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Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.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

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.

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TABLE OF CONTENTS

TOPIC **PAGE NO.**

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.

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.

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.

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.

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

- 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**

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).

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

- 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

- 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.

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.

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.