
Hysterectomy
Intersex Surgery
Labiaplasty
Male Chest Contouring
Metoidioplasty
Orchiectomy
Ovariectomy
Penectomy
Penile Prosthesis
Permanent Hair Removal
Phalloplasty
Salpingo-oophorectomy
Scrotoplasty
Sex Reassignment Surgery
Transgender Surgery
Transsexual Surgery
Urethroplasty
Vaginoplasty
Vulvoplasty

This criteria subset covers primary genital and chest procedures for patients undergoing gender affirmation surgery (GAS), including single and multi-stage procedures. This criteria set does not cover revisional procedures for GAS.

According to the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders defines gender dysphoria as a condition where sex assigned at birth is incongruent with experienced or desired gender, resulting in distress and suffering. Distress must persist for at least six months and result in a desire to change. (1, 2) Transgender persons are described as someone whose gender identity, behavior or expression, is not typical of that assigned at birth, including those who are gender dysphoric. In the United States, approximately 0.6%, or 1.4 million adults identify as transgender individuals. The prevalence is similar worldwide and has doubled in the last decade. (3)
Therapeutic options for gender dysphoria or transgender individuals include psychotherapy, hormonal treatment, and gender affirmation surgery (GAS). Dressing, acting, or speaking consistent with the correct gender, taking hormones, changing one's name, and surgical intervention are possible activities carried out to identify with the correct gender. Some transgender individuals do not define themselves as conforming to the gender binary (male or female) and may also use terms such as gender non-conforming, pangender, agender, bigender, polygender, gender fluid, gender queer, or gender neutral. This will impact their treatment choices. (4)
GAS is a treatment option for gender dysphoria and is often the final stage of transition. GAS is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical modalities working in conjunction with each other to assist the candidate for gender affirmation achieve successful outcomes. Before undertaking GAS, candidates need to undergo important medical and psychological

evaluations to confirm that surgery is the most appropriate treatment choice. Procedures vary significantly from female-to-male and male-to-female and are generally comprised of a series of primary and secondary sex character changes, chest reconstruction, facial alterations and voice-modification. After working with a transgender care team, a surgical plan is tailored to the individual's needs to relieve gender dysphoria. Treatment standardization in this population is not possible as clinical presentations and symptoms will vary significantly with each individual. A specialized, multidisciplinary transgender care team may include, but is not limited to, practitioners in primary care, behavioral health, speech and language therapy, dermatology, endocrinology, urology, gynecology, and plastic surgery. Collaborative care, joint participation in goal setting along with regular follow-up is crucial. (4, 5, 2)

Although there are many publications on gender affirmation surgery (GAS), most articles are observational case studies, have less than 30 participants, do not have strong evidence, or are focused on surgical technique. There is a paucity of published evidence that is adequately powered or designed to allow definitive conclusions on safety and efficacy of the individual surgical procedures. Surgical technique and observational case studies represent the largest body of evidence. Future research is needed to improve patient selection, surgical procedure selection and patient outcome.

Statistics around GAS are primarily estimations. Private facilities are not mandated to report this data; there are variations on how surgical procedures are staged and many of the procedures are identified as simply cosmetic, therefore making data collection difficult. In addition, the complexity and various reconstructive scenarios distinguishing procedures with multiple stages from revisional affirmation surgery is not truly accounted for. Although estimates vary, the American Society of Plastic Surgeons stated that there was a 155% increase in gender affirmation surgeries in 2017, approximating over 8,300 facial, body contouring and sex surgeries. (6)

Delaying treatment for those with gender dysphoria is not a reasonable treatment option. This can lead to negative consequences, such as delay or arrest in emotional, social, or intellectual development. Isolating oneself from family and friends, being excluded from society, becoming a victim of bullying and self-harm all may be seen when there is an impediment or interruption in care. Some individuals, notably adolescents, may develop psychiatric issues including anxiety, depression, and suicidal ideation. (7, 4, 2)

Guidelines agree that gender affirmation surgical intervention is appropriate for individuals 18 years of age or older, as these procedures are irreversible; however, behavioral health counseling and hormone therapy may be used to treat individuals who have been diagnosed with gender dysphoria at an earlier age. The sooner the diagnosis is made and treatment options are discussed, the more successful the individual is when transitioning. (8, 5, 2, 9)

This is a procedure that can be performed for either medically necessary or cosmetic purposes. The criteria as written are intended solely for use in determining the medical appropriateness of this procedure and do not cover this procedure when performed for cosmetic reasons.

InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders.

Origination date: 03-31-2017
Release date: 04-16-2021

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From: Myers, Jennifer J <jennifer.j.myers@wv.gov>
Sent: Thursday, October 21, 2021 12:39 PM
To: Emily Proctor <EBProctor@kepro.com>; Karen Wilkinson <Karen.Wilkinson@kepro.com>; Alicia Perry <aperry@kepro.com>
Subject: [External]now I need any criteria you have for:

hysterectomy, oophorectomy, vaginoplasty, orchiectomy, penectomy, and phalloplasty

And of course, as soon as possible.

Thank you.

Jennifer Myers
Director of Professional Services
Bureau for Medical Services
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—

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,**
Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS' RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

INTERROGATORIES

1. Identify all persons with involvement in, or knowledge of, the creation, review, and maintenance of the Exclusion of coverage for Gender-Confirming Care in the Health Plans offered through West Virginia's Medicaid Program.

   RESPONSE: Objection. All persons having "knowledge of" any exclusion is overly broad and burdensome and could entail countless people inside and outside of the Defendant WVDHHR. Knowledge of the creation of any exclusion by the individual Managed Care Organizations, as well as review and maintenance of any such exclusion, would be with the individual MCOs.

Without waiving these objections, the following individuals have been involved in the process of determining whether coverage is excluded:

Dr. James Becker, Medical Director, West Virginia Bureau for Medical Services

Jennifer J. Myers, Director of Professional Services, Bureau for Medical Services

Tanya Cyrus, Chief Quality and Integrity Officer, Bureau for Medical Services

Carrie Mallory, Program Manager, Bureau for Medical Services

Karen Burgess, Certified Coder, Office of Program Integrity

Cynthia Shelton, former Director of Operations, Bureau for Medical Services.

2. Describe in detail the factual basis for each governmental interest that Defendants contend supports the Exclusion.

   RESPONSE: These Defendants state that they provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations.

3. Identify and describe in detail every instance in which a Health Plan offered through West Virginia's Medicaid Program provides partial or full coverage for Gender-Confirming Care of any kind, including but not limited to counseling and/or therapy, hormone therapy, or surgery. Include in you answer the coverage criteria for such care and the date such coverage began.

   RESPONSE: Objection. This question seeking "every instance" is overly broad and burdensome. Without waiving the objection, with respect to any gender-confirming care that it is requested through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs regarding any care requested through them.

   Upon information and belief, counseling is a covered service. These defendants would not necessarily know the reason for counseling and whether it was related to gender-confirming care or some other reason.

   To the extent that this Request includes hormone therapy, these defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed.

Further, without waiving the objection, with regard to hormone therapy, these Defendants do not have a database where they keep track of the information in the manner requested. The data is not kept in a manner which would allow them to identify which patients have requested hormone therapy for gender confirming care. Information is tracked by the medication or drug requested, not the diagnosis or reason for the request. Upon information and belief, there are no gender edits for most estrogen and testosterone containing products, so coverage would not be denied on the basis that the hormone therapy was sought as part of gender-confirming care.

With respect to pharmacy services, please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

4. Identify all conditions, diagnostic codes, or instances where coverage for hormone therapy is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
   a. Diagnostic code(s);
   b. Procedure code(s);
   c. Medical necessity criteria.

RESPONSE: These defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed. Without waiving this objection please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

5. Identify all conditions, diagnostic codes, or instances where coverage for mastectomy, breast reduction surgery, and chest reconstruction surgery is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    d. Diagnostic code(s);
    e. Procedure code(s);
    f. Medical necessity criteria.

RESPONSE: With respect to any such care requested or provided through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs.

Please see BMS Provider Manual Chapter 519.16 Surgical Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.16_Surgical_Services.pdf.

6. Describe in detail the factual basis for the decision to no longer exclude coverage for hormone therapy as treatment for gender dysphoria in the Health Plans offered through West Virginia's Medicaid Program.

RESPONSE: Upon information and belief, in or around 2017 it came to the attention of then-Pharmacy Director that claims were being denied based on gender edits that were in place for estrogen and testosterone containing products. After consulting with the Medical Director, a decision was made to remove the gender edits so that the hormone therapy would not be denied on the basis of gender.

7. Identify all persons, including but not limited to persons affiliated with the Rational Drug Therapy Program, who have been involved in the decision to provide coverage for hormone therapy as treatment for gender dysphoria.

   RESPONSE: Upon information and belief, former Pharmacy Director Vicki Cunningham and Medical Director Dr. James Becker were involved in removal of the gender edit.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS RESPONSE TO PLAINTIFF'SFIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,**
Individually and on behalf of all others similarly situated,

Plaintiffs,

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v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS' SEVENTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

SUPPLEMENTAL RESPONSE: See documents received from Aetna, marked as Exhibit 125, regarding Plaintiff Anderson. The undersigned bates numbered the pdf documents using the number assigned by Aetna as FAI0000000578 to FAI0000000603. All materials are CONFIDENTIAL.

4. All Documents and communications relating to the Exclusion, including but not limited to:

    a. All Documents and communications relating to the decision to maintain the Exclusion in the Health Plans in any plan year.

    b. All Documents and communications relating to the decision to permit coverage for hormone therapy for the purpose of treating gender dysphoria.

    c. All Document and communications relating to evaluating, examining, analyzing, and/or considering the Exclusion in any way.

SUPPLEMENTAL RESPONSE: See BMS Policy Manual, Chapter 100, attached as Exhibit 123 (Bates No. DHHRBMS020639 – 20653).

17. Documents obtained from third parties as a result of authorizations, releases and/or subpoenas relating to the subject matter of this lawsuit.

SUPPLEMENTAL RESPONSE: See Exhibit 125, which consists of documents provided by Aetna regarding Plaintiff Anderson. See also documents provided by Unicare regarding Plaintiff Fain, previously produced and marked as Exhibits 93 and 94.

20. All communications related to legislation and/or lobbying surrounding the Exclusion and/or coverage for medical care for transgender people and gender dysphoria.

SUPPLEMENTAL RESPONSE: These Defendants are not aware of any responsive documents.

23. All Documents which Defendants considered, relied upon, or intend to rely upon, in answering each interrogatory and each request for admission in this action.

SUPPLEMENTAL RESPONSE: See BMS Policy Manual, Chapter 200, attached as Exhibit 124, (Bates No. DHHRBMS020654-20683).

24. To the extent not requested above, all Documents that Defendants may rely upon to support their defenses against Plaintiff's claims in this action.

SUPPLEMENTAL RESPONSE: See all documents produced in this matter.

WILLIAM CROUCH,
CYNTHIA BEANE, and
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HEALTH AND HUMAN RESOURCES,
BUREAU FOR MEDICAL SERVICES,

By counsel

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Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 9th day of March, 2022, a true and exact copy of **DEFENDANTS' SEVENTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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