West Virginia
HealthCheck

Talking Points for HealthCheck Technical Assistance-page 3
Revised 2-2018

- Any treatment plan that necessitates services that ***exceed*** benefit limitations or services that are ***not included*** in West Virginia's State Medicaid Plan must be documented during a HealthCheck initial, periodic or interperiodic screening.

- Prior authorization is required for any item or service that exceeds benefit limitations or any item or service that is not included in West Virginia's State Medicaid Plan, the need for which having been identified during a HealthCheck initial, periodic or interperiodic screening.

- When requesting an item or service requiring prior authorization it is the responsibility of the prescribing primary care provider to submit the **(1)** appropriate clinical documentation i.e., ICD-10 code(s), all information required on the **(2)** Preventive Health Screening form (PHS) page 3, **(3)** the appropriate prior authorization form, for service or item, along with corresponding documentation of the **(4)** HealthCheck screening (initial, periodic or interperiodic) encounter and other pertinent documentation from the preceding six (6) months.

- **"EP"** is the required modifier for all HealthCheck claim details for fee-for-service claims. Utilizing the appropriate evaluation and management (E/M) code with the "EP" modifier appended, the primary care provider designates all services related to early and periodic screening, diagnosis and treatment (EPSDT) of the Medicaid eligible individual. Contact the appropriate MCO for EPSDT designation claim requirements.

Requests for prior authorization should be sent directly from the primary care provider to the specific fax number listed on the appropriate item/service prior authorization form.

For further information:

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West Virginia HealthCheck Program

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