



CHAPTER 300—PROVIDER PARTICIPATION REQUIREMENTS

CHANGE LOG

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

March 1, 2007

Section 320.9



Introduction: The error contained in the cost report due date for Intermediate Care Facilities for the Mentally Retarded and Long Term Care Facilities has been corrected to reflect 60 days after the end of the annual reporting period for ICF/MR and 60 days after the end of the 6 month reporting period for LTC instead of the last day of the second month following the 6 month reporting period previously listed.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

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

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

Section 320.9

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

Old Policy: Not applicable.

New Policy: 320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

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

WVDHHR-Office of Accountability & Management Reporting

ATTN: Division of Audit & Rate Setting

1900 Kanawha Blvd., East

State Capitol Complex

Building 3, Room 550

Charleston, WV 25305



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



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

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

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

Section 320.10

Old Policy: Not applicable

New Policy: 320.10 Cost Report Extensions

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



- B. The Medicare program may issue extensions in filing cost reports due to various administrative causes. Generally, these extensions are issued as blanket extensions to specified groups of providers due to software issues or late program changes. In instances where a provider files both with Medicare and with WV Medicaid, OAMR will extend the cost report due date to agree with the Medicare approved extension. A provider must notify OAMR of the Medicare extension.
- C. Providers may file an extension request due to extenuating circumstances any time prior to the cost report deadline for filing. Each request will be evaluated by OAMR. The acceptance or rejection of the request will be based upon whether the late preparation of the report had been caused by circumstances within or outside of the provider's control. If the late filing is due to circumstances within the provider's control, the request will be denied.

Section 320.11

Old Policy: Not Applicable

New Policy: 320.11 Cost Report Exemptions

Low utilization exemptions requirements:

- A. Providers that have low WV Medicaid utilization may qualify for an exemption in filing their annual WV Medicaid cost report. Providers that render services to five or less WV Medicaid recipients during the provider's fiscal year may request an exemption in filing their annual cost report. A provider that meets the low utilization criterion must file a written request for the exemption directly to the OAMR prior to the cost report's due date. If the request for an exemption is approved by OAMR, the provider will be notified in writing.
- B. Providers that have no WV Medicaid utilization during their fiscal year must provide a written statement to OAMR confirming that fact prior to the cost report due date. Providers that meet the no utilization criterion will not be required to file an annual report with the WV Medicaid program.
- C. The OAMR reserves the right to approve or reject a provider's request for an exemption regardless of compliance with exemption criteria and require a complete and acceptable cost report.

Section 320.12

Old Policy: Not applicable.



New Policy: Cost Report Late Filing Penalties

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

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

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

Sections 310, 320, 330, 340, 350

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

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Sections 310, 340, 360

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

Directions: Replace the pages containing these sections.

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



Sections 310.2

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

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 310.5

Introduction: Added a sentence to first paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 320.4

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

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 320.5

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

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Sections 320.6

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

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.



Section 340

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

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Section 340.6

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

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.



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CHAPTER 300—PROVIDER PARTICIPATION REQUIREMENTS

300 INTRODUCTION

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

310 ENROLLMENT PROCESS

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

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

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

310.1 ENROLLMENT PACKET

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

The packet contains the following items:

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

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

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



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

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

310.2 IDENTIFICATION NUMBERS

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

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

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

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

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

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

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

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



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

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

310.3 STATE LICENSURE

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

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

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

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

310.4 REPORT NEW INFORMATION

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

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

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

Unisys
P. O. Box 625
Charleston, WV 25322



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

310.5 CHANGE IN PRACTICE OWNERSHIP

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

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

310.6 ENROLLMENT MAY BE DENIED

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

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

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

310.7 VOLUNTARY AND INVOLUNTARY WITHDRAWAL

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

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



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

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

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

320 REQUIREMENTS AND RESPONSIBILITIES

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

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

320.1 DISCRIMINATION PROHIBITED

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

320.2 ACCEPT NEW PATIENT AS MEDICAID OR PRIVATE-PAY

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

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



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

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

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

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

320.3 OBTAIN PRIOR AUTHORIZATION

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

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

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

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

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



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

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

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

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

320.4 BILL OTHER PAYERS FIRST

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

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

320.5 DOCUMENT AND RETAIN RECORDS

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

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



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

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

The electronic medical records and signature guidelines follow:

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



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

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

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

320.6 PROTECT MEMBER PRIVACY

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

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

320.8 DISCLOSE INFORMATION

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

320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

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

WVDHHR-Office of Accountability & Management Reporting
ATTN: Division of Audit & Rate Setting
1900 Kanawha Blvd., East
State Capitol Complex
Building 3, Room 550
Charleston, WV 25305



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



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

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

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

320.10 Cost Report Extensions

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



- B. The Medicare program may issue extensions in filing cost reports due to various administrative causes. Generally, these extensions are issued as blanket extensions to specified groups of providers due to software issues or late program changes. In instances where a provider files both with Medicare and with WV Medicaid, OAMR will extend the cost report due date to agree with the Medicare approved extension. A provider must notify OAMR of the Medicare extension.
- C. Providers may file an extension request due to extenuating circumstances any time prior to the cost report deadline for filing. Each request will be evaluated by OAMR. The acceptance or rejection of the request will be based upon whether the late preparation of the report had been caused by circumstances within or outside of the provider's control. If the late filing is due to circumstances within the provider's control, the request will be denied.

320.11 Cost Report Exemptions

Low utilization exemptions requirements:

- D. Providers that have low WV Medicaid utilization may qualify for an exemption in filing their annual WV Medicaid cost report. Providers that render services to five or less WV Medicaid recipients during the provider's fiscal year may request an exemption in filing their annual cost report. A provider that meets the low utilization criterion must file a written request for the exemption directly to the OAMR prior to the cost report's due date. If the request for an exemption is approved by OAMR, the provider will be notified in writing.
- E. Providers that have no WV Medicaid utilization during their fiscal year must provide a written statement to OAMR confirming that fact prior to the cost report due date. Providers that meet the no utilization criterion will not be required to file an annual report with the WV Medicaid program.
- F. The OAMR reserves the right to approve or reject a provider's request for an exemption regardless of compliance with exemption criteria and require a complete and acceptable cost report.

320.12 Cost Report Late Filing Penalties

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

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



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

330 OUT-OF-STATE SERVICES

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

330.1 EMERGENCY CARE

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

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

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

330.2 NON-EMERGENCY CARE

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

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

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



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

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

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

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

340 BILLING PROCEDURES

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

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

340.1 PAYER OF LAST RESORT

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

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

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

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



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

Third party information may appear on the member's Medicaid card. This information is subject to change and should be verified with the member at the time of service. The Third Party Liability (TPL) Unit should be notified if other coverage has changed or been terminated. The TPL Unit can be reached at 1-304-558-1700.

340.2 INSTRUCTIONS AND PROCEDURES

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

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

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

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

340.3 ELECTRONIC CLAIM SUBMISSIONS

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

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

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

340.4 ELECTRONIC REMITTANCE VOUCHER (ERV)



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

340.5 ELECTRONIC FUNDS TRANSFER (EFT)

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

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

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

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

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

340.6 CLAIM SUBMISSION TIMELINES

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

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

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

350 REIMBURSEMENT

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

WV Medicaid does not pay for any service rendered by a provider who is not enrolled with the Medicaid Program on the day the service is furnished, except for medically necessary,



documented emergencies. All reimbursable services must be consistent with the WV Medicaid benefit package and rendered according to all applicable state and federal laws and regulations.

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

- A practitioner's employer, if the practitioner is required as a condition of employment to turn over his/her fees to the employer
- The facility where the service is rendered, if the practitioner has a signed contract that requires the facility to submit the claim, or if required by Medicaid policy.

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

360 SUPPORT SERVICES

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

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

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

360.1 MEDICAID FORMS

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

360.2 EDUCATION SEMINARS

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

360.3 TECHNICAL ASSISTANCE

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

1-304-348-3360

Charleston Area



1-888-483-0793

In-State toll free

1-304-348-3360

Out-of-State

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

360.4 NEWSLETTER

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

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

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