WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

CHAPTER 538 SCHOOL-BASED HEALTH SERVICES (SBHS)

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CHAPTER 538 SCHOOL-BASED HEALTH SERVICES (SBHS)

BACKGROUND

The West Virginia Medicaid program offers a comprehensive scope of medically necessary services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal regulations. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the West Virginia Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of School-Based Health Services (SBHS). The policies and procedures set forth herein are promulgated as regulations governing the provision of SBHS in the Medicaid program as approved by the Centers for Medicare and Medicaid Services (CMS) and administered by the West Virginia Department of Health and Human Resources (DHHR). As set forth in this chapter students enrolled in Medicaid are referred to as members.

The BMS has a joint goal with Medicaid enrolled providers to ensure effective services are provided to Medicaid members.

All School-Based Health providers must cooperate fully with the Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the Medicaid members while conforming to state and federal confidentiality requirements.

All Medicaid members have the right to freedom of choice when choosing a provider for treatment. A Medicaid member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid members are in violation of their provider agreement.

All Medicaid enrolled providers should coordinate care if a Medicaid member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is the forefront of the member's treatment. Appropriate releases of information should be signed in order that Health Insurance Portability and Accountability Act (HIPAA) Compliant Coordination of Care takes place.

POLICY

538.1 MEMBER ELIGIBILITY

The SBHS program includes medically necessary covered health care services pursuant to an Individualized Education Plan (IEP) provided by or through the West Virginia Department of Education (DOE) or a Local Education Agency (LEA). These medically necessary health care services must be ordered by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) within the scope of license as defined under the West Virginia Code to eligible special education members from age three through age 21. Additional services may be provided in the school setting through a Federal Qualified Health Center (FQHC) or Rural Health Clinic (RHC) which are governed by *Chapter 522, Federally Qualified Health Center and Rural Health Clinic Services* of the BMS Provider Manual.

538.2 MEDICAL NECESSITY

All services covered in this chapter are subject to a determination of medical necessity. Medical necessity

is defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis or treatment of an illness;
- Provided for the diagnosis or direct care of an illness;
- Within the standards of good practice;
- Not primarily for the convenience of the member or provider; and
- The most appropriate level of care that can be safely provided.

Medical necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

1. Diagnosis (as determined by a physician, PA, APRN, or licensed, supervised, or school psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Service is the appropriate level of care

538.3 PROVIDER ENROLLMENT

All LEAs must follow all applicable policies in the BMS Provider Manual including, but not limited to, the following: *Chapter 100, General Administration and Information*, *Chapter 200, Definitions and Acronyms*, and *Chapter 800(B), Program Integrity.*

In order to participate in the West Virginia Medicaid program and receive payment from the BMS, providers of services must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements* and:

- All documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the committee. Based on this review, the LEA must determine which services staff are qualified to provide.
- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records.

Participating providers must develop standards for staff training, supervision, and compliance monitoring in accordance with existing state policy and federal regulations.

538.3.1 Enrollment Requirements: Staff Qualifications

Documentation including required licenses, certifications, proof of completion of training, must be kept on file at the Central Office of the County Boards of Education.
All further staff qualifications will be indicated under the services identified in this chapter. All documentation for staff including college transcripts, certifications, credentials, background checks, and

trainings should be kept in the staff's personnel file and may be reviewed at any time by BMS or BMS' contractors or state and federal auditors.

538.4 PROVIDER EXCLUSIONS TO RENDERING SERVICE

LEA or educational entity operated under the support of the State Board of Education or West Virginia DOE are responsible to ensure that all provider staff, having direct contact with members must not have been convicted of the following crimes:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm; felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

LEAs are required to submit a monthly report to the DOE Medicaid Coordinator that indicates whether any Medicaid providers employed by an LEA (either billing fee for service or included on the Random Moment Time Study rosters/annual cost report) have been arrested for any of the crimes listed in the BMS Provider Manual. If no arrests in a particular month have taken place, a report will still be submitted to the DOE Medicaid coordinator stating that no arrests are reported.

LEA or educational entity operated under the support of the State Board of Education (BOE) or DOE, are responsible to ensure that all provider staff, having direct contact with members who are not on the Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE).

The LEIE is a listing of any individual on that cannot provide Medicaid services. If an LEA employee who renders services to Medicaid members is found on this list, it must be reported to BMS every month.

538.5 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by the BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information*, of the BMS Provider Manual and are subject to review by state and federal auditors.

538.6 SCHOOL-BASED HEALTH SERVICES PROVIDER REVIEWS

The primary means of monitoring the quality of services is through provider reviews conducted by the contracted agent as determined by the BMS by a defined cycle.

The contracted agent performs on-site, and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site provider reviews and/or desk reviews may be conducted by the contracted agent in follow up to receipt of Incident Management Reports, complaint data, Plan of Corrections (POC), etc.

Upon completion of each provider review, the contracted agent conducts a face-to-face exit summation with staff as chosen by the LEA to attend. Following the exit summation, the contracted agent will make available to the provider a draft exit report and a POC to be completed by the provider. If potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send comments back to the contracted agent. After the 30-day comment period has ended, the BMS will review the draft exit report and any comments submitted by the provider and issue a final report to the provider's executive director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of services. A cover letter to the provider's executive director will outline the following options to effectuate repayment:

- Payment to the BMS within 60 days after the BMS notifies the provider of the overpayment; or
- Placement of a lien by the BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payment.

If the provider disagrees with the final report, the provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual. The provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention. **The letter must be addressed to the following:**

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the contracted agent review, then the provider will receive a final letter and a final report from BMS.

Plan of Correction: In addition to the draft exit report sent to the providers, the contracted agent will also send a draft POC electronically. Providers are required to complete the POC and electronically submit a POC to the contracted agent for approval within 30 calendar days of receipt of the draft POC from the contracted agent. BMS may place a hold on claims if an approved POC is not received by the contracted agent within the specified time frame. The POC must include the following:

- How the deficient practice for the services cited will be corrected;
- What system will be put into place to prevent recurrence of the deficient practice;
- How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
- The date the POC will be completed; and
- Any provider-specific training requests related to the deficiencies.

For information relating to additional audits that may be conducted for services contained in this chapter please see *Chapter 800(B), Program Integrity* of the BMS Provider Manual that identifies other State/Federal auditing bodies and related procedures.

538.7 TRAINING AND TECHNICAL ASSISTANCE

The contracted agent develops and conducts training for providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

538.8 OTHER ADMINISTRATIVE REQUIREMENTS

Other administrative requirements that must be met by the LEA include but are not limited to the following:

- The provider must assure implementation of BMS' policies and procedures pertaining to the plan of care, documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid members records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, service providers must comply with the documentation and maintenance of records requirements described in *Chapter*

100, General Administration and Information, and *Chapter 300, Provider Participation Requirements* of the Provider Manual.

- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- BMS Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the appropriate fee schedule for services provided.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), except for services billed under the T1017 SE Code for Targeted Case Management.

538.9 TELEHEALTH SERVICES

For information on requirements on using telehealth as a modality to render services see *Chapter 519.17, Telehealth Services*

538.10 DOCUMENTATION

The BMS recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy-based system. When services require documentation BMS will accept both types of documentation. Electronic signatures are accepted when an electronic time stamp is included. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Please refer to the following:

- Appendix 538A – Nursing Billing Form
- Appendix 538B – Audiological Billing Form
- Appendix 538C – Speech Therapy Billing Form
- Appendix 538D – Psychological Billing Form
- Appendix 538E – Personal Care Medicaid Log
- Appendix 538F – Occupational Therapy Billing Form
- Appendix 538G – Physical Therapy Billing Form
- Appendix 538H – Targeted Case Management Form
- Appendix 538I – Transportation Billing Form

538.11 NURSING SERVICES

School-Based Nursing Services are face-to-face skilled nursing services that enable a Medicaid member to receive medical monitoring, interventions, and nursing services in their educational setting. Please see Appendix 538A – Nursing Billing Form.

538.11.1 Anaphylactic Reaction – Assessment/Evaluation

Procedure Code:	T1001 SE
Service Unit:	Event
Telehealth:	Available (Only with Registered Nurse (RN) or Licensed Practical Nurse (LPN) at originating site)
Service Limits:	Two per calendar year

Staff Credentials: Must be performed by certified school nurse or a registered nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse

Definition: An assessment or evaluation used to develop a written emergency plan of care for members with a documented history of anaphylactic reaction or potential for anaphylaxis in conjunction with member, parent/guardian and principal. The plan of care should include step-by-step instructions to follow and emergency phone numbers.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date and location of service;
- Nurse's signature with credentials;
- Member's Plan of Care (POC);
- If telehealth is utilized documentation must reflect such: and
- Appropriate recommendations consistent with the findings of the assessment/evaluation.

538.11.2 Anaphylactic Reaction – Individual

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: In cases of known allergies, designated trained personnel will give appropriate amount of medication ordered by the licensed prescriber.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop times, and location of service;
- Nurse's signature with credentials;
- Member's POC;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.3 Manual Resuscitator

Procedure Code: 92950
Service Unit: Event
Telehealth: Not Available
Service Limits: 10 per Calendar Year

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: The use of a manual resuscitator in the school setting and during co-curricular events. Includes hyperventilation, oxygenation, ventilator failure with physician, PA, or APRN order.

Documentation: Documentation must contain the following and be completed within 20 calendar days

from the date of service:

- Date and location of service;
- Nurse's signature with credentials;
- Member's POC;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.4 Postural Drainage and Percussion

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Performing percussion and/or postural drainage in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's POC;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.5 Catheterization

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: The performance of cleaning and sterilization of intermittent catheterization in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's POC;
- Documentation of individual service; and

- Appropriate recommendations consistent with the findings of the individual service.

538.11.6 Catheterization Self-Management

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or a registered nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Training that is developed for the caring of one's self to become independent and knowledgeable to successfully manage urinary catherization to reduce chance of infection and autonomic dysreflexia.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's POC;
- If telehealth is utilized, documentation must state this as the place of service; and
- Appropriate recommendations consistent with the findings of the assessment/evaluation.

538.11.7 Mechanical Ventilator

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.
Definition: Mechanical ventilation of the member in the school setting and during co-curricular events. Hands on management included.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's POC;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.8 Seizure Management

Procedure Code: T1001 SE
Service Unit: Event

Telehealth: Not Available
Service Limits: Two per calendar year

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Seizure management in the school setting and during co-curricular events

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date and location of service;
- Nurse's signature with credentials;
- Member's POC or emergency health care plan;
- Documentation of individual service;
- Appropriate recommendations consistent with the findings of the individual service; and
- Emergency health care plan.

538.11.9 Diabetic Management

Procedure Code: T1001 SE
Service Unit: Event
Telehealth: Available for nurse supervision for self-administration
Service Limits: Two per calendar year

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Diabetic management in a school setting or co-curricular activities.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- If telehealth is utilized, documentation must state this as the place of service; and
- Appropriate recommendations consistent with the findings of the assessment/evaluation.

538.11.10 Subcutaneous Insulin Infusion-by Pump

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Available for nurse supervision for self-administration
Service Limits: 10 units per instructional day
Staff Credentials: Must be performed by a certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of insulin by pump in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service.

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.11 Subcutaneous Insulin Infusion by Injection

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Available for nurse supervision for self-administration
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of insulin by injection in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- If telehealth is utilized, documentation must state this as the place of service; and
- Appropriate recommendations consistent with the findings of the assessment/evaluation.

538.11.12 Measurement of Blood Sugar

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Available for nurse supervision for self-administration
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or a registered nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse

Definition: Measurement of member's blood glucose levels in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service.

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and

- Appropriate recommendations consistent with the findings of the individual service.

538.11.13 Emergency Medication Administration

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of emergency medication in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.14 Oral Suctioning

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: Ten units per instructional day
Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Oral suctioning and nasopharyngeal suctioning in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.15 Enteral Feeding

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Feeding via a gastric tube in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.16 Ostomy Care

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Management of emptying or changing an ostomy system in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service.

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.17 Tracheostomy Care

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day
Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Emergency care and cleaning of a tracheostomy tube and stoma in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service.

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.18 Oxygen Administration

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration and safe use of oxygen in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service.

- Date, start and stop time, and location of Service
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.19 Inhalation Therapy

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Available for nurse supervision and self-administration (only with RN or LPN at main site
Service Limits: 10 units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of inhalation therapy by machine in the school setting and during co-curricular events.
Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.20 Peak Flow Meter

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Available Only with RN or LPN at main site
Service Limits: Ten units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Use of a peak flow meter in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.11.21 Long Term Medication Administration

Procedure Code: T1000 SE
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: Ten units per instructional day

Staff Credentials: Must be performed by certified school nurse or an RN under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of long-term medication in the school setting and during co-curricular events.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service.

- Date, start and stop time, and location of service;
- Nurse's signature with credentials;
- Member's health care plan;
- Documentation of individual service; and
- Appropriate recommendations consistent with the findings of the individual service.

538.12 SPEECH, LANGUAGE, AND AUDIOLOGY SERVICES

Speech and audiology services must be ordered by a physician, PA, or APRN and provided by or under the direction of an enrolled licensed speech therapist or audiologist.

Speech Language Pathologist (SLP): To render speech language pathology services to Medicaid members under School-Based Health Services, the SLP must be licensed by the West Virginia Board of Examiners Speech-Language Pathology and Audiology and must comply with all rules and regulations

under WV Code §30-32-1 thru §30-32-23.

School Speech Language Pathology Assistants (SSLPA): To render speech language pathology services to Medicaid members under School-Based Health Services, the SSLPA must have an associate degree, bachelor's degree, or master's degree in speech pathology. The SSLPA will be indirectly supervised by an SLP associated with the LEA that they are employed with. The SLP is not required to directly supervise the SSLPA but must be available in case of any emergent issues.

Non-Covered Services for speech, language, and audiology services include, but are not limited to:

- Evaluations by the SSLPA
- Experimental/investigative services/procedures for research purposes
- Evaluations provided by an employee or an individual that has a financial interest with providers of devices
- Speech therapy services provided:
    - To individuals who are not Medicaid eligible on the date of service
    - By persons not duly certified to provide the services
    - To members showing no progress in treatment/therapy
- Upgrades to, or subsequent versions of the speech-generating device software program or memory modules that may include enhanced features or other improvements
- Any device that is not a dedicated augmentative and alternative communication/speech generating device or can run software for purposes other than speech generating device (e.g., word processing application, accounting program, or other non-medical functions)
- Augmentative communication (AC) speech-generating systems or devices intended to meet social, educational, vocational or non-medical needs
- Any device that allows input of information by a pen-based system using a stylus and handwriting recognition software, keyboard, or downloaded from a personal computer using special cables and software
- Multiple speech-generating devices or software programs that perform the same essential function are considered a duplication of services and are not medically necessary
- Laptop computers or desktop computers which may be programmed to perform the same function as a speech-generating device
- Printers (which are not a built-in component of an augmentative communication/speech-generating device), printer paper, printer cables
- Environmental control devices which are not a built-in component
- Purchase of a new personal computer (PC), repair or replacement of a previously owned personal computer, repair or replacement of a previously owned PC or any related hardware
- Extended vocabulary software packages
- An AC device provided without severe speech impairment
- Rental of hearing aids
- Hearing aids, hearing aid evaluations and fittings for members 21 years and older
- Personal Frequency Modulation (FM) Systems
- Assistive technology devices that are maintained at a school facility for the general use of disabled members and assistive technology services related to the use of such devices
- Upgrading of hearing aids to accommodate school facility FM systems

Speech therapy is deemed not medically necessary when the member has:

- Reached the highest level of functioning and is no longer progressing; OR

- The established plan of care goals and objectives are met; OR
- The established plan of care does not require the skills of a speech-language therapist/pathologist; OR
- The member or his/her legal representative has demonstrated the knowledge and skill of providing the speech therapy regime themselves.

Required Documentation: A written referral from the treating/prescribing practitioner with pertinent clinical documentation for service(s) requested. The referral must include, but is not limited to:

- The member's name;
- Date of referral;
- Type of service requested;
- Frequency and duration of treatment;
- Diagnosis,
- Physician's, PA's, or APRN's signature. Supporting documentation must not be more than six months old;
- The plan of care which must include, but is not limited to:
    - The date the plan was developed;
    - Diagnosis;
    - Short-and long-term functional goals,
    - Measurable treatment objectives;
    - Frequency and duration of treatment;
    - Education/training in speech therapy or hearing devices for the member or their legal representative to attain maximum rehabilitation
    - Prognosis;
    - Date discussed with member or legal representative;
    - Signature and date of the member or legal representative agreeing to the treatment;
    - Date, and signature and title of the individual providing treatment; and
    - Plan of care may be developed from information found in the IEP.
- An audiology evaluation with audiometric results which cannot be more than six months old prior to dispensing the hearing aid.

Please see Appendix 538B Audiological Therapy Billing Form or Appendix 538C Speech Therapy Billing Form.

Codes 92521, 92522, 92523 and 92524 are used to report evaluation of speech production, receptive language, and expressive language abilities. Tests may examine speech sound production, articulatory movements of oral musculature, the patient's ability to understand the meaning and intent of written and verbal expressions, and the appropriate formulation and utterance of expressive thought.

538.12.1 Individual - Speech, Language, Voice, Communication, Auditory Processing

Procedure Code: 92507
Service Unit: 15-minute unit
Telehealth: Available
Service Limits: 24 units per calendar month

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology or a SSLPA.

Definition: Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service. Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified speech therapy needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. Documentation must also include the following:

- Member Service Plan;
- Signature with credentials;
- Date, start and stop time, and location of service; and
- Utilized Interventions.

538.12.2 Group - Speech, Language, Voice, Communication, Auditory Processing

Procedure Code: 92508
Service Unit: 15-minute unit
Telehealth: Available
Service Limits: 24 units per calendar month

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology or a SSLPA.

Definition: Treatment of Speech, language, voice, communication, and/or auditory processing disorder; individual

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service. Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified speech therapy needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. Documentation must also include the following:

- Member Service Plan;
- Signature with credentials;
- Date, start and stop time, and location of service; and
- Utilized Interventions.

538.12.3 Evaluation of Speech Fluency

Procedure Code: 92521
Service Unit: Event (completed evaluation)

Telehealth: Not Available
Service Limits: One Event per Year
SSLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: An integrated evaluation to determine speech fluency e.g. stuttering, cluttering etc.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of Service
- Physician, PA or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current International Classification of Diseases (ICD) methodology and rationale for diagnosis;
- Medicaid Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.4 Evaluation of Speech Sound Production

Procedure Code: 92522
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
Cannot be billed the same day as 92523
(SSLPA cannot render this service)

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: An integrated evaluation to determine speech sound production (e.g. articulation, phonological process, apraxia, and dysarthria).

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Medicaid Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.5 Evaluation of Speech Sound Production with Evaluation of Language Comprehension

Procedure Code: 92523
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
Cannot be billed the same day as 92522
(SSLPA cannot render this service)

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: An integrated evaluation to determine speech sound production (e.g. articulation, phonological process, apraxia, and dysarthria with evaluation of language comprehension and expression (e.g.) receptive and expressive language)

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.6 Behavioral and Qualitative Analysis

Procedure Code: 92524
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
(SSLPA cannot render this service)

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: An integrated evaluation to determine behavioral and qualitative analysis of voice and resonance.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA or APRN order for the evaluation;

- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.7 Speech Auditory Threshold

Procedure Code: 92555
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: An integrated evaluation to determine speech audiometry threshold.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service:
- Physician, PA, or APRN order for the evaluation:
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.8 Speech Audiometry with Speech Recognition

Procedure Code: 92556
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year
Cannot be billed the same date of service as 92555

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: A comprehensive audiometry threshold evaluation and speech recognition.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of Service
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.9 Comprehensive Audiometry Threshold Evaluation with Speech Recognition

Procedure Code: 92557
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
Cannot be billed the same date of service as 92552, 92533, 92555, or 92556

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: A comprehensive audiometry threshold evaluation and speech recognition.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.10 Loudness Balance Test

Procedure Code: 92562
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Loudness Balance Test, alternate binaural or monaural

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.11 Tympanometry

Procedure Code: 92567
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year
(SSLPA cannot render this service)

Staff Credentials: Must be performed by a West Virginia licensed RN, under the direction of a licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Tympanometry (impedance testing).

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.12 Acoustic Reflex Testing

Procedure Code: 92568
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Acoustic Reflex Testing; threshold.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.13 Acoustic Immittance Testing

Procedure Code: 92570
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year
(SSLPA cannot render this service)

Staff Credentials: Must be performed by a West Virginia licensed RN under the direction of a licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Acoustic Immittance testing includes tympanometry (impedance testing) acoustic reflex threshold.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of Service
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.14 Filtered Speech Test

Procedure Code: 92571
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event Per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Filtered speech test.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.15 Conditioning Play Audiometry

Procedure Code: 92582
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: Four Events Per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Conditioning play audiometry.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.16 Select Picture Audiometry

Procedure Code: 92583
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Select picture audiometry.
Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.17 Distortion Product Evoked Otoacoustic Emission

Procedure Code: 92587
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Distortion Product Evoked Otoacoustic Emission: Limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;
- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.18 Hearing Aid Examination - Monaural

Procedure Code: 92590
Service Unit: Event (completed evaluation)
Telehealth: Not Available

Service Limits: Two Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.
Definition: Hearing Aid Examination and selection; monaural.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.19 Hearing Aid Examination - Binaural

Procedure Code: 92591
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Two Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Hearing aid examination and selection; binaural.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.20 Hearing Aid Check- Monaural

Procedure Code: 92592
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Hearing aid check; monaural.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Provider's signature with credentials;
- Documentation with results of check; and
- Appropriate recommendations consistent with the findings of the check.

538.12.21 Hearing Aid Check - Binaural

Procedure Code: 92593
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Hearing aid check; binaural.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Provider's signature with credentials;
- Documentation with results of check; and
- Appropriate recommendations consistent with the findings of the check.

538.12.22 Electroacoustic Evaluation for Hearing Aid - Monaural

Procedure Code: 92594
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Electroacoustic evaluation for hearing aid; monaural

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of evaluation;
- Evaluator's signature with credentials;
- Presenting problem;

- Duration and frequency of symptoms;
- Member's diagnosis per current ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.12.23 Ear Protector Attenuation Measurements

Procedure Code: 92595
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology and Audiology.

Definition: Ear protector attenuation measurements.

Documentation: Documentation must contain the following and be completed within 35 calendar days from the date of service:

- Date, start and stop time, location of service;
- Physician, PA, or APRN order for the evaluation;
- Purpose of measurements;
- Evaluator's signature with credentials;
- Presenting problem;
- Member's diagnosis per current ICD methodology; and
- Documentation of measurements.

538.13 PSYCHOLOGICAL SERVICES

Psychological services include assessments, testing, and therapeutic services that are used to diagnose and treat individuals with suspected or identified diagnosis of emotional, developmental or substance abuse issues. Please see Appendix 538D Psychological Billing Form.

538.13.1 Assessment Services

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff credentialed by the internal credentialing policies and procedures of the agency. Assessment services are designed to make determinations concerning the mental, physical, and functional status of the member.

538.13.1.1 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: 90791
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: Two events per year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a Board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date and location of service;
- Purpose of evaluation;
- Psychiatrist's/psychologist's signature with credentials;
- Presenting problem;
- History of member's presenting illness;
- Duration and frequency of symptoms;
- Current and past medication efficacy and compliance;
- Psychiatric history up to present day;
- Medical history related to behavioral health condition;
- Mental Status Exam must include the following elements:
  - Appearance
  - Behavior
  - Attitude
  - Level of consciousness;
  - Orientation;
  - Speech;
  - Mood and Affect;
  - Thought process/form and thought content;
  - Suicidality and homicidally; and
  - Insight and judgment
- Member's diagnosis per current Diagnostic and Statistical Manual of Mental Disorders (DSM) or ICD methodology and rationale for diagnosis;
- Member's prognosis and rationale; and
- Appropriate recommendations consistent with the findings of the evaluation.

538.13.2 Testing Services

The following services are used for the testing of cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. The service report times include the face-to-face time with the patient and the time spent interpreting and preparing the report.

538.13.2.1 Psychological Testing, Administration and Scoring

Procedure Code: 96130
Service Unit: 60 minutes
Telehealth: Not Available

Service Limits: Two units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a Board Approved-supervisor or a school psychologist as deemed and approved by the DOE.

Definition: Psychological testing evaluation services by a psychologist, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment of planning and report and interactive feedback to the patient, family member(s) or caregiver(s) when performed; first hour.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Signature with credentials;
- Purpose of the evaluation;
- Documentation that member was present for the evaluation;
- Report must contain results (score and category) of the administered tests/evaluations;
- Report must contain interpretation of the administered tests/evaluations;
- Mental Status Exam must include the following elements:
    - Appearance;
    - Behavior;
    - Attitude;
    - Level of consciousness;
    - Orientation;
    - Speech;
    - Mood and affect;
    - Thought process/form and thought content;
    - Suicidality and homicidally; and
    - Insight and judgment
- Rendering of the member's diagnosis within the current DSM or ICD methodology; and
- Recommendations consistent with the findings of administered tests/evaluations.

Service Exclusions:

- Psychometrician/technician work
- Computer - scoring
- Self-administered assessments
- Computer - interpretation
- Interns may not bill for this service

Procedure Code: 96131
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: Four units per calendar year

Definition: Psychological Testing and evaluation by professional, additional hour (See 96130 for additional information).

Service Exclusion: Must utilize 96130 to be able to bill for 96131.

Test Administration and Scoring:

Procedure Code: 96136
Service Unit: 30 minutes
Telehealth: Not Available
Service Limits: One unit per calendar year

Procedure Code: 96137
Service Unit: 30 minutes
Telehealth: Not Available
Service Limits: Four units per calendar year

538.13.2.2 Developmental Testing: Limited

Procedure Code: 96110
Service Unit: Event (completed interpretation and report)
Telehealth: Not Available
Service Limits: Two Events per calendar year

Payment Limits: This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96130) has been billed in the last six months.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: This is limited to developmental testing with interpretation and report**.**

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service:

- Date, start and stop time, and location of service;
- Purpose of evaluation;
- Signature with credentials;
- Documentation that the member was present for the evaluation;
- Documentation must contain the results (scores and category) of the administered tests/evaluations;
- Documentation must contain interpretation, diagnosis, and recommendations;
- Mental Status Exam must include the following elements:
    - Appearance;
    - Behavior;
    - Attitude;
    - Level of consciousness;
    - Orientation;
    - Speech;
    - Mood and affect;
    - Thought process/form and thought content;
    - Suicidality and homicidally; and

  - Insight and judgment.
- Rendering of the member's diagnosis within the current DSM or ICD methodology; and
- Recommendations consistent with the findings of the administered tests/evaluations.

538.13.3 Psychotherapy Services

Psychotherapy times are face-to-face services with member and/or family member. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832, 38-52 minutes for 90834, and 53 or more minutes for 90837).

Procedure Code: 90832
Service Unit: 1 unit = 16-37 minutes
Telehealth: Available
Service Limits: 20 units per calendar year

Procedure Code: 90834
Service Unit: 1 unit = 38-52 minutes
Telehealth: Available
Service Limits: 20 units per calendar year

Procedure Code: 90837
Service Unit: 1 unit = 53 or more minutes
Telehealth: Available
Service Limits: 20 units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a Board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service. Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. Documentation must also include the following:

- Member Service Plan;
- Signature with credentials;
- Date, start and stop time, and location of service; and
- Utilized interventions

538.13.3.1 Family Psychotherapy (without the patient present)

Procedure Code: 90846
Service Unit: 1 unit = 45-50 minutes
Telehealth: Available
Service Limits: 20 units per Calendar Year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy without the patient present in the therapeutic session.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service. Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following:

- Member's Service Plan;
- Signature with credentials;
- Date, tart and stop times, and location of service; and
- Utilized interventions.

538.13.3.2 Family Psychotherapy (with the patient present)

Procedure Code: 90847
Service Unit: 1 Unit = 45-50 minutes
Telehealth: Available
Service Limits: 20 Units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy with the patient present in the therapeutic session.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service. Documentation must indicate how often this service is to be provided. There

must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following:

- Member's Service Plan;
- Signature with credentials;
- Date, start and stop time, and location of service; and
- Utilized interventions.

538.13.3.3 Group Psychotherapy (Other than of a multiple-family group)

Procedure Code: 90853
Service Unit: 1 Unit = 60 minutes
Telehealth: Available
Service Limits: 20 Units per calendar year
Maximum limit of 12 individuals in a group setting

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: Group psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service. Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following:

- Signature with credentials;
- Group topic;
- Date, tart and stop time, and location of service; and
- Utilized interventions.

538.13.3.4 Psychotherapy for Crisis

Procedure Code: 90839
Service Unit: 1 Unit = 60 Minutes
Telehealth: Not Available

Service Limits: Four per calendar year

Procedure Code: 90840
Service Unit: Add on code for each additional 30 minutes of psychotherapy for crisis, used in conjunction with 90839
Telehealth: Not Available
Service Limits: Four per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychology, or a supervised psychologist who is supervised by a board-approved supervisor or a school psychologist as deemed and approved by the DOE.

Definition: Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to patient in high distress. Codes 90839 and 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the psychologist providing psychotherapy for the crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state the psychologist must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791.

Documentation: Documentation must contain the following and be completed within 20 calendar days from the date of service. There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis. The documentation must also include the following:

- Signature with credentials;
- Safety plan;
- Date, start and stop time, and location of service;
- Mental Status Exam must include the following elements:
    - Appearance;
    - Behavior;
    - Attitude;
    - Level of consciousness;
    - Orientation;
    - Speech;
    - Mood and affect;
    - Thought process/form and thought content;
    - Suicidality and homicidality; and
    - Insight and judgment.

Service Exclusions:

- Response to a domestic violence situation
- Admission to a hospital
- Admission to a Crisis Stabilization Unit (CSU)

- Transportation or time waiting for transportation
- Removal of a minor or an incapacitated adult from an abusive or neglectful household
- Completion of certification for involuntary commitment

538.14 PERSONAL CARE SERVICES (ONE-ON-ONE AIDE)

Procedure Code: T1019 SE
Service Unit: 15-Minute Unit
Telehealth: Not Available
Service Limits: 28 units per instructional day

Staff Credentials: Services are furnished by providers who have satisfactorily completed a program for home health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions. Providers must have completed a GED or high school diploma. Providers must complete AND continue to have up to date training for the following:

- CPR/First Aid;
- Abuse, neglect, exploitation and mandatory reporting requirements training; and
- HIPAA/confidentiality training.

The following are the positions that have been identified as providers of personal care services by the DOE:

- Aide I; Aide II; Aide III; and Aide IV
- Paraprofessional
- Autism mentor
- Early Childhood Classroom Assistant Teacher (ECCAT) I; ECCAT II; and ECCAT III
- Braille specialist
- Sign support specialist
- Educational Sign Language Interpreter I and Educational Sign Language Interpreter II
- Licensed Practical Nurse (LPN)

Definition: Services related to a child's physical and behavioral health requirements, including assistance with eating, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, use of adaptive equipment, ambulation and exercise, behavior modification, and/or other remedial services necessary to promote a child's ability to participate in, and benefit from, the educational setting. Aide services can be shared across two staff. However, each staff must document their service time with the member. Interpreters and autism mentors can serve as personal care aides. Parents cannot be counted as personal care aides.

Documentation: Documentation must be completed within 20 calendar days from the date of service. Please see Appendix 538E – Personal Care Medicaid Log for more information.

538.15 OCCUPATIONAL AND PHYSCIAL THERAPY

To be reimbursed, occupational and physical therapy services must be ordered by a physician, PA or APRN and provided by or under the direction of a registered licensed occupational /physical therapist on an outpatient basis in the school setting.

"Under the direction of" means that the therapist is on the premises when the services are rendered and is available for any emergency or question that may arise. As circumstances permit, the therapist must be involved in patient education, including but not limited to, teaching the patient exercise, manipulation, and how to use devices for their own rehabilitation.

Documentation: Documentation must be completed within 20 calendar days from the date of service. Please see Appendix 538F Occupational Therapy Billing Form or Appendix 538G Physical Therapy Billing Form.

Continuous progress/improvement must be documented for coverage of therapy. The member must show compliance with therapy.

Continuation of services may be considered, when an exacerbated episode of a chronic condition is clearly documented.

A member has the freedom to choose services from Medicaid providers outside the school system. However, West Virginia cannot cover this duplication of services, that is, pay claims for the same services provided in the school system and also outside the school system by private. The LEA is responsible to have the Medicaid member's representative sign consent for treatment form for any occupational or physical therapy services provided at a school that is intended to be billed to Medicaid.

When school is not in session, continuation of therapy services, if necessary, should be coordinated with a qualified therapist in private practice. The plan of care established by the school system should be written in a way that the private practitioner can pick up where the school therapist ended.

Physical Therapy Assistant (PTA) Regulations to Bill under a Licensed Physical Therapist: All PTAs must meet and follow the regulations under WV State Code §16-1-1 thru 16-1-9.

Certified Occupational Therapy Assistant (COTA) Regulations to Bill under a Licensed Occupational Therapist: All COTAs must meet and follow the regulations under WV State Code §30-28-1 thru 30-28-21.

Service Exclusions:

- Occupational/physical therapy services that are rendered to an inpatient in a hospital, skilled nursing facility, or other facility.
- Occupational/physical therapy services furnished to persons who are not eligible for such services on the date the services are rendered.
- Occupational/physical therapy services for members who have reached maximum rehabilitation potential.
- Separate payment for hot or cold packs (CPT 97010). Payment for this code has been bundled into the payment for other services.
- Experimental services or drugs.

538.15.1 Physical Therapy Evaluation

Procedure Code: 97161 - Physical therapy evaluation low complexity
97162 - Physical therapy evaluation moderate complexity
97163 - Physical therapy evaluation high complexity

Service Unit: Event
Telehealth: Not Available
Service Limits: One per code per Calendar Year

Staff Credentials: Must be performed by a West Virginia licensed physical therapist.

Definition: Physical therapy evaluation.

Documentation: Documentation of the evaluation must contain the following and be completed within 20 calendar days from the date of service:

- Physical therapy diagnosis;
- Recent physical therapy;
- Prior functional status;
- Plan of Care;
- Physical therapy profile and context;
- Tolerance to Instrumental Activities of Daily Living (IADLS);
- Tolerance to activities;
- Current splint and orthoses;
- Recommendations;
- Prognosis for treatment;
- Signature with credentials;
- Date, start and stop time and location of service.

538.15.2 Occupational Therapy Evaluation

Procedure Code: 97165 - Occupational therapy evaluation low complexity
97166 - Occupational therapy evaluation moderate complexity
97167 - Occupational l therapy evaluation high complexity
Service Unit: Event
Telehealth: Not Available
Service Limits: One per code per Calendar Year

Staff Credentials: Must be performed by a West Virginia licensed occupational therapist.

Definition: Occupational therapy evaluation.

Documentation: Documentation of the evaluation must contain the following and be completed within 20 calendar days from the date of service:

- Occupational therapy diagnosis;
- Recent occupational therapy;
- Prior functional status;
- Weight bearing activities;
- Occupational therapy profile and context
- Tolerance to IADLs;
- Tolerance to activities;
- Current splint and orthoses;
- Recommendation;

- Prognosis for treatment;
- Signature with credentials;
- Date, start and stop time, and location of service.

538.15.3 Physical Therapy Re-Evaluation

Procedure Code: 97164
Service Unit: Event
Telehealth: Not Available
Service Limits: Two per Calendar Year

Staff Credentials: Must be performed by a West Virginia licensed physical therapist.

Definition: Physical therapy re-evaluation.

Documentation: Documentation of the re-evaluation must contain the following and be completed within 20 calendar days from the date of service:

- Change or no change of physical therapy diagnosis;
- Frequency of physical therapy duration of physical therapy;
- Prognosis toward established goals;
- Member compliance to treatment;
- Signature with credentials;
- Date, start and stop time, and location of service.

538.15.4 Occupational Therapy Re-Evaluation

Procedure Code: 97168
Service Unit: Event
Telehealth: Not Available
Service Limits: Two per Calendar Year

Staff Credentials: Must be performed by a West Virginia licensed occupational therapist.

Definition: Occupational physical therapy re-evaluation.

Documentation: Documentation of the re-evaluation must contain the following and be completed within 20 calendar days from the date of service:

- Change or no change of occupational therapy diagnosis;
- Frequency and duration of occupational therapy;
- Prognosis toward established goals;
- Member compliance to treatment;
- Update to tolerance to IADLS;
- Signature with credentials;
- Date, start and stop time, and location of service.

538.15.5 Occupational/Physical Therapy Services

Procedure Code: 97032 (GO for Occupational Therapy or GP for Physical Therapy)

Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes.

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97110 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA

Definition: Therapeutic procedure one or more areas each 15 minutes therapeutic exercise to develop strength and endurance range of motion and flexibility.

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97112 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;

- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97113 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97116 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Gait training and stair climbing.

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97140 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes.

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97150 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA.

Definition: Therapeutic procedure(s), group (two or more individuals).

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97530 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance).

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

Procedure Code: 97533 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15-minute unit
Telehealth: Not Available
Service Limits: 20 per Calendar Month

Staff Credentials: Must be performed by a West Virginia licensed physical therapist, PTA, licensed occupational therapist, or COTA.

Definition: Sensory integrative techniques to enhance sensory processing and promote adaptive

response to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes.

Documentation: Documentation must include the following:

- Member Service Plan;
- Physical therapy/occupational therapy utilized interventions;
- Signature with credentials; and
- Date, start and stop times, and location of service.

538.16 TARGETED CASE MANAGEMENT (TCM) SERVICES

Procedure Code: T1017 SE
Service Unit: 15-Minute Unit
Telehealth: Available
Service Limits: Five units per instructional day

Staff Credentials: The following credentials are accepted for a TCM provider to render this service:

- A psychologist with a master or doctoral degree from an accredited program;
- A licensed social worker;
- A licensed RN;
- A master's or bachelors' degree granted by an accredited college or university in one of the following human services fields:
    - Psychology;
    - Criminal Justice;
    - Board of Regents with health specialization;
    - Recreational Therapy;
    - Political Science;
    - Nursing;
    - Sociology;
    - Social Work;
    - Counseling;
    - Teacher Education;
    - Behavioral Health Liberal Arts or;
- Other degrees approved by the DOE.

TCM services are a component of the TCM Service Plan. TCM identifies and addresses special health problems and needs that affect the member's ability to learn, assist the child to gain and coordinate access to a broad range of medical, social, educational, and other services, and ensures that the member receives effective and timely services appropriate to their needs.

The relationship of the targeted case manager with a member and his or her family should be one of a partnership. As such, members, parents, and families are not merely spectators of case management recommendations, but active participants in care planning throughout the case management process. This is a necessary perspective for the member's needs and/or preferences to be considered and addressed individually and within the environment in which the person resides.

Accordingly, organized strategies that empower members, parents, and families to assume and carry out their responsibilities must be included in this mutual planning process. It is very important that a targeted

case manager is aware of and sensitive to the values, attitudes, and beliefs that are unique to each family. Values concerning approaches and styles of parenting and/or family life vary according to culture. The effectiveness of TCM is positively impacted by a demonstrated respect for cultural variations among families. Thus, it is critical that case managers be able to identify and understand cultural beliefs, values, attitudes, and morals by which beneficiaries and their families operate.

TCM effectiveness is further enhanced when integrated with other services and resources identified through a systems perspective, considering all active participants in the individual's life (including the individual's parents, family, and significant others and any involved service providers). Interschool collaboration is crucial to ensuring that a member's needs are adequately met without duplication of services. Thus, it is important for a system to exist within each school to ensure that targeted case managers are communicating with other professionals and involved parties, coordinating care and services and meeting the specific needs of each individual and, as appropriate, the needs of families.

TCM is the coordination of services to ensure that eligible Medicaid members have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying individual problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist beneficiaries and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid beneficiary are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs.

The LEA is required to have the member's Targeted Case Management Consent Form (please see Appendix 538H Targeted Case Management Consent Form) signed by the member's legal representative and kept in the member's file. LEA's may not bill for TCM services until the form is completed and signed by the member's representative.

TCM services must include any of the following activities:

1. **Needs Assessment and Reassessment:** Reviewing of the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. Results of assessments and evaluations are reviewed, and a meeting is held with the individual, his or her parent(s) and /or guardian, and the case manager to determine whether services are needed and, if so, to develop a service plan. At a minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed.

2. **Development and Revision of the TCM Service Plan:** Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parents(s) or legal guardian, and the case manager. Development (and periodic revision) of the TCM Service Plan will specify the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually. The IEP is not the TCM Service Plan.

3. **Referral and Related Activities:** Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. This is

accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the individual, his or her parent(s) or legal guardian and the case manager and between the individual, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual. This may also include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

4. **Monitoring and Follow-Up Activities:** The case manager shall conduct regular monitoring and follow-up activities with the client, the client's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the individual's TCM Service Plan. Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of TCM services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties. The periodic reviews will be conducted as necessary but at least annually.

All services must be fully documented in the member's record.

Non-Duplication of Services: If a member chooses to have TCM services from another provider agency as a result of being members of other covered targeted groups such as foster children etc.; the School-Based Health Services providers will ensure that TCM activities are coordinated to avoid duplication of services.

TCM includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. TCM activities shall not restrict or be used as a condition to restrict a client's access to other services under the state plan.

538.17 TRANSPORTATION SERVICES

Transportation services are the services used to physically transport a member to/from a therapeutic or diagnostic Medicaid service. Transportation must only be provided to members.

538.17.1 Non-Emergency Medical Transportation - with Bus Aide

Procedure Code: T2001 SE
Service Unit: Trip
Service Limits: Four one-way trips per instructional day

Definition: Non-emergency Medical Transportation with attendant is a service in which a one-way transport of a member by a vehicle other than an ambulance is provided. If more than one member is being transported, each member's transport to the Medicaid service is billable. Non-Emergency Transportation with an attendant may only be billed when a Medicaid covered service is billed for the same date of service and the attendant is present during the transport.

Documentation: Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times. Please see Appendix 538I Transportation Billing Form.

538.17.2 Non-Emergency Transportation

Procedure Code: T2002 SE
Service Unit: Trip
Service Limits: Four one-way trips per instructional day

Definition: Non-emergency Medical Transportation is a service in which a one-way transport of a member by a vehicle other than an ambulance is provided. If more than one member is being transported, each member's transport to the Medicaid service is billable. Non-Emergency Transportation may only be billed when a Medicaid covered service is billed for the same date of service

Documentation: Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times. Please see Appendix 538I Transportation Billing Form.

538.18 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* of the Provider Manual.

538.19 SERVICE EXCLUSIONS

In addition to the exclusions listed in *Chapter 100, General Administration and Information*, the BMS will not pay for the following services:

- Telephone consultations - excluding T1017;
- Meeting with the member or member's family for the sole purpose of reviewing evaluation and/or results;
- Missed appointments, including but not limited to, canceled appointments and appointments not kept;
- Services not meeting the definition of medical necessity;
- Time spent in preparation of reports including IEPs;
- A copy of medical report when the agency paid for the original service;
- Experimental services or drugs;
- Any activity provided for the purpose of leisure or recreation; and
- Services rendered outside the scope of a provider's license.

538.20 ROUNDING UNITS OF SERVICE

Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. **Units of service based on an episode or event cannot be rounded**.

Many services are described as being "planned," "structured," or "scheduled." If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.

Services billed in 15-minute units are eligible for rounding. Minutes in excess of the daily limit are not eligible for rounding.

In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded down to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months. Only whole units of service may be billed.**

538.21 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

Providers of services must comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each West Virginia Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
- All required documentation must be maintained for at least five years at the central office of the County Board of Education/LEA. These records are subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by the BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.
- Providers of services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

538.22 BILLING PROCEDURES

Claims from providers must be submitted on the current BMS approved designated forms or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.

- The amount billed to the BMS must represent the provider's usual and customary charge for the

services delivered.
- Claims must be accurately completed with required information.
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.
- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

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.

Abuse and Neglect: As defined in WV Code §49-1-3

Advanced Practice Registered Nurse (APRN): As defined in West Virginia Code §30-7-1**:** A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

Audiologist: A person who practices audiology in accordance within their licensure, scope of practice and is licensed by the West Virginia Board of Examiners for Speech-Language Pathology and Audiology as defined in WV Code §30-32**.**

Augmentative Communication (AC)/Speech Generating Device: A speech aid that provides the ability to meet functional speaking needs of members with severe speech impairment.

Behavioral Health Condition: A mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment.

Billing Agent: The party to whom Medicaid program billing has been designated to.

Billing Tool: The form used for listing provider services so the billing agent can generate the CMS 1500 claim. Can be performed electronically or manually.
Binaural: Pertaining to both ears. Only 1 unit and binaural procedure codes are to be billed when supplying hearing devices for both ears.

Certified Occupational Therapy Assistant (COTA): An Associate of Arts graduate employed by and under the direct supervision of an Occupational Therapist and is licensed by the Board of Occupational Therapy in West Virginia.

Certified School Nurse: A registered professional nurse, who is licensed by the West Virginia Board of Examiners for Registered Professional Nurses (W.Va. Code §30-7-1, et seq.), who has completed a DOE approved program as defined in the West Virginia Board of Education (WVBE) Policy 5100: Approval of Educational Personnel Preparation Programs (W.Va. §126CSR114), and meets the requirements for certification contained in WVBE Policy 5202: Minimum Requirements for the Licensure

of Professional/Paraprofessional Personnel and Advanced Salary Classifications (W.Va. 126CSR136) (hereinafter Policy 5202). The certified school nurse must be employed by the county board of education or the county health department as specified in W.Va. Code §18-5-22. These policies can be found on the DOE website.

Cochlear Implant: An implanted electronic hearing device, designed to produce useful hearing sensations to a member with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear.

Communication Disorder: An impairment in a person's ability to receive, send, process, and comprehend concepts of verbal, nonverbal, and graphic symbol systems.

County School Districts: Any of the 55 local school systems responsible for providing public education in West Virginia.

Direct Supervision: Supervision that is provided by a licensed individual who monitors LEA providers and is required to be present in the school setting when services are being rendered.

Foster Child: The West Virginia Department of Health and Human Resources (DHHR) defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Freedom of Choice: Unless formally waived by the federal government, state Medicaid programs must allow Medicaid recipients to obtain services from any institution, agency, person, pharmacy or organization that qualifies as a Medicaid provider. For school-based services, a member and/or his/her parents could elect to receive services either through the DOE or through any other Medicaid provider. Freedom of choice for school-based services must be documented in the member's record and maintained for a five-year period.

Group Number: The number assigned to each district for billing Medicaid. The group number must be on all claims submitted. Individual providers for the following specialties: audiologists, occupational therapists, physical therapists, psychologists, registered nurses and speech language therapists must also provide their individual Medicaid provider number.

Hearing Aid: An electronic device that increases the loudness of sounds and speech for the hearing impaired.

Human Services Degree: A master's or bachelors' degree granted by an accredited college or university in one of the following human services fields:

- A psychologist with a masters' or doctoral degree from an accredited program;
- A licensed social worker;
- A licensed RN;
- Psychology;
- Criminal Justice;
- Board of Regents with health specialization;
- Recreational Therapy;

- Political Science;
- Nursing;
- Sociology;
- Social Work;
- Counseling;
- Teacher Education;
- Behavioral Health Liberal Arts or;
- Other degrees approved by the DOE.

(Note: Some services require specific degrees as listed in this manual. See specific services for detailed information on staff qualifications.)

In-Direct Supervision: Supervision that is provided by a licensed individual who monitors LEA providers, but is not required to be present, in the school setting when services are being rendered.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the West Virginia Board of Examiners of Psychologist and is in current good standing with the board.

Local Education Agency (LEA): As defined in Elementary and Secondary Education Act (ESEA), a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools.

Medicaid: Created as Title XIX of the Social Security Act in 1965, Medicaid is a federal/state health insurance program for low-income individuals administered by the states and funded from federal and state revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. States have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery. In general, Medicaid covers low-income mothers and children, elderly people who need long-term care services and people with disabilities.

Medicaid Eligible Member: Any student who has been determined by the DHHR as eligible to receive Medicaid benefits.

Medical Necessity: Based upon the member's diagnosis(es), all service(s) provided to the member are medically necessary. Medical necessity for school-based services must be documented in the member's record and maintained for a five-year period.

Member Number: The 11-digit number designated for each Medicaid recipient. This number must be included on all claims.

Member Service Plan: A required written document developed by the service provider which is individualized to the member's health needs and consists of specific goals and objectives.

Monaural: Pertaining to one ear. Only one unit and the monaural procedure codes are to be billed when supplying a hearing device for one ear. Each ear cannot be billed separately.

Occupational Therapist: A graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association (AMA) and the American Occupational Therapy Association and is licensed or registered in West Virginia.

Physical Therapist: A graduate of a program of physical therapy approved by the American Physical Therapy Association and the Committee on Allied Health Education and Accreditation of the AMA, and is licensed or registered in the State in which he or she Practices

Physical Therapy Assistant (PTA): An Associates of Arts graduate under the direct supervision of a Physical Therapist and licensed by the Board of Physical Therapy in the State he/she practices.

Physician: As defined in WV Code §30-3-10, an individual who has been issued a license to practice medicine in the state of West Virginia by the West Virginia Board of Medicine and is in good standing with the board; or an individual licensed by the West Virginia Board of Osteopathy in accordance with WV Code §30-14-6.

Physician Assistant: An individual who meets the credentials described in West Virginia Code Annotated, §30-3-13 and §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Physician Extender: A medical professional including an APRN or a physician's assistant functioning within his or her legal scope of practice.

Physician's Order: A written prescription from a licensed medical physician authorizing the provision of services. It contains the diagnosis, etc., to substantiate the medical necessity of the services.

Physician's Referral: A recommendation from a licensed physician for a member to receive services. The referral must be documented in the member's file with the name of the physician, date of the referral and the service(s) for which the member was referred, and the diagnosis to substantiate the medical necessity for the service(s).

Plan of Care (POC): a document listing the Medicaid billable services included in a student's IEP. The plan includes measurable treatment goals and/or objectives as appropriate for therapy and/or behavior. The document also includes a list of specific billable services with frequency, initiation and duration dates. Attachments to the Plan of Care as appropriate are Nursing Health Care Plans, Behavior Intervention Plans and Re-evaluation Determination Plans. Signatures of the parent, case manager and therapists are required.

Procedure Codes: The Medicaid program uses the American Medical Association Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) as its base for identifying particular procedures.

Registered Nurse (RN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse and in good standing with the West Virginia Board of Examiners for Registered

Professional Nurses or a person who has completed a BA or Bachelor of Science in Nursing and is approved by the DOE as a school nurse.

Related Services: Those services identified as but not limited to audiology, speech/language therapy, occupational therapy, physical therapy, psychological services, and private duty nursing.

Speech-Language Pathologist (SLP): A person who practices speech language pathology in accordance within their licensure, scope of practice and is licensed by the West Virginia Board of Examiners for Speech-Language Pathology and Audiology as defined in WV Code §30-32**.**

School Speech-Language Pathologist Assistant (SSLPA): An employee of the LEA that holds an Associate, Bachelors or master's degree who is not licensed by the West Virginia Board of Examiners for Speech-Language Pathology & Audiology but has been deemed by the West Virginia Department of Education to provide speech language pathology services in the school setting.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision program.

Utilization Management Contractor (UMC): The contracted agent of BMS who performs retrospective reviews on school-based services.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	School-Based Health Services (SBHS)	August 1, 2015
Entire Chapter	Updated *Section 538.4, Fingerprint-Based Background Checks* Regarding Information Exchange between LEA's, WVDE and BMS regarding criminal background information and exclusions from participating as a provider. *538.8 Other Administrative Requirements* Moved to page 9. Updated Table of Contents *Glossary* Removed BMS; Covered Services; Designated Legal Representative (DLR); DHHR; Medicare; Medicare/Medicaid Patient. Updated Member ID Number to Member Number.	August 1, 2017
Entire Chapter	Updated Nursing Services section, Psychological Codes, Glossary, and Appendix H. Clarified telehealth services.	August 1, 2019