



CHAPTER 100 GENERAL INFORMATION

TABLE OF CONTENTS

SECTION	PAGE NUMBER
Background	3
Policy	3
100.1 Program relationships	4
100.2 Medicaid Related Programs	4
100.3 Other Resource Information	5
100.4 Purpose Of The Manual	5
100.5 Organization of the Manual	5
100.5.1 Manual Updates	6
100.6 Medicaid Program Provider Enrollment Guidelines	6
100.7 Provider Disclosure Requirements.....	7
West Virginia Medicaid Benefits	8
100.8 Covered Services	8
100.9 Prior Authorization of Services	9
100.10 General Non-Covered Services	10
100.11 Out-of-State Services	11
100.12 Claims Processing Schedule.....	12
100.13 Electronic Claims Submission	12
100.14 Certification of Claim Form.....	12
100.15 Timely Claims Filing	13
100.16 Third Party Liability (TPL).....	13
100.17 Appeals.....	14
100.18 Activities that Constitute Fraudulent Practices, or Abuse of the Program	15



CHAPTER 100 GENERAL INFORMATION

100.19 Prosecution and Penalty 16

100.20 Fraud, Waste, and Abuse..... 16

Methods of Inquiry 17

100.21 Written or Phone Inquiries..... 17

Glossary..... 20

Change Log 20

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

CHAPTER 100 GENERAL INFORMATION

BACKGROUND

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, its relationship to other programs (for example, Children with Special Healthcare 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 in state and out-of-state providers.

In addition, this chapter sets forth the Bureau for Medical Services (BMS) general administrative requirements for all providers enrolled in the West Virginia Medicaid Program concerning the services provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein and published as regulations governing of the provision of all services in the Medicaid program are administrated by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

POLICY

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 West Virginia 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 West Virginia.

The mission of the West Virginia 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. BMS contracts with the Bureau for Families Assistance and the Bureau for Social Services to determine eligibility for Medicaid. BMS monitors and tracks program information related to member eligibility, service utilization, program expenditures, fraud, waste, abuse, and financial management.

BMS maintains the West Virginia 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,

CHAPTER 100 GENERAL INFORMATION

the Medical Services Fund Advisory Council (MSFAC), appointed by the Commissioner, reviews the change, and makes appropriate recommendations to BMS prior to implementation.

Additional information and requirements may also be found in the other chapters of the BMS Policy Manuals, please see [Chapter 300, Provider Participation Requirements](#) for applicable provider manuals, covered services, limitations and exclusions, for specific healthcare areas of expertise.

100.1 PROGRAM RELATIONSHIPS

Medicaid's 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.
- West Virginia 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 after Medicare and Medicare Supplemental payments. Medicaid is always the payer of last resort.
- Refer to [Chapter 300, Provider Participation Requirements](#) for more specific provider information on the Medicare program and its relationship to West Virginia Medicaid, including Medicare provider numbers as part of Medicaid participation responsibilities and for information related to claim submission procedures for services rendered to a "dual eligible" member.

100.2 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 program
- West Virginia Birth to Three program
- Women, Infants, and Children Nutrition (WIC) program
- Family Planning program
- Breast and Cervical Cancer Diagnosis and Treatment Fund
- Right From the Start program
- 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.

CHAPTER 100 GENERAL INFORMATION

100.3 OTHER RESOURCE INFORMATION

West Virginia'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](#).

The [CMS website](#) is also an excellent resource to use in conjunction with the [BMS website](#).

100.4 PURPOSE OF THE MANUAL

The West Virginia Medicaid provider manual contains detailed information about the West Virginia Medicaid Program. The manual summarizes the description and administration of the West Virginia Medicaid Program. BMS makes every attempt to ensure that the information contained in the provider manual is concise and reliable as of the date of issuance. Compliance with all applicable West Virginia 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.

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.

100.5 ORGANIZATION OF THE MANUAL

The West Virginia Medicaid provider manual is organized consistently for all providers and services. The following is a listing of the organization and format of each chapter:

- **Cover Page:** The [Provider Manual website](#) acts as a cover page for the manual and includes important notices related to the manual and general notices.
- **Table of Contents:** The table of contents for the manual follows the cover page. Chapter titles, chapter subtopics, and appendices are identified and labeled to facilitate information retrieval.
- **Chapter Titles:**
 - *Chapter 100, Medicaid General Information*
 - *Chapter 200, Definitions and Acronyms*
 - *Chapter 300, Provider Participation Requirements*
 - *Chapter 400 Member Eligibility*
 - *Chapter 500s, Covered Services, Limitations, and Exclusions*
 - *Chapter 600, Reimbursement Methodologies*
 - *Chapter 700, West Virginia Clearance for Access: Registration & Employment Screening (WV CARES)*
 - *Chapter 800, Program Integrity*

CHAPTER 100 GENERAL INFORMATION

- *Chapter 900, Estate Recovery*
- *Chapter 1000, Quality Assurance*

100.5.1 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 email or posted on the [BMS website](#).

Retaining, filing, and understanding the West Virginia 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, Provider Participation Requirements](#) for additional information on your responsibility for reporting changes.

100.6 MEDICAID PROGRAM PROVIDER ENROLLMENT GUIDELINES

Provider Enrollment/Relations

An effective Medicaid Program is dependent upon the support and cooperation of the providers that render medical care and services. BMS is responsible for establishing and maintaining effective communication with providers participating in the Medicaid Program. Appropriate provider relations staff is available to respond to provider inquiries regarding:

1. Program policy;
2. Reimbursement;
3. Proper filing of claims; and
4. Various other issues.

For information and requirements regarding participation in the West Virginia 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 to:

PO Box 2002
Charleston, WV 25327-2002.

This includes changes to addresses, group affiliations, specialty services, telephone numbers, tax ID, Medicare provider numbers, etc.

CHAPTER 100 GENERAL INFORMATION

Provider Participation

Any provider may make application to enroll in the West Virginia Medicaid Program. For specific provider enrollment requirements, please refer to [Chapter 300, Provider Participation Requirements](#) and/or applicable provider manuals.

Exclusion from Participation

The Commissioner of BMS, or his/her designee, may suspend or exclude a provider from participation in the Medicaid Program for violation of the rules, regulations, or the conviction of a crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Medicaid Program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. For information regarding a document/desk review, refer to [Chapter 800 Program Integrity, Section 800.11.2 Provider Request for Document/Desk Review \(DDR\)](#).

Provider Exclusion by Medicare (Title XVIII)

A provider, who is excluded from participation in the Medicare Program (Title XVIII), is also excluded from participation in the Medicaid Program effective with the date of exclusion from Medicare.

Exclusion by State Medicaid Agency

A provider who is excluded from participation in the Medicaid Program (Title XIX) of another state must be excluded or denied participation in programs administered by BMS with the effective date the West Virginia BMS is notified of such exclusion.

100.7 PROVIDER DISCLOSURE REQUIREMENTS

Providers must disclose to BMS the identity of any person who:

- Has ownership of five or more percent or controlling interest in the provider practice or is an agent or managing employee of the provider.
- Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services.
- Has been included in the Office of the Inspector General's List of Excluded Individuals/Entities.
- Has been convicted of any crime related to health care delivery.

Maintenance Of Records

Providers must maintain records in accordance with Federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by BMS or the U.S. DHHS.

- The provider must make all records and documentation available upon request to BMS and/or DHHS. Such records and documentation must include but not be limited to:
 - Financial records
 - Member information
 - Description of Medicaid service implementation

CHAPTER 100 GENERAL INFORMATION

Identification of Service Sites

- Dates of service for each Service Component by Member
- Client records
- Personnel records
- For additional requirements, refer to [Chapter 300 Provider Participation Requirements](#) and applicable provider manuals for the specific service requirements

WEST VIRGINIA MEDICAID BENEFITS

100.8 COVERED SERVICES

The West Virginia 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 West Virginia Medicaid Program:

- Aged and Disabled Waiver Services (ADW)
- Children with Serious Emotional Disorder Waiver (CSEDW)
- Substance Use Disorder (SUD) Waiver
- Behavioral Health Clinic and Rehabilitation services
- Chiropractic services
- Oral Health Services
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Ambulatory Surgical Center
- Early & Periodic Screening, Diagnosis & Treatment Program (EPSDT) – also known as HealthCheck
- Family Planning Services
- Home Health Services
- Hospice Care Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Traumatic Brain Injury Waiver (TBIW)
- Inpatient Hospital Services, Acute care
- Inpatient Psychiatric Services for individuals under age 21
- Inpatient Rehabilitation Services
- Intellectual Developmental Disabilities Waiver (IDDW)
- Nurse Practitioner Services
- Nurse Midwife Services
- Nursing Facility Services
- Occupational/Physical Therapy Services
- Optometry Services
- Outpatient Hospital Services
- Personal Care Services



CHAPTER 100 GENERAL INFORMATION

- Pharmacy 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.

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

100.9 PRIOR AUTHORIZATION OF SERVICES

Please see applicable manuals for prior authorization requirements.

The provider must contact the medical review organization to obtain prior authorization for members who have exhausted their service limits.

To receive payment from BMS, a provider shall comply with all prior authorization requirements. The BMS, in its sole discretion, determines what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment. All other requirements must be met for payment.

Medical review organizations under contract to BMS are the final clinical authority. Also see [Chapter 518, Pharmacy Services](#).

Inpatient Admission Approval and Prior Authorization

To obtain inpatient hospital pre-certification and prior authorization of services, call 1-800-346-8272.

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

Pre-service review and prior authorization are 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

CHAPTER 100 GENERAL INFORMATION

- 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
- Intellectual Development Disabilities (IDDW)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

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.

100.10 GENERAL NON-COVERED SERVICES

The West Virginia 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
- 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 services or drugs
- Optometry services for individuals over age 21, except the first pair of glasses after cataract surgery

CHAPTER 100 GENERAL INFORMATION

- 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
- 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.
- Services documented with verbiage exactly like or like previous entries (cloned documentation). This includes photocopying of previous documentation including signatures.

* 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, Member Eligibility](#) for additional information on member responsibilities for payment, and applicable provider manuals for specific covered and non-covered services.

The "WV Works" Program covers dental and optometry services for certain eligible adults. Contact the local DHHR office for questions regarding specific benefits and possible coverage for patients.

100.11 OUT-OF-STATE SERVICES

Non-emergency, out-of-state services provided to West Virginia Medicaid members routinely require prior authorization from BMS. For MCO members, follow the respective MCO prior-authorization requirements. If applicable, contact BMS at 304-558-1700.

The following are exceptions to this policy:

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

A physician practicing in West Virginia, who determines it necessary to refer a Medicaid member out of state for outpatient physician services should submit a request to BMS. 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 West Virginia (services available within the state are not covered outside the state)
5. Other pertinent information.

CHAPTER 100 GENERAL 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, Provider Participation Requirements](#) for additional information regarding out-of-state providers.

100.12 CLAIMS PROCESSING SCHEDULE

BMS processes provider payments once per week. Approved claims are posted to accounts payable after MMIS adjudication cycles. Approved claims are held in accounts payable until sufficient funds are available for payment. The provider payment cycle begins each Friday.

The Provider Relations department assists with questions regarding claims reimbursement, including face-to-face meetings where applicable. Further information regarding billing and reimbursement can be found in applicable provider manuals and [Chapter 600, Methodologies Reimbursement](#).

100.13 ELECTRONIC CLAIMS SUBMISSION

Submitting claims via electronic media offers the advantage of speed and accuracy in processing. The provider may submit Medicaid claims through an electronic medium or choose from several firms that offer electronic submission services.

BMS Policy encourages electronic claim submission, as well as requires electronic funds transfer from its enrolled providers. If interested in submitting claims via electronic media, contact the Electronic Claim Specialists at the address below:

Bureau for Medical Services
C/O West Virginia MMIS Subcontractor
EMC Department
P.O. Box 2002
Charleston, West Virginia 25327-2002

100.14 CERTIFICATION OF CLAIM FORM

The medical services provider (professional practitioner or organization) is completely and solely responsible for the content of a claim. Federal regulations require that the following statement be printed on all Medicaid claim forms:

"This is to certify that the information on this invoice is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

CHAPTER 100 GENERAL INFORMATION

The provider is responsible for all information provided on a claim form. This certification is also on the provider enrollment which can be accepted in place of the statement on the claim form.

100.15 TIMELY CLAIMS FILING

Federal regulations mandate that BMS must require providers to submit claims no later than 12 months from date of service. The West Virginia Medicaid Program will allow 24 months from the date of service for denied claims to be billed with corrections or paid claims to be replaced provided that the claims meet the requirements including requirements in [42 CFR 447.45](#). Clean claims can be processed without obtaining additional information from the provider or a third party. Claims must have been timely filed. i.e., received by Medicaid within 12 months from date of service; must be on a prescribed form or through an approved electronic media transaction; must have valid National Provider Identifier (NPI) number and member ID number and a valid date of service. Services not billed prior to one year from the date of service cannot be added to a claim after a claim is one year old. Timely filing is the responsibility of the providers and is not subject to document/desk review hearings.

Previously submitted claims that are over 12 months from dates of service must be billed on the appropriate paper claim form to the Bureau's fiscal agent with appropriate documentation ([See Chapter 300, Provider Participation Requirements, Section 340.2](#)).

Exceptions to the 12-month time limit are:

- Corrected claims that were billed prior to the 12-month time limit and before 24 months from the date of service with copy of remittance advice (rejections, 824 and Return to Provider (RTP) letters are not accepted as proof of timely filing).
- Medicare primary claims billed within 12 months of the Medicare pay date with a copy or the Explanation of Medicare Benefits (EOMB). Medicaid can pay said claim within six months after notice of disposition of the Medicare claim.
- Claims for members with backdated Medicaid cards billed within 12 months of the issuance of the Medicaid card with a copy of the Medicaid card.

Providers submitting excessive duplicate claims may be subject to a monetary assessment and/or may be subject to further examination by BMS.

For additional information and requirements, please refer to [Chapter 300 Provider Participation Requirements](#).

100.16 THIRD PARTY LIABILITY (TPL)

Federal regulations mandate that States identify any potentially liable third-party resource available to meet a member's medical expenses. The "third party" may be an individual, institution, corporation, or public/private agency liable for all or part of the member's medical costs, e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS/TRICARE, Medicare, etc. There is no Medicaid reimbursement for any covered service for an eligible member that is eligible for payment by a Workers Compensation Plan.

It is important to note that 42 CFR 447.20(b) states that a provider may not refuse to furnish services covered under the Medicaid Plan to an eligible individual on account of a third party's potential liability for the service.

CHAPTER 100 GENERAL INFORMATION

Prior to submitting a claim to Medicaid, the provider must secure information regarding possible third-party coverage. Once identified, the provider must bill the third party. All requirements of the third-party insurance plan must be met before Medicaid will reimburse including use of in-network providers. After receipt of payment, the provider may then bill the claim to Medicaid. For medical claims, the provider must report the TPL payment, and any member liability amounts. The provider must report the third-party payment and member liability amounts. If the third party denies payment for services, the provider must submit a claim on paper along with a copy of the Explanation of Benefits denying payment by the third party. The attached copy must contain the written denial reason. If a denial code is used, a description of the code must be attached.

If a provider learns of the potential for third party liability after Medicaid has paid, the provider must first refund Medicaid using the Void/Adjustment process described in [Chapter 600, Reimbursement Methodologies](#). A claim is then submitted to the third-party payer and if necessary, the provider re-bills Medicaid along with a copy of the third party's explanation of benefits.

If the member receives the insurance payment or notice of denial, it is the member's responsibility to forward the payment or denial to the provider. The member is considered a "private pay" until such time as the member provides the needed information to the provider.

Medicaid members are not responsible for any third party related co-insurance amounts, deductible amounts, or HMO related co-pays and deductibles, even if the claim payment is zero when the claim payment has been reduced as a result of the insurance payment or capitation agreement.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and TPL related are subject to a filing deadline of 12 months from the date of the Medicare payment.

For additional TPL information and requirements, refer to [Chapter 100 General Information, Chapter 300 Provider Participation Requirements, Chapter 400 Member Eligibility, and Chapter 600 Reimbursement Methodologies](#).

BMS, pursuant to federal and state law, recovers medical assistance payments from two sources. One is payment that is the responsibility of a member's insurance policy which pays primary to Medicaid. A provider is required to bill a member's insurance prior to billing Medicaid. The second source of third-party recovery is subrogation. A member executes an assignment of benefits upon enrolling in Medicaid. If a member recovers payment from a liable third party, such as from an accident or lawsuit, Medicaid is entitled to payment of the medical assistance paid due to the accident, etc.

100.17 APPEALS

BMS offers three different types of appeals as listed below. Requirements regarding who may initiate the appeals and the current time frames are as follows:

a. Prior Authorization Contractor Reconsideration of Medical Necessity Determination

Issues concerning medical necessity determinations may be appealed through the reconsideration process to the Utilization Management Contractor (UMC). At present, either the provider or member may initiate a request for reconsideration of any negative medical necessity determination issued by WVMI. The UMC must receive the written request and supporting documentation within 60 days of the notification of denial. Services that are initiated subsequent to the prior authorization denial are not reimbursable unless a subsequent reconsideration or

CHAPTER 100 GENERAL INFORMATION

department appeal reverses the initial denial. Consequently, any provider who initiates services subsequent to the UMC denial does so at risk. A prior authorization denial may result in either a provider appeal if a service has been provided and payment denied or a member appeal if a covered service has been denied or reduced.

b. DHHR Agency Fair Hearings Process

The Agency Fair Hearings Process provides an appeal mechanism through which applicants or members may appeal any adverse decision regarding eligibility or termination, denial, suspension, or reduction of covered services. For further information on the Fair Hearings Process, refer to [Chapter 400, Member Eligibility](#).

c. Service Denials

For the process regarding service denial appeals, refer to [Chapter 800 Program Integrity, Section 800.11 Appeal Process](#).

100.18 ACTIVITIES THAT CONSTITUTE FRAUDULENT PRACTICES, OR ABUSE OF THE PROGRAM

The following is a non-inclusive sample list, of practices that constitute fraudulent practices, waste within or abuse of the West Virginia Medicaid Program:

- Billing for services, supplies, or equipment which were not rendered to or used for Medicaid members
- Billing for supplies or equipment that are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually useless
- Flagrant and persistent over-utilization of medical and paramedical services with little or no regard for results, the member's ailments, condition, medical needs, or the physician's orders
- Claiming of costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Misrepresentations of dates and descriptions of services rendered, or the identity of the member or the individual who rendered the services
- Duplicate billing - this includes billing the West Virginia Medicaid Program twice for the same services
- Arrangements with employees, independent contractors, suppliers, and others, designed primarily to overcharge the West Virginia Medicaid Program with various devices (commissions, fee splitting) used to siphon off or conceal illegal payments
- Charging the West Virginia Medicaid Program, by subterfuge, costs not incurred, or which were attributable to non-program activities, other enterprises, or personal expenses
- Failure to comply with State and Federal laws or the regulations of the State or Federal agencies that govern the practice of a provider's respective profession, business, or trade
- Failure to comply with West Virginia Medicaid Program regulations, or submission of false certification of Medicaid billing forms or reports
- Failure to report or perform offsetting adjustments on Medicaid claims to reflect payment by other payers
- Billing for services paid for by another entity
- Upcoding is when a provider increases the bill by exaggerating or falsely representing what medical conditions were present and/or what services were provided. An example of upcoding would be when a two-minute visit for diagnosis and treatment of an upper respiratory condition is upgraded from a low reimbursement rate code to a code that indicates a more serious ailment, for

CHAPTER 100 GENERAL INFORMATION

example, a more severe bronchitis or sinus infection which required a one-hour visit because of a nebulizer treatment. Whether or not the additional services billed were provided or not, if they were not medically necessary, there is fraud.

- Other schemes or artifices that are in violation of state and federal law.

For additional information and requirements, please refer to [Chapter 300, Provider Participation Requirements](#).

100.19 PROSECUTION AND PENALTY

Fraud is a serious crime. Suspected fraud will be referred to the proper government entities for investigation and prosecution. Criminal and civil penalties are severe for fraud, waste and abuse in the Medicaid program. Refer to the West Virginia Code and the United States Code for likely criminal and civil sanctions and penalties.

Federal Penalties

Federal criminal and civil penalties are too numerous to list. Possible penalties include prison, fines, and exclusion from federal and state programs. Refer to the United States Code for likely sanctions and penalties.

Protective Services - Mandatory Reporting Of Incidence Of Abuse, Neglect, or Emergency Situation

West Virginia State law provides for mandatory reporting of abuse or neglect of adults and children and assesses penalties for failure to do so.

The West Virginia Codes §9-6-9; §9-6-11; §9-6-14; §49-6A-3; §49-6A-8 provide in pertinent part that any medical, dental, or mental health professional, social service worker, and person, official or institution etc. are mandated to report incidence of abuse, neglect, or emergency situation of an incapacitated adult or child.

Failure to report is a misdemeanor and is punishable by not more than one hundred dollars or imprisonment in a regional jail for not more than 10 days or both.

A person who has control of an incapacitated adult and willfully creates an emergency situation that leads to abuse and neglect and/or who knowingly permits another to abuse and/or neglect an incapacitated adult is guilty of a felony.

100.20 FRAUD, WASTE, 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. 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 West Virginia State Law.

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicaid Program, such as the over-utilization of services or the misuse of resources.

CHAPTER 100 GENERAL INFORMATION

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. Any provider that acts in a repetitive manner to cause unnecessary costs for the Medicaid Program is considered abusive of the Medicaid Program.

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.

METHODS OF INQUIRY

100.21 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 [BMS website](#).

Voice Response System

West Virginia 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.

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 Managed Care Organization



CHAPTER 100 GENERAL INFORMATION

(MCO) Program Mountain Health Trust (MHT) or Mountain Health Promise (MHP) have the name and telephone number of the MCO 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 MCO, when applicable
5. Billed to the MCO 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, Member Eligibility](#).

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 8:00 a.m. to 5:00 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 8:00 a.m. to 6:00 p.m. at 1-888-483-0793. You may also access the EDI provider website, wvmis@gainwelltechnologies.com for additional information.

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 West Virginia Medicaid Program, including hospital pre-certification and prior authorization of applicable

CHAPTER 100 GENERAL INFORMATION

services. (Note: For MCO enrolled members, follow the respective MCO's admission approval and prior authorization requirements).

Behavioral Health Services

You may obtain prior authorization for behavioral health clinic and rehabilitation services by calling the UMC Vendor at 1-800-378-0284.

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	304-352-6728 or 304-558-2020
Nursing Facility	304-352-6728 or 304-558-2020

If you need information regarding the payment of audits and cost settlements, call 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 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 West Virginia 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 the MCO programs known as the MHT and MHP Programs.

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.

CHAPTER 100 GENERAL INFORMATION

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.

Out-Of-State Services

Non-emergency, out-of-state services provided to West Virginia Medicaid members routinely require prior authorization from BMS. For MCO members, follow the respective MCO prior-authorization requirements. If applicable, contact BMS at 304-558-1700.

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.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Chapter 100 General Administration	3/1/2023