535.1 BIPOLAR AND HEPATITIS IN HEALTH HOMES

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535.1 BIPOLAR AND HEPATITIS IN HEALTH HOMES

BACKGROUND

Health Homes are a model of care authorized for high need, high-cost members with chronic physical conditions or serious mental illness. The Health Home is to be a comprehensive system of care coordination for these Medicaid members with chronic conditions. Health Homes providers will coordinate all primary, acute, behavioral health and long-term services and supports to treat the "whole person" across his/her lifespan. This section of policy must be read in conjunction with *Chapter 535, Health Homes*. All requirements for Health Homes in Chapter 535 apply to Health Homes providers for this target population.

West Virginia is implementing health homes for various eligible populations in specific geographic regions. This policy provides information about the program for members with a Bipolar Disorder diagnosis infected with or at risk for Hepatitis B and/or Hepatitis C receiving services in the six counties identified with the highest bipolar population.

POLICY

535.1.1 MEMBER ELIGIBILITY

This program targets members who have a diagnosis of a Bipolar Disorder; are infected with or at risk for Hepatitis B and/or Hepatitis C; and are receiving services in the following counties: Cabell, Kanawha, Putnam, Mercer, Raleigh, and Wayne. The qualifying diagnoses for Bipolar Disorders are listed in *Appendix 535.1A*.

535.1.2 DOCUMENTATION REQUIREMENTS

An initial and periodic assessment and information review of each enrollee will include, as appropriate, but not be limited to, the following:

- Centers for Disease Control and Prevention (CDC) Hepatitis Risk Assessment
- Screening – Brief Intervention, and Referral to Treatment (SBIRT) Assessment to screen for substance abuse
- Evaluation of Suicide Risk
- Patient Health Questionnaire
- Assist Questionnaire
- Composite International Diagnostic Interview (CIDI)-based Bipolar Screening Scale
- Functional Screening
- Medication Reconciliation
- Specific Laboratory Results as appropriate for each individual enrollee- Hepatitis B and C testing
- Relevant Biometrics
- Treatment History
- Written crisis plan for each enrollee

The interactive web-based assessment tool may be found on the WV Bureau for Medical Services' Health Homes site at http://www.dhhr.wv.gov/bms/HH/Pages/default.aspx

535.1.3 PRIOR AUTHORIZATION

Prior Authorization is required for all covered Health Home services. Prior Authorization is requested through the UMC contractor.

535.1.4 REIMBURSEMENT

Reimbursement will be regularly reviewed. Providers cannot bill for both targeted case management and Health Home services for the same member at the same time.

535.1.5 LEVELS OF SERVICES

The WV Health Home Bipolar/Hepatitis Program is a two-level service system, comprised of both a Standard and an Intensive Health Home Service.

535.1.5.1 Level-I Health Home Standard Service

HCPCS Code: S0281
HCPCS Description: Medical home program, comprehensive care coordination and planning, maintenance of plan - Standard Level I
Service Unit: 1 per calendar month

The basic Level I Health Home standard service code is intended to cover the provision of all of the Health Home services as determined to be appropriate to meet the member's needs. At the time of enrollment, the Health Home requests prior authorization of the Level I service for each enrollee through the UMC contractor. There must be a minimum of one contact per month.

535.1.5.2 Level-II Health Home Intensive Service

HCPCS Code: S0281-TF
HCPCS Description: Medical home program, comprehensive care coordination and planning, maintenance of plan - Intensive Level II
Service Unit: 1 per calendar year (12 months)

Level II is available for those health home enrollees determined to require more intensive service for a period. Prior authorization of the Level II intensive service is requested through the UMC contractor. Each Medicaid member who qualifies will receive a one-month authorization. Authorization is based on clinical information presented by the Health Home provider, including history of hospitalizations, emergency room utilization, assessment scores, and clinical judgment documenting a deterioration of the enrollee's condition and a crisis situation requiring stabilization. Level II is only reimbursable one time per calendar year (12 months) and must be billed with a TF modifier.

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GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

REFERENCES

West Virginia State Plan Amendment for Health Homes *SPA14-0009*.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
New Policy	Bipolar and Hepatitis in Health Homes		April 1, 2015