Mountain Health Trust (MHT) Program

The Mountain Health Trust (MHT) program includes West Virginia (WV) Medicaid which includes: Temporary Assistance for Needy Families (TANF), Expansion (WV Health Bridge), and Supplemental Security (SSI), the West Virginia Children's Health Insurance Program (WVCHIP) membership.

The Health Plan (THP) began administering health care benefits to WV Medicaid Members on September 1, 1996, and WVCHIP members on January 1, 2021. THP currently serves MHT members in all 55 West Virginia counties.

Mountain Health Trust Member ID Cards and Member Eligibility

THP will issue Mountain Health Trust members one ID card.

The member is expected to present their ID card when receiving services. Each eligible individual family member will have a separate ID card with their own plan ID number. The THP member ID card has the applicable program logo and important information including:

- Member's plan ID # including – 01 suffix (the suffix must be included when submitting claims)
- West Virginia Department of Health and Human Services (WVDHHR) assigned member ID number
- Member's name
- Member's Primary Care Physician (PCP) name
- PCP phone number

THP sends an ID card to the member once, unless the member changes PCPs or requests a replacement.

All members, except newborns, become effective on the first of each month and become terminated on the last day of the month. To verify member eligibility please visit THP's secure provider portal or call the Customer Service Department at 1.888.613.8385. If you do not have access to THP's provider portal, please contact Provider Data Quality (PDQ) ate-mail: pdq@healthplan.org

When medically necessary, physicians and practitioners are required to makes services available 24 hours a day, seven days a week. Physicians must comply with the access standards set forth in **Chapter 11- Quality** of the provider manual.

THP must cover a member's out-of-network services covered under the Mountain Health Trust if THP's provider network is unable to provide those services. THP will ensure the member's cost is no greater than if the service were rendered within THP's provider network. Out-of-network services must be covered as adequately and as timely as if those services were provided within THP's provider network, and for as long as the THP provider network is unable to provide the service.

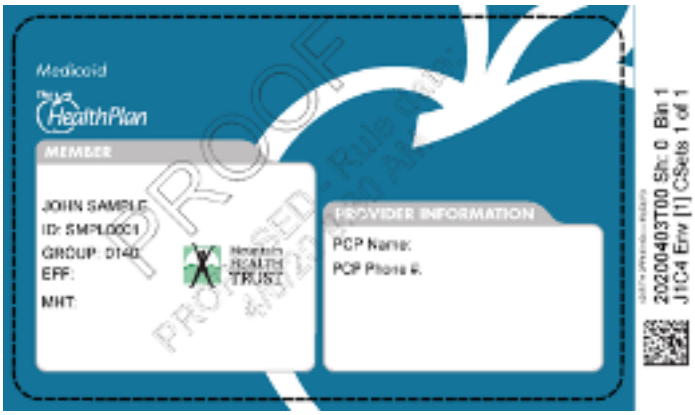
THP must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency and/or limited reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. THP also ensures the THP provider network offer MHT members with physical and/or mental disabilities physical access, reasonable accommodations for physical access, and accessible equipment.

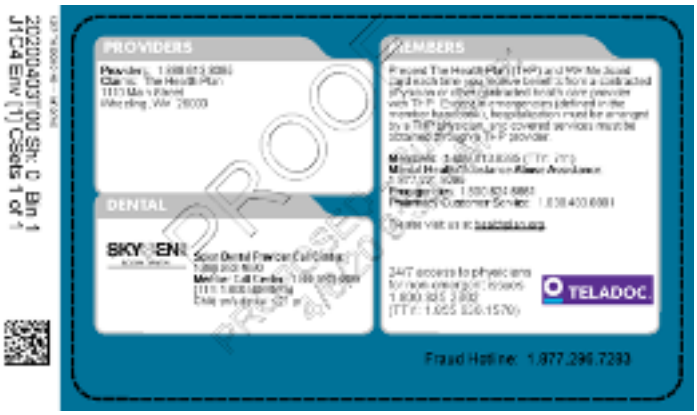
Mountain Health Trust Member ID Cards

The THP Medicaid member ID cards are color-coded blue to more easily identify THP's Medicaid population. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

WV Medicaid

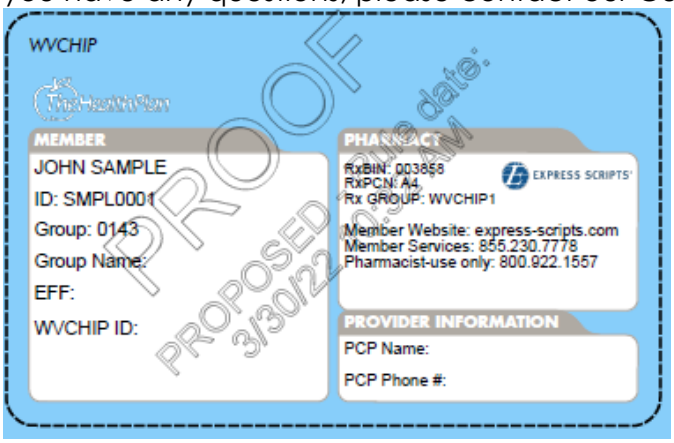
Group number: 0140, 0141 and 0142

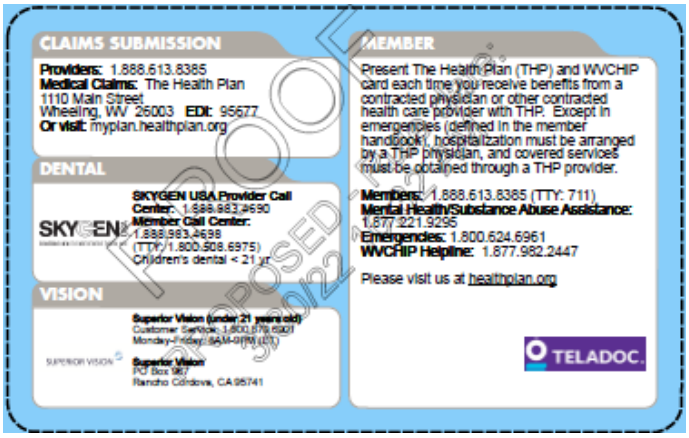


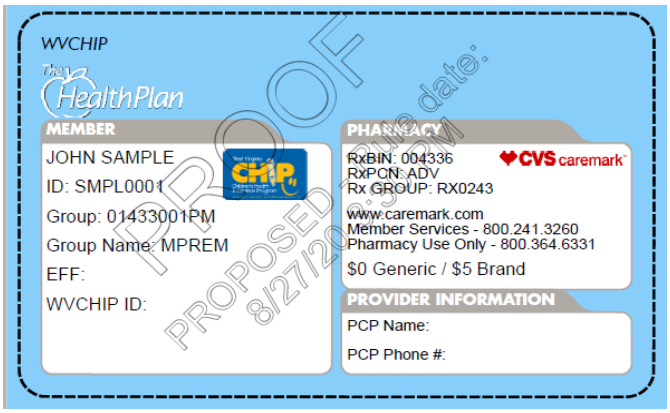


WVCHIP ID Card

The THP WVCHIP cards are color-coded light blue to more easily identify the WVCHIP population. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.







Medicaid Benefits and Exclusions at a Glance

Benefit packages differ, depending on the member's age and whether the member is covered under Mountain Health Trust or West Virginia Health Bridge.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits
Medical • **Primary Care/Specialist Office Visits/FQHC/RHC–** Includes physician, physician assistant, nurse practitioner and nurse midwife services. • **Physician Services–** Certain services may require prior authorization or have service limits. May be delivered through telehealth**.** • **Laboratory and X-ray Services–** Includes lab services related to substance abuse treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires prior authorization. • **Clinics–** Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children. • **Private Duty Nursing –** For children ages 0-21, Requires prior authorization. Limits apply.
Hospital • **Inpatient**– Includes all inpatient services (including bariatric and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Some behavioral health inpatient stays are not included. Requires prior authorization. • **Organ and Tissue Transplants–** Corneal transplants only. • **Outpatient–** Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services**.**
Ambulatory Surgical Care • Includes services and equipment for surgical procedures.
Emergency • **Post-stabilization–** Includes care after an emergency health condition is under control. Care provided in a hospital or other setting. • **Emergency Transportation–** Includes ambulance and air ambulance. Out-of-state requires prior authorization.
Rehabilitation • **Pulmonary Rehabilitation–** Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Maximum of 12 weeks or 36 visits per calendar year. • **Cardiac Rehabilitation–** Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery. • **Inpatient Rehabilitation–** Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility; limited to 60 days per calendar year). Requires prior authorization.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Specialty

- **Podiatry—** Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Surgical procedures other than in-office require prior authorization.
- **Physical and Occupational Therapy—**Combined 20 visits per year for habilitative and rehabilitative services. Prior authorization required on the 21st visit.
- **Speech Therapy—For children (ages 0-21**): Prior authorization required. The benefit limit is 20 visits per calendar year. For adults (21 and older): Limited to specific medical/surgical conditions and prior authorization is required.
- **Chiropractor—** Limited to manual manipulation of the spine and X-ray exam related to service. Any chiropractor properly qualified may engage in the use of physiotherapeutic devices, physiotherapeutic modalities, physical therapy and physical therapy techniques. Chiropractic, physical therapy (PT), occupational therapy (OT), and osteopathic manipulation are permitted when performed by a chiropractor for chronic pain management. Coverage is limited to (20) chiro/PT/OT/osteopathic manipulation combined visits per qualifying event (e.g., broken arm).
- **Handicapped Children's Services/Children with Special Health Care Needs Services—** Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist—**Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires prior authorization.

Preventive Care and Disease Management

- **EPSDT—** (ages 0-21) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require prior authorization.
- **Tobacco Cessation—**Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children.
- **Sexually Transmitted Disease Services—**Includes screening for a sexually transmitted disease from a PCP or a specialist in our network.
- **Preventive Screenings**
  - Annual pap smear for cervical cancer screening beginning at age 18, earlier if medically necessary.
  - Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year.
  - Prostate cancer screening: Beginning at age 50.
  - Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Maternity

- **Right From The Start—**Includes prenatal care and care coordination. Services covered through 12-month postpartum and infants less than one year old.
- **Family Planning—**Services to aid recipients of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered.
- **Maternity Care—**Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics

- Requires prior authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

Requires prior authorization for all visits. If the member revokes three times, the member is no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Prior authorization required prior to second certification period.

Dental

- **For children (ages 0-21)**
  - Must use participating practitioners (see provider directory or call Skygen Dental, 1.888.983.4698).
  - Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization.
- **For adults (21 and older)**
  - Must use participating practitioners (see provider directory or call Skygen Dental, 1.888.983.4698).
  - $1,000 benefit for preventive and restorative dental care
  - Emergency dental procedures
  - TMJ is not covered for adults.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Vision

- **For children (ages 0–21)**
  - Must use participating vision services practitioners. See provider directory or call Superior Vision.
  - Vision screening and therapy.
  - One eye exam covered once every 12 months.
  - Limited one frame per year.
  - Contact lenses covered for certain diagnoses.
  - Repairs.
- **For adults (21 and older)**
  - Adults limited to medical treatment only.
  - Refraction costs are covered as part of payment for exam.
  - Medical contact lenses for adults and children covered for certain diagnoses.
  - One pair of glasses up to 60 days after cataract surgery.

Diabetes Management

Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination. If annual exam reveals abnormal conditions, any follow-up appointment with a specialist will require prior authorization from the member's PCP.

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Hearing

- **For children (ages 0–21)**
  - Audiology screening/testing does not require authorization (only if referred by a PCP or ENT practitioner).
  - One hearing aid every five years.
  - Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures or devinces may have service limits or require prior authorization. Augmentation communication devices limited to children under 21 years of age and require prior approval.
- **For adults (21 and older)**
  - Requires prior authorization for functional testing for specific medical conditions.
  - Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility –** Includes services for children (up to age 21) with mental illness and substance use disorder. Limited frequency and amount of services. Certain services require prior authorization. Children's residential treatment is not covered.
- **Inpatient Psychiatric Services under age 21 –** Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization. Children's residential treatment is not covered
- **Inpatient Psychiatric Services for ages 21-64 –** Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization.
- **Outpatient –** Includes services for individuals with mental illness and substance use disorder. Providers of ACT and IOP must be certified by the BMS. Certain services require prior authorization. Most services may be provided by telehealth.
- **Psychological Testing–** Some evaluation and testing procedures have frequency restrictions.
- **Drug Screening –** Laboratory services to screen for presence of one or more drugs of use. Limits apply and prior authorization is required for some testing.
- **Substance Use Disorder (SUD) Services –** Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance use disorder. Prior authorization is required for some services.

Gender Affirmation Surgery

- **For members aged 21 and up for gender dysphoria**

Applied Behavior Analysis (ABA)

- For members with a primary diagnosis of Autism Spectrum Disorder
- ABA benefits can continue if treatment is determined medically necessary, continues to exhibit consistent progress at three-month intervals, and is in accordance with treatment plan requirements described in this policy guideline

*There are additional services on this list. If you have questions on whether a service is covered, please call THP at 1.888.613.8385.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.
Early Intervention Services for Children Three and Under
Nursing Facility Services – Includes nursing, social services, and therapy.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.
ICF/MR Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires physician or psychiatrist certification.
Prescription Drugs – Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor, Hepatitis-C, weight gain, cosmetic, hair growth, fertility, less than effective, and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.
School-based Services – Service limitations are listed in the fee for service Medicaid provider manual.
Transportation – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: 1.844.549.8353.

WVCHIP Benefits at a Glance

Benefit	Scope of Benefit
Allergy Services	• Testing and treatment for allergies Includes all testing and related treatment services
Applied Behavior Analysis (ABA)	For members with a primary diagnosis of Autism Spectrum Disorder
Ambulance Services	• Emergency ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary Facility to facility ground ambulance transportation service that are medically necessary are covered
Behavioral Health Outpatient Counseling	• Counseling for behavioral or mental health care needs by a licensed professional • Limited to 26 visits without prior authorization. Visit limit is inclusive of outpatient behavioral/mental health services, partial hospitalization, crisis stabilization, intensive outpatient treatment, and other BH/MH services.
Cardiac or Pulmonary Rehabilitation	• A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department Limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack occurring in the 12 months preceding treatment, heart failure, coronary bypass surgery, or stabilized angina pectoris
Chelation Therapy	For reduction of lead and other metals
Chiropractic Services	• Limited to manual manipulation of the spine and X-ray exam related to service. Limited to a maximum of 20 visits per qualifying event. Authorization required after 20 visits
Continuous Glucose Monitor	• For members with diabetes mellitus who often experience unexplained hypoglycemia or impaired awareness of hypoglycemia that puts them at risk or considered otherwise unstable. Covered per FDA age indications Devices that monitor glucose continuously.
Contraceptive Drugs and Devices or Birth Control	• Covered as appropriate per FDA guidelines for age or other restrictions • Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy • Includes, but is not limited to:

	○ IUD and IUCD insertions, or any other invasive contraceptive procedures/devices ○ Implantable medications ○ Hormonal contraceptive methods - oral, transdermal, intravaginal, injectable hormonal contraceptives ○ Barrier contraceptive methods – e.g., diaphragms/cervical caps • Emergency contraceptives – e.g. Plan B and Ella Over the counter contraceptive medications – e.g., anything with a spermicide, prescription required for coverage under FFS
Cosmetic/ Reconstructive Surgery	• Surgery to repair defects or injuries When required as the result of accidental injury or disease, or when performed to correct birth defects, such as cleft lip and palate
Dental Services	Services provided by a dentist, orthodontist, or oral surgeon. Members over 19 are limited to $1,000 per year for preventive dental care. Emergency care is separate from this limit.
Durable Medical Equipment and Related Supplies	• Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. For the initial purchase and reasonable replacement of standard implant and orthotic/prosthetic devices, and for the rental or purchase (at WVCHIP's discretion) of standard durable medical equipment, when prescribed by a physician For members who have received covered services from an out-of-state facility and require Durable Medical Equipment (DME)/medical supplies, Orthotics and Prosthetic devices and appliances, and other related services or items that are medically necessary at discharge, a written prescription by the respective out-of-state attending physician must be presented to a West Virginia provider for provision of services requested. This is required to assure the warranty is valid and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WVCHIP members. Other DME policies apply
Emergency Outpatient Services and Supplies	• Emergency outpatient services are covered Includes acute medical or accidental care provided in an outpatient facility, urgent care facility, or a provider's office
Foot Care	• Foot care services • Includes medically necessary foot care performed by a health care provider practicing within the scope of his/her license, including such services as: ○ Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exostosis ○ Removal of nail matrix or root ○ Treatment of mycotic infections

	○ Diabetic foot care (may include routine foot care) Surgical procedures other than in office require prior authorization
Hearing Services	• Hearing exams and hearing aids Includes annual examinations and medically necessary external hearing aids with prior authorization
HealthCheck	• Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT). • This includes periodic, comprehensive health examinations; developmental delay, vision, dental, and hearing assessments; immunizations; and treatment for follow-up of conditions found through the health examination as covered by WVCHIP HealthCheck requires standard health screening forms to be completed by providers at well-child exams. See dhhr.wv.gov/healthcheck/Pages/default.aspx for more information
Hemophilia Program	• WVCHIP has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide quality hemophilia services at a reasonable cost to WVCHIP members. Members who participate in the program will be eligible for the following benefits: • An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 100% with no copay. (This evaluation is not intended to replace, or interrupt care provided by your existing medical home provider or specialists) • Hemophilia expenses, including factor replacement products, incurred at CAMC or WVUH will be paid at 100% with no copay after prior authorization. • Lodging and travel ○ Lodging expenses for child and 1 or 2 adults/guardians incurred to enable the member to receive services from the Hemophilia Disease Management Program. Lodging must be at an approved travel lodge and will be covered at 100% of charge ○ Travel expenses incurred between the member's home and the medical facility to receive services in connection with the Hemophilia Disease Management Program. Gas will be reimbursed at the federal rate for one vehicle. Reimbursement of meal expenses up to $30 per day per person. Receipts are required for meal reimbursement Submit receipts to The Health Plan
Home Health Services	• Intermittent health services of a home health agency when prescribed by a physician

	Services must be provided in the home, by or under the supervision of a registered nurse, for care and treatment that would otherwise require confinement in a hospital or skilled nursing facility
Hospice Care	In-home care provided to a terminally ill individual as an alternative to hospitalization
Hyperlipidemia (High Cholesterol) Screening	• WVCHIP, along with HealthCheck, has adopted the American Heart Association's (AHA) guidelines regarding blood cholesterol screening for all children and adolescents • Beginning at age 2, WVCHIP recommends, but does not require, that all children and adolescents have a hyperlipidemia risk screening to determine their risk of developing high cholesterol. When one or more risk factors indicate the child is high risk, an initial measurement of total cholesterol can be obtained. Additional testing and follow-up should be based on total cholesterol levels, following the American Academy of Pediatrics' recommendations for cholesterol management
Immunizations for Children and Adolescents	• Standard immunizations for children and adolescents. • All age-appropriate vaccines through age 18 are covered as recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunizations. WVCHIP covers immunizations as part of an associated office visit to a doctor enrolled in the Vaccines for Children (VFC) program. See "Well Child Care" or the "Immunization Schedules" located at chip.wv.gov for more details. WVCHIP purchases vaccines from the State's VFC program. This program allows physicians to provide free vaccines to children. Members should receive vaccinations from providers that participate in this program Out-of-State vaccinations are not covered
Immunizations for Pregnant Members 19 and Over	• Immunizations for pregnant women over age 19 The following immunizations will be covered for members enrolled in the Pregnant Women's Program, unless contraindicated per the immunization guidelines: hepatitis A, hepatitis B, herpes zoster, human papillomavirus, influenza (flu shot), measles, mumps, rubella, meningococcal pneumococcal, tetanus, diphtheria, pertussis, and varicella as recommended by the American Academy of Family Physicians
Inpatient Hospital and Related Services	Confinement in a hospital including semi-private room, special care units, and related services and supplies during confinement
Inpatient Medical Rehabilitation Services	Services related to inpatient facilities that provide rehabilitation services
Iron-Deficiency Anemia Screening	• Anemia screening • WVCHIP, along with HealthCheck, requires that all infants are tested (hemoglobin and/or hematocrit) for iron-deficiency

	anemia at 12 months of age. Providers are encouraged to screen all infants and children at each well-child exam visit to determine those who are at risk for anemia • Those at high risk or those with known risk factors should be tested at more frequent intervals as recommended by the CDC This screening will also be covered as needed for pregnant women
Laboratory Services	• Laboratory and x-ray services provided in a facility other than a hospital outpatient department Including, but not limited to, iron deficiency anemia, lead testing, complete blood count, chemistry panel, glucose, urinalysis, total cholesterol, tuberculosis, etc.
Lead Risk Screen	• A lead risk screen must be completed on all children between the ages of 6 months and 6 years at each initial and periodic visit A child is considered high risk if there are one or more checked responses on the Lead Risk Screen and low risk if no responses are checked. Serum blood testing is required at 12 and 24 months and up to 72 months if the child has never been screened
Maternity Services **WVCHIP under age 19** **WVCHIP pregnant mothers over 19**	• Maternal care services including prenatal obstetrical care, midwife services, birthing centers, delivery, and postpartum care service. • WVCHIP pregnant mothers are only eligible for up to 12 months postpartum care • If a member is pregnant at the time of turning 19 and aging out of WVCHIP coverage, the member needs to contact DHHR to be evaluated for WVCHIP pregnancy coverage • Maternity services: Coverage includes but is not limited to two ultrasounds during a pregnancy without prior authorization; testing for Downs Syndrome, Associated Protein Plasma-A, etc., with prior authorization; and inpatient stays for vaginal/cesarean delivery, breast pumps and breastfeeding education Sterilization is covered for members over 19
Mental Health and Substance Use Disorder Services	• Mental health services • Substance use disorder services This may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (including a physician's office)
MRA/ MRI	Magnetic Resonance Angiography (MRA) services • Magnetic Resonance Imaging (MRI) services Requires prior authorization
Neuromuscular stimulators, bone growth stimulators, vagal nerve stimulators, and brain nerve stimulators	Stimulators for bone growth, neuromuscular, and vagal and brain nerves

Nutritional Counseling	Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires pre-authorization.
Nutritional Supplements	When it is the only means of nutrition and prescribed by your physician or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related
Oral Surgery	Only covered for extracting impacted teeth, medically necessary orthognathism (straightening of the jaw) and medically necessary ridge reconstruction
Organ Transplants	• Organ transplants are covered when deemed medically necessary and non-experimental, under fee-for-service Members that have received an organ transplant or are being evaluated for transplant will be transitioned to fee-for-service WVCHIP
Orthodontia Services	• Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development • Treatment is routinely accomplished through fixed appliance therapy and maintenance visits Comprehensive orthodontic treatment is payable once in the member's lifetime
Outpatient Diagnostic and Therapeutic Services	Laboratory and diagnostic tests and therapeutic treatments as ordered by your physician
Outpatient Hospital Services	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service
Outpatient Therapy Services: **Physical Therapy** **Occupational Therapy**	• Combined 20 visits per year for habilitative and rehabilitative services. Authorization required beyond 20 visits.
Speech Therapy	• Pre-authorization required. The benefit limit is 20 visits per calendar year. • For adults (21 and older): Limited to specific medical/surgical conditions and pre-authorization is required.
Pap Smear	Annual pap smear and the associated office visit to screen for cervical abnormalities
PET Scan	• Photo Emission Topography scan Prior authorization required
Professional Services	• Physician or other licensed provider for treatment of an illness, injury or medical condition Includes outpatient and inpatient services such as surgery, anesthesia, radiology, office visits, and urgent care visits

Skilled Nursing	Facility based nursing services to those who require 24-hour nursing level of care
Sleep Apnea	• Treatment for sleep apnea All sleep testing, equipment, and supplies are covered
Specialty Drugs (Physician Administered)	• * Specialty drugs for acute and chronic diseases Acute and chronic diseases such as rheumatoid arthritis, anemia, cerebral palsy, hemophilia, osteoporosis, hepatitis, cancer, multiple sclerosis, and growth hormone therapy are examples of conditions that specialty medications are covered
Substance Use Disorder (SUD) Residential Services	Residential treatment services to treat those with substance abuse. Prior authorization is required. Age 18 and older only.
Tobacco Cessation	• CHIP members may receive two 12-week treatment cycles per year. There is no limit on tobacco cessation counseling. THP will provide 100% coverage for the tobacco cessation benefit. THP will cover an initial and follow-up visit to the member's physician or nurse practitioner at no cost to the member Prescription drugs and aides covered under FFS outpatient pharmacy benefit
Transportation	WV CHIP covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.
Urgent Care and After-Hours Clinic Visits	A visit to an urgent care or after-hours clinic is treated as a physician visit for illness
Vision Services	• Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. • Covered benefits include annual exams and eyewear. Lenses/frames or contacts are limited to a maximum benefit of $125 per year. The year starts on the date of service. The office visit and examination are covered in addition to the $125 eyewear limit Services are limited to those aged 21 and over to just medical services.
Well Child Care	• A complete preventive care checkup includes, but is not limited to: o Height and weight measurement o BMI calculation o Blood Pressure Check o Objective vision and hearing screening o Objective developmental/behavioral assessment o Lead risk screen

	○ Physical examination ○ Age-appropriate immunizations as indicated by physician • Wellness visits are covered at: ○ 3-5 days after birth ○ 1 month ○ 2 months ○ 4 months ○ Every 3 months from 6 to 18 months ○ 24 months ○ 30 months ○ 3 years old ○ 4 years old ○ Annually after age 4 to 18 years old • Objective– developmental screening tool is to be administered to child at the 9, 18, and 30 months well child visits Objective– autism screening tool is to be administered to the child at the 18 and 24 months well child visits

Benefits Under Fee-for-Service WVCHIP
Abortion – Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.
Early Intervention Services for Children Three and Under
Tubal Ligation - Includes doctor and hospital charges.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Prescription Drugs – Please contact Express Scripts for any questions regarding prescription drug coverage.
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.
School-based Services – Service limitations are listed in the fee for service Medicaid provider manual.
Transportation – WV Medicaid covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.
Opioid Treatment Program - Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.

MHT Benefit Exclusions

Some services are not available through The Health Plan or Medicaid/WVCHIP. If a member chooses to get these services, the member may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- All non-medically necessary services.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Cosmetic/plastic surgery will be covered only to correct conditions from accidents/injuries like a car accident and birth defects like a cleft lip. Breast implants are covered only for mastectomy due to breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- Removal/replacement of breast implants must be proven medically necessary. Implants must have been inserted for reconstructive purposes due to mastectomy for breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- These conditions must have happened while you were a member of The Health Plan. If not, The Health Plan must determine an ongoing history of medically necessary cosmetic/plastic surgery to correct these conditions. The Health Plan may do so by looking at your past medical records.
- Removal of breast implants that were inserted for cosmetic reasons only will not be covered.
- Oral surgery for adults will be covered to correct conditions from accidents/injuries, like a car accident. The accident/injury must have happened *while* you were a member of The Health Plan. An oral surgeon *must* be needed to correct these conditions. These services must start within six months of the accident/injury.
- Custodial or home care, rest and respite care, or other services primarily to assist in the activities of daily living and personal comfort items (to include cleansing and luxury items). This includes personal services and residential services.
- Health care that is for research, investigation, or experimental as determined by The Health Plan. The Health Plan will look at standards of the AMA, FDA, NIH, Medicare, or reports of consultants to decide if a health care treatment is experimental or investigational.
- Private rooms are not paid for, except when medically needed and approved by The Health Plan. Personal or comfort items and services like guest meals, lodging, radio, television, and telephone.
- Hospital or medical care for problems that state or local law requires treatment in a public facility.
- Any injury or sickness when any benefits, settlements, awards, or damages will be received or paid. This also includes workers' comp, employer's liability or similar law or act. This applies even if you waived your rights to workers' comp, employer's liability, or similar laws or acts. Be sure to tell The Health Plan if you will get any benefits, settlements, awards, damages, or workers' comp.
- Reversal of voluntary sterilization and associated services and/or expenses.

- Sterilization for members under age 21.
- Special services not approved by The Health Plan.
- Provider and medical services outside the service area will not be paid for if you knew you would need these services before you left the service area. If you know you will need services and you may be traveling soon, tell your PCP or The Health Plan.
- Hearing aid evaluations, bone-anchored hearing aids, cochlear implants, hearing aids, hearing aid supplies, batteries and repairs will only be covered for members under the age of 21. Coverage depends on hearing loss and The Health Plan guidelines.
- Exams for insurance, sports physicals, camp physicals, or daycare physicals will not be paid for unless it is part of your yearly physical exam given by your PCP.
- Medical and surgical treatment for *all* infertility services.
- Abortions are covered by fee-for-service.
- Long-term cardiac and pulmonary, physical, respiratory, occupational or speech therapy will only be paid for in certain situations, such as for children.
- Services for acupressure, hypnosis, electrolysis, Christian Science treatment and autopsy. Any education or training classes including Lamaze and to quit smoking (unless under RFTS). Estrogen and androgen pellet implants, arch supports, massage, and paternity testing are not covered.
- Liposuction, panniculectomies or abdominoplasty, such as surgery to remove fatty tissue ("tummy tucks").
- Work hardening programs, including functional capacity evaluations.
- Services at non-medical weight loss clinics and diet centers, mini-gastric bypass surgery, and gastric balloon for treatment of obesity. Consideration for bariatric surgery and related services require prior authorization. Also included are wiring of the jaw, weight control programs, screening for weight control programs, and similar services.
- Organ transplants and related expenses are covered under FFS.
- Vision services for members over age 21 are limited to medical treatment only and require an approved referral to a participating ophthalmologist.
- Practitioner and medical services that are not medically necessary or appropriate as determined by The Health Plan will not be paid for.
- Other limitations specifically stated in the provider and medical benefits list in this handbook.
- Services not provided, arranged, or authorized by your practitioner, except in an emergency or when allowed in this policy. Elective pre-surgery testing on an inpatient basis without the authorization of The Health Plan's medical director.
- Sports-related devices.
- Acupuncture, unless it is for anesthesia used with a covered procedure.
- Services by a practitioner with the same legal address or who is a member of the covered person's family. This includes spouse, brothers, sisters, parents or children.

- Unlicensed services by a practitioner.
- War-related injuries or treatment in a state or federal provider for military or service-related injuries or disabilities
- Non-medical services related to the treatment of temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD). WV Medicaid covers TMJ for children up to age 21.
- If a member decides to get hospice services instead of medical treatment, the member gives up the right to other Mountain Health Trust (WV Medicaid) services for the terminal illness. Coverage continues for other medical conditions not related to the terminal illness.
- Sterilization of a mentally incompetent or institutionalized person.
- Inpatient tests not ordered by the attending practitioner or other licensed practitioner, except in cases of emergency.
- Therapy and related services for a patient showing no progress. Speech therapy for members ages 0-21 must meet criteria and be pre-authorized. Speech therapy for adults is not a covered benefit except when medically needed as a result of specific medical/surgical conditions such as ALS, cerebral palsy, stroke, or physical trauma.
- Non-emergency transportation is covered by FFS Medicaid.
- Services that, in the judgment of your practitioner, are not medically appropriate or not required by accepted standards of medical practice or the plan rules governing services
- Megavitamin therapy.
- Services performed after your physician has advised the member that further services are not medically appropriate or not covered services.
- Homeopathic treatments.
- Treatment for flat foot and subluxation of the foot are not covered.

*This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, the member may have to pay. If you have a question about whether a service is covered, please call 1-888-613-8385.

Additional Resources for Mountain Health Trust Members

Program	Description	MHT Population	Contact Information
Tobacco Cessation	The Health Plan's nationally certified ALA (American Lung Association) tobacco cessation facilitator engages and educates the member to assist in developing a member specific tobacco quit plan. The program addresses: • Developing a plan to quit • Getting support and encouragement • Learning new skills and behaviors • Getting medication, if necessary, to assist with quitting and how to take it correctly • Preparing for relapse and difficult situations	All	1.888.613.8385
Free Cell Phones for Medicaid Members	THP has partnered with SafeLink to offer the LifeLine program to our members at no cost. Members receive: • A smartphone with 1GB data and 1,000 monthly minutes • Unlimited text • Free calls to The Health Plan	Medicaid	1.877.631.2550 safelink.com Promo code: THPWV
Non-Emergent Transportation	• Members with Medicaid or WVCHIP may be eligible for transportation services • Members can contact NEMT broker to schedule a reservation	All	1.844.549.8353
Right From The Start Program (RFTS)	Statewide program that helps WV mothers and their babies lead healthier lives by offering home visitation services with a designated coordinator (RN or LSW)	All	wvdhhr.org/rfts
West Virginia Birth to Three Program	WV Birth to Three services are administered by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child and Family Health in cooperation with the Early Intervention Interagency Coordinating Council (ICC)	All	1.304.558.5388

Program	Description	MHT Population	Contact Information
Children with Special Healthcare Needs (CSHCN)	CSHCHN Program was created to assist families who have children with conditions that need special care	All	1.304.558.5388
Teladoc	24/7/365 access to providers for non-emergent issues	All	1.800.TELADOC (1.800.835.2362)

Physician and Practitioner Hours of Operation

Physicians and practitioners must ensure hours of operation for members' care are convenient, do not discriminate against members, and are no less than the hours of operation offered to commercial members or to Medicaid fee for service. Physicians and practitioners must ensure that waiting time to be seen is minimal that the MHT member waiting time standard is the same wait time standard for commercial members. Physicians and practitioners cannot discriminate against MHT members in the order that patients are seen, or in the order that appointments are given (meaning, physicians and practitioners are not permitted to schedule "Medicaid-only" days).

Cultural Competency, Implicit Bias, and Social Determinants of Health (SDoH)

Mountain Health Trust (WV Medicaid/WVCHIP) providers are required to perform healthcare services in a culturally competent manner to all members. This includes members with limited English proficiency and/or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of sex, sexual orientation, or gender identity.

To ensure that providers provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) provider education. THP's Cultural Competency/Social Determinants of Health Training is available on THP's provider portal Resource Library. THP's Practice Management Consultants (PMC) will discuss this cultural competency training during meetings with your office and are available for individualized education sessions. To request a training session, please contact your PMC.

HealthCheck (EPSDT)

Early and periodic screening, diagnosis, and treatment (EPSDT) are medically necessary services, including interperiodic and periodic screenings, listed in section 1905(a) of the Social Security Act. EPSDT entitles MHT-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of MHT-covered services listed in section 1905(a) of the Social Security Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.

EPSDT services should be provided to all children and young adults up to age 21. The provider should perform the screening (periodic, comprehensive child health assessments) for all eligible members.

EPSDT services should be regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

At a minimum, these screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development)
2. An unclothed physical exam
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the advisory committee on immunization practices
6. Hearing testing
7. Dental services (furnished by direct referral from a PCP to a dentist for children beginning six months after the first tooth erupts or by 12 months of age);The PCP must urge members to see their dental provider at least once every six (6) months for regular check-ups, preventive pediatric dental care, and any services necessary to meet the MEMBER'S diagnostic, preventive, restorative, surgical, and emergency dental needs.
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

It is important to document all the above on the member's chart or electronic health record (EHR) as well as referrals. The provider should submit an 837P or 1500 claim form with the appropriate diagnosis codes, and procedure codes and modifiers. **The EP modifier must be billed on all EPSDT services.** EPSDT claims are paid without any coordination of benefits. Further information including current EPSDT forms and periodicity guidelines is available at:

- dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx
- dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx

If the provider performs a well-child exam at the same time as a sick visit, please use the appropriate diagnosis, procedure, and modifier codes.

THP members receive a reminder notice that a well-child exam is due.

Medicaid Copays

Medicaid members have copays for select services. The following copays apply:

Service	Tier 1 Up to 50% FPL	Tier 2 50.01 to 100% FPL	Tier 3 100.01% of FPL
Inpatient hospital (acute care 11x)	$0	$35	$75
Office visit (physicians and nurse practitioners) (99201-99205, 99212-99215 only for office visits for new and established patients based on level of care)	$0	$2	$4
Non-emergency use of emergency department hospital only (Lowest level, 99282, of emergency room visits in hospitals. The definition of this visit is an emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making)	$8	$8	$8
Any outpatient surgical services rendered in a physician's office, ASC or outpatient hospital, excluding emergency rooms	$0	$2	$4

Members and providers can access copay and member eligibility information through the WV Medicaid Fiscal Agents AVRS system by calling 1.888.483.0793.

Maximum Out-of-Pocket (OOP):

Each calendar year quarter, members will have a maximum out-of-pocket (OOP) payment. The OOP is the most the member will ever be required to pay in any given quarter regardless of the number of health care services received. The following table shows the OOP for each tier level:

Tier Level	Out-of-Pocket Maximum
1 (Up to 50% FPL)	$8
2 (50.01 - 100% FPL)	$71
3 (100.01% FPL and above)	$143

Copayment Exemptions

As of January 1, 2014, some individuals who receive Medicaid services will be expected to pay copayments for certain services.

Exempt from the copayment requirements are:

- Behavioral health
- Pregnant women, including pregnancy-related services up to 12-month postpartum
- Children under age 21, and
- Native American and Alaska natives.

Services exempt from copayment include:

- Long term care
- Hospice
- Medicaid waiver
- Breast and Cervical Cancer Treatment Program
- Family planning, and
- Emergency services

Copayments are based on the member's level of income and may not exceed 5% of the member's household income. Providers may not deny services to individuals whose income falls below 100% of the federal poverty level due to their inability to make a copayment.

Medicaid Prescription Benefit

Pharmacy services for WV Medicaid managed care organization (MCO) members are administered by the traditional fee-for-service pharmacy program. All prescriptions should be billed with the information below:

- BIN 610164
- PCN DRWVPROD

Questions regarding claims processing should be directed to the Medicaid Fiscal Agent's POS Pharmacy Help Desk at 1.888.483.0801. Vendor specification document can be found on the West Virginia Medicaid Management Information System website for further information regarding claims processing.

WVCHIP Copays

WVCHIP members participate in some level of cost sharing (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives. **There are no copayments for maternity services or pregnant women 19 years of age or older.**

WVCHIP has three enrollment groups in the plan. Each enrollment group has a different level of cost sharing.

Medical Services and Prescription Benefits	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Generic Prescriptions	No copay	No copay	No copay
Listed Brand Prescriptions	$5	$10	$15
Non-listed Brand Prescriptions	Full retail cost	Full retail cost	Full retail cost
Multisource Prescriptions	No copay	$10	$15
Primary Care Physician Medical Home Physician Visit	No copay	No copay	No copay
Physician Visit (non-medical home)	$5	$15	$20
Preventive Services	No copay	No copay	No copay
Immunizations	No copay	No copay	No copay
Inpatient Hospital Admissions	No copay	$25	$25
Outpatient Surgical Services	No copay	$25	$25
Emergency Department (waived if admitted)	No copay	$35	$35
Vision Services	No copay	No copay	No copay
Dental Benefit	No copay	No copay	$25 copay for some non-preventive services

Note: Copayments are waived for all office visits to member's medical home.

Out of Pocket Maximums

The maximum copayment amounts applied during a benefit year are as follows:

# of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
1 Child Prescription Maximum	$100	$100	$150
2 Children Medical Maximum	$300	$300	$400
2 Children Prescription Maximum	$200	$200	$250
3 or more Children Medical Maximum	$450	$450	$600
3 or more Children Prescription Maximum	$300	$300	$350
Dental Services	Does not apply	Does not apply	$150 per family

WVCHIP Prescription Benefit

Pharmacy services for WVCHIP managed care organization (MCO) members are administered by the traditional CHIP pharmacy program via Express Scripts. All prescriptions should be billed with the information below:

- BIN 003858
- PCN A4
- RX Group WVCHIP1

Questions regarding claims processing should be directed to Express Scripts at 1.800.922.1557.

Mountain Health Trust Out-of-Network Non-Patient Facing Provider Reimbursement and Emergency Reimbursement

Effective August 1, 2019, services rendered by out-of-network non-patient facing providers will only be reimbursed if an authorization is obtained prior to the service being conducted. Reimbursement for services prior authorized to out-of-network non-patient facing providers will be at 80% of the current MHT fee schedule.

Failure to obtain prior authorization for any service performed by an out-of-network non-patient facing provider will result in claim denial.

Under federal law and WV State code, the MHT program prohibits balance billing by all practitioners, regardless of location. All out-of-network practitioners' claims for providing non-emergency medical services will be denied unless the services have been prior authorized.

Emergency out-of-network MHT-covered services are eligible for reimbursement. The documentation provided with the claim must clearly indicate an emergency situation existed.

The Health Plan may pay for covered services due to out-of-network hospital transfers if:

- Medically necessary services are not available in plan.
- WV Medicaid members are traveling outside the state and need emergency medical treatment.
- Services have been pre-approved by The Health Plan.

For documented emergencies, the member may be admitted without prior approval in-network or out-of-network, but the request for authorization and documentation must be submitted within 24 hours of admission.

WVCHIP Emergency Services by Non-Participating Providers

Covered Emergency Services by non-participating providers shall be subject to the minimum payment rate requirements paid by the WVCHIP fee-for-service program.

Family Planning

Family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

Family planning services may be obtained by a Mountain Health Trust member without a referral or prior authorization through any MHT family planning provider, regardless that family planning provider's THP participation status.

Family planning services include:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- History and physical exam
- Pap smear and lab tests if medically indicated as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STD) if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up and care for complications associated with contraceptive methods issued by the family planning provider
- Provisions for contraceptive pills, devices, and supplies (Depo-Provera injections are permissible, prescriptions are to be issued for contraceptive pills)
- Tubal ligation and vasectomies (consent forms required)
- Pregnancy testing and counseling
- Family planning provided at postpartum visits and/or discharge post-delivery (postpartum care should be provided within eight weeks of delivery)

Local Health Departments

THP contracts with West Virginia Health Departments to provide certain MHT services without a referral. These services include:

- All sexually transmitted disease (STD) services including screening, diagnosis, and treatment
- HIV services including screening and diagnostic studies
- Tuberculosis services including screening, diagnosis, and treatment
- Childhood immunizations
- Family planning
- HealthCheck

The Health Department should forward all records to the member's PCP and/or OB/GYN provider.

Environmental lead assessments for THP's pediatric members with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. THP is responsible for reimbursing those blood lead screenings.

Surgical Sterilization Consent Forms

THP, in accordance with WV Medicaid / WVCHIP guidelines, will continue to require state surgical consent forms for:

- Hysterectomy
- Voluntary sterilizations (male or female)
- Pregnancy termination

The surgical sterilization consent forms for voluntary sterilizations must be completed and signed by the WV Medicaid / WV CHIP member 30 days prior to the surgery. The consent form is valid for 180 days. THP does not need the surgical consent form.

Surgical sterilization consent forms are available at https://healthplan.org/providers/resources.

Effective July 1, 2020, THP will reimburse for tubal ligation regardless of the number of days from the members consent and the tubal ligation.

Pregnancy Billing and Newborn Enrollment and Billing

In accordance with the state of West Virginia requirements to effectively monitor and/or provide appropriate intervention during the member's antepartum, delivery, and postpartum period, THP adopted the state's pregnancy and newborn guidelines. THP requires all providers rendering antepartum care to submit the appropriate code for each encounter during the antepartum period; those antepartum services will be separately reimbursed. THP also requires separate billing for the delivery and postpartum services.

THP requires Prenatal Risk Screening Instrument (PRSI) to be completed upon the initial pregnancy encounter when the estimated confinement date (EDC) date is determined. Physicians and practitioners are asked to complete the PRSI and fax the completed form to THP at 740.695.5297.

The PRSI form is available on the West Virginia Department of Health and Human Resources' (DHHR) Office of Maternal, Child and Family Health website: wvdhhr.org "Office of Maternal Child & Family Health" "WV Prenatal Risk Screening Instrument Form."

Based on this screening tool, THP contacts members to begin tracking their pregnancy. THP expects an initial prenatal care visit to be scheduled within fourteen (14) days of when a THP member is found to be pregnant. Any member who has a high-risk pregnancy will be referred to the prenatal care coordinators who are nurses with obstetrics experience. If the member smokes, they are also referred to the tobacco cessation program. Outreach representatives monitor the low-risk pregnancies on a trimester basis. THP will encourage members to participate with the Women, Infant, and Children's (WIC) program.

When the THP MHT member gives birth, her newborn(s) is automatically covered from date of birth. THP's enrollment specialist calls new mothers in the hospital to enroll the newborn(s). The new mother is reminded to apply for a Social Security Number for the newborn and to select a PCP for the baby. THP will emphasize well-child visits and immunizations and will mail a newborn packet when mailing the newborn's member ID card.

THP's outreach representatives make postnatal contacts to mothers of newborns. This contact is done to remind the member to schedule a postpartum checkup within eight weeks of delivery and to review the Edinburgh Postnatal Depression Scale (EPDS) for postpartum depression. If the member has a high EPDS score, they are referred to THP's prenatal care coordinators who notify the member's OB provider.

Members qualify for THP's postnatal incentive plan by going to their postnatal appointment within 7-84 days after delivery.

Women's Access to Health Care

In accordance with the Women's Health and Cancer Rights Act of 1998, THP covers reconstructive surgery after a mastectomy under the same terms and conditions as other regular inpatient services under the Plan, and will include:

- Coverage for reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymph edema.

These services are in consultation with the attending physician and the member and approved as medically necessary and appropriate by THP.

THP allows women to have direct access to a range of women's health care providers, including obstetricians/gynecologists, advanced nurse practitioners, certified nurse midwives, and physician assistants. *This information is disclosed to members in the Member Handbook.*

An annual pap test and physical breast exam is encouraged for each member and may be done by the PCP and/or OB/GYN.

Tobacco Cessation

THP encourages members to participate in sponsored tobacco cessation classes which are free of charge. A staff member will provide the member with one-on-one personal support that can help him/her quit. Members can qualify for THP's tobacco cessation incentive by completing the THP-sponsored program.

Diabetes

THP covers Insulin pumps in specific medical cases. THP covers diet management and education. THP covers blood glucose monitors for diabetic members when a participating provider writes the order, and the monitor is obtained from a participating provider. For WV Medicaid, Continuous Glucose Monitors (CGMs) are covered under the fee-for-service pharmacy benefit. For WV CHIP, CGMs should be submitted as a medical claim to the Health Plan.

Diabetic members should have an annual health assessment, dilated eye exam, kidney testing, and fasting lipid profile. Quarterly visits are encouraged for foot exams, HbA1c, blood pressure, and diabetes education. The Health Plan sends diabetic members a yearly coupon as a reminder to have the dilated eye exam.

Medicaid Behavioral Health Services

THP provides behavioral health services as outlined in the Bureau for Medical Services (BMS) provider manual. BMS' provider manual may be accessed on the WV DHHR website.

The following BMS provider manual provide detailed information regarding services typically provided by behavioral health providers:

- Chapter 503: Licensed Behavioral Health Centers
- Chapter 504 Substance Use Disorders Services
- Chapter 510 Hospital Services
- Chapter 519: Practitioner Services
- Chapter 521: Behavioral Health Outpatient Services
- Chapter 522: Federally Qualified Health Centers and Rural Health Centers Services
- Chapter 523: Targeted Case Management and
- Chapter 531: Psychiatric Residential Treatment Facilities for Children Under 21

While THP will cover behavioral health services as required by BMS, THP and BMS may have differing prior authorization requirements. Please refer to THP's website for our prior-authorization list.

WVCHIP Behavioral Health Services

WVCHIP members do not need a referral for behavioral health services. THP's Member Services team can help families, primary care providers, or members locate behavioral health providers.

THP provides inpatient acute psychiatric care and outpatient behavioral health services to WV CHIP members. This benefit includes acute inpatient psychiatric care, outpatient mental health services, outpatient and residential treatment for substance use (alcohol and drugs) services and Applied Behavior Analysis. All providers must be fully licensed and credentialed by THP before providing services.

Billing must include the rendering provider on the claim.

Some services may require prior authorization. Please review the WVCHIP Behavioral Health Payment Policy located on the THP website.

Behavioral Health Services Not Covered:

- Any services that are covered by fee-for-service
- School-based services
- Children's Residential Treatment

If there is a mental health or substance use emergency, please call 911 right away.

Court Ordered Services

Medically necessary court ordered treatment services are covered by The Health Plan. Court ordered services are subject to WVCHIP medical necessity reviews and determination.

Mountain Health Trust Behavioral Health Billing Guidelines

THP requires credentialing of all licensed behavioral health practitioners operating within a physician's practice except LGSWs and LCSWs operating under the guidance of a medical professional (Medicaid) or unlicensed individuals operating in an Office Based Medication Assisted Treatment (OBMAT)program. For WV CHIP members, outpatient behavioral health services must be provided by a licensed medical or behavioral health practitioner who is credentialed by THP and listed as rendering provider on the claim. Please refer to Section ## for Behavioral Health Credentialing guidelines.

Unlicensed personnel may not bill for behavioral health services within a physician's practice except for supervised psychologists officially approved by the WV Board of Examiners of Psychology (Please see below for exceptions for OBMAT). THP will only reimburse supervised psychologists when providing services to our Medicaid members. A supervised psychologist must appear in the directory of the West Virginia Board of Examiners of Psychologists located on their website at psychbd.wv.gov/license-info/license-search.

All providers must be fully licensed and credentialed with THP to provide services to CHIP members.

Please note that this guideline does not apply to physician's offices within Licensed Behavioral Health Centers (LBHC). Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

THP, in conformity with Mental Health Parity rules, does not require prior-authorization for clinic-based behavioral health outpatient services. THP's prior- authorization list is available on the corporate website "For Providers" section.

THP defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP's Customer Service Department at 1.800.624.6961.

Medicaid

Chapter 519.2 and Chapter 521 of the Bureau for Medical Services (BMS) provider manual describes the circumstances under which a licensed behavioral health practitioner may provide services under the auspices of a physician's practice (these rules do not apply to physicians or practitioners employed by a licensed behavioral health center or an FQHC/RHC). The chapters are available on the WV DHHR's website. **For the purpose of this section only, physician is understood to include physician extenders such as APRN and PA.**

OBMAT programs properly certified/registered with the Office of Health Facility Licensure and Certification Exception

This exception applies to members with WV Medicaid coverage/benefits.

Physicians may have appropriately licensed behavioral health staff working under them to provide behavioral health services which include the following: Licensed Professional Counselor (LPC), Licensed Independent Clinical Social Worker (LICSW), Licensed Certified Social Worker (LCSW), Licensed Graduate Social Worker (LGSW), Supervised Psychologist and Licensed Psychologist (LP).

BMS does not specify that a licensed behavioral health practitioner must practice under the supervision of a psychiatrist, nor does it make any statement about the scope of practice of the supervising physician.

The following staff may bill for behavioral health services in a medical clinic setting:

- Licensed Psychologist
- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Practitioner (CNP)
- Physician Assistant-Certified (PA-C)
- Supervised Psychologist officially approved by the West Virginia Board of Pharmacy (WVBOP)
- Licensed Independent Social Worker (LICSW)Licensed Certified Social Worker (LCSW)Licensed Graduate Social Worker (LGSW)Licensed Professional Counselor (LPC)

WV Medicaid requires all staff, except for LCSW and the LGSW, bill under their own rendering National Provider Identifier (NPI), using procedure codes without a modifier.

Staff other than LCSW and the LGSW must be credentialed with THP before they can bill for services. The LCSW and LGSW may bill under the physician's NPI with an AJ modifier on the CPT code and do not need to be credentialed by THP.

Office Based Medication Assisted Treatment (OBMAT) programs (applies to WV Medicaid only): In those OBMAT programs that are properly certified/registered with the Office of Health Facility Licensure and Certification (OHFLAC) the following staffing requirements/permissions will apply. **These individuals may bill under the physician's NPI using the AJ modifier so long as the appropriate supervision requirements are met**:

The following are the minimum supervision requirements per degree/credential type:

- Bachelor's Degree in Human Services without Alcohol and Drug Counselor Credential*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.
- Master's Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.
- Doctoral Level, Non-Licensed*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

THP payment, authorization and approval methodologies conform to BMS requirements as stated in the manuals.

THP utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on CAQH or WV Department of Insurance.

The rendering provider is required to have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the NPPES website.

Commercial and self-insured policies may vary. Please call Behavorial Health customer services at 1.877.221.9295 with questions regarding these types of policy coverages.

THP will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan's Special Investigations Unit (SIU) for fraud, waste, and abuse. New network providers may be requested to submit planned procedures for prepayment review. Out of network providers are required to submit prior authorization for all services.

Medicaid Adult Dental

Dental Services: Adults age 21 and over

West Virginia Medicaid members age 21 and over qualify for $1,000 in preventive and restorative dental care. Any amount over $1,000 is the responsibility of the member. Providers may only bill members using the Medicaid fee schedule for any services rendered that exceed $1,000.

Skygen USA is THP's dental benefit administrator. Providers must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website skygenusa.com. Skygen's Provider Manual is available online.

In addition to preventive and restorative dental care, THP members have access to emergent procedures to evaluate and treat fractures, reduce pain, or eliminate infection (without financial cap applied). Specifically, fractures of the mandible and maxilla, biopsy, removal of tumors, and emergency extractions.

For a list of codes available under each benefit, view the BMS' Provider Manual Chapter 505 (Oral Health Services) section located at dhhr.wv.gov, then "Providers", then "Manual."

Prior authorization may be required for specific services and when service limits are exceeded. Please contact Skygen for a complete listing of codes requiring authorization, as well as any documentation requirements.

Dental services in a hospital setting

All procedures provided by a dentist or oral surgeon in a hospital setting require a prior authorization. Refer to the BMS website for covered oral health services for adults over the age of 21.

Medicaid Children's Dental

THP covers children's dental services (up to age 21). Skygen USA is THP's dental benefit administrator. Providers must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website skygenusa.com. Skygen's Provider Manual is available online.

Children's (up to age 21) dental services rendered in hospital setting require the dental provider

to obtain a prior authorization from Skygen USA. Skygen issues the prior authorization, the dental provider must contact THP at 1.888.613.8385 to obtain the prior authorization for the hospital services. THP prior authorization.

Oral Health Fluoride Varnish Program

Primary care providers may receive reimbursement for fluoride varnish application.

- Fluoride varnish is reimbursable to both ***medical and dental*** providers:
  - May be billed two times/year for each type of provider = four fluoride varnish treatments/year
  - Patient must be under 21 years old
  - Code may only be billed once within a six-month period per each type of provider
- **Medical Providers**
  - Bill procedure code 99188
  - Apply during time of well-child visit or health screening
  - Oral health risk assessment should be conducted prior to application
- **Dental Providers**
  - Bill procedure code D1206
  - Provide service at a dental visit
- **Topical application of fluoride** (excluding fluoride varnish)
  - Bill procedure code D1208
  - **CANNOT** bill D1206 with D1208

Additional information regarding this program is on the BMS website.

Immunization Registry

The West Virginia statewide immunization information system (WVSIIS) for all children, adolescents, and adults is a confidential, computerized information system to maintain immunization records. Children often receive immunizations from several providers which fragments the immunization record , causing missed doses or over immunization. The benefits of this registry are access to a current immunization record, better patient care, and higher immunization rates and less disease.

Childhood and adolescent immunization reviews should be done at well-child visits as well as during urgent problem-oriented visits.

For more information about this registry please call 1.877.408.8930 or visit the website at wvimm.org/wvsiis.

Appeals and Grievances

Complaints and Grievances

- The member can file a complaint, also called a grievance, at any time.
- If a member is unhappy with something that happened while receiving health care services, the member can file a complaint or grievance. Examples of why a member might file a complaint or grievance include:
  - The member is feeling they were not treated with respect
  - Unsatisfied with the health care received
  - It took too long to get an appointment
  - Disagreement with a decision that we made
- To file a complaint or grievance, the member should call The Health Plan at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, the member may fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003
- The member will need to send us a letter that has:
  - Name
  - Mailing address
  - The reason for filing the complaint and what the member wants The Health Plan to do
  - The doctor or authorized representative can also file a complaint or grievance for the member.

THP will notify the member when a complaint or grievance is received. THP will conduct a full investigation and issue a decision between 30 calendar days and 90 calendar days; at times, THP may ask for extra time before making a decision.

THP will provide translation services, as needed, at no cost to the member who wants to file a complaint or grievance.

Member Appeals

If a member believes his or her benefits were unfairly denied, reduced, delayed, or stopped, the member has the right to file an appeal with The Health Plan.

- To file an appeal, the member can call THP at 1.888.613.8385.
- To file an appeal in writing, the member can mail it to THP at 1110 Main Street Wheeling, WV 26003.
- The member will need to send us a letter that has:
    - Member name
    - Provider's name
    - The date of service
    - Member mailing address
    - The reason why we should change our decision
    - A copy of any information that supports the appeal, such as written comments, additional documents, records, or information related to the appeal
    - A doctor or authorized representative can also file an appeal for the member. THP will not take punitive action against providers who request an expedited resolution or support a member's appeal

If a member calls and gives an appeal over the phone, THP will acknowledge the appeal in a letter. A member must file an appeal within sixty (60) calendar days from the date on THP's notice of action.

THP will notify member their appeal was received. The member can obtain copies of documents, records, and information about the appeal without a charge. That information could include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits. A THP Appeals Committee will review the member's appeal. THP's Appeal Committee includes does not include individuals involved in the initial decision to not authorize or pay for the services. If the appeal involves a medical issue, the THP Appeals Committee will speak with a health care professional with the appropriate training and experience necessary for making the decision. THP identifies the following titles and qualifications for the Appeals Committee members:

- Medical Director(s) – board-certified practitioners (radiology, behavioral health, obstetrics/gynecology, and/or general surgeon with current state licensures)
- Nurse Navigator(s)_ – registered nurses with current state licensures.

THP must process and respond to the appeal within thirty (30) calendar days.

If THP needs more information for the appeal, or if the member wants to provide more information, either the member or THP can ask for fourteen (14) more calendar days to finish the appeal. If THP decides to extend the review time to finish the appeal, the member will be notified in writing within two (2) calendar days.

THP will continue benefits during the time of an appeal process.

Fast (Expedited) Appeals

If an appeal is about our decision to not approve or to not pay for some or all health care services, and the member needs an appeal decision fast, the member can ask for a fast appeal by calling THP at 1.888.613.8385.

The member must request the fast appeal within (60) calendar days of the denial date.

If THP allows a fast appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get the appeal. We will call the member twenty-four (24) hours after we get the appeal to let the member know the date, time, and place of the meeting. We will decide on the appeal no later than seventy-two (72) hours after receipt. If THP determines that an appeal is not a fast appeal, THP will provide the fast appeal request to the State so that they can determine a timeframe for resolution. The member will get a written notice explaining the next steps in the process.

To file a fast appeal, the member will need to provide us with:

- Member name
- Provider's name
- The date of service
- Member mailing address
- The reason why we should change our decision
- A copy of any information supporting the appeal, such as written comments, additional documents, records, or information related to the appeal

A member can file a Fast Appeal by either calling us, or mailing the information to:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone Number: 1.888.613.8385

If THP decides the appeal is not a fast appeal, then THP will handle as a normal appeal as described in the section above.

The member has the right to file a grievance if unhappy with the decision to deny the fast appeal.

THP will continue benefits during the time of an appeal process.

State Fair Hearing Process

If a member is not happy with THP's appeal decision, and the appeal is about our decision to deny, reduce, change, or terminate payment for health care services, a member can request a State Fair Hearing. A member can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. The member will receive a notice mailed within thirteen (13) calendar days before any action is taken. The member must request a State Fair Hearing within 120 calendar days from the notice of THP's appeal decision. The member may also request a State Fair Hearing if THP does not meet the timeframe for deciding on the appeal.

Send requests for State Fair Hearing to:

Medicaid State Fair Hearing	WVCHIP State Fair Hearing
Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301-3708	Bureau for Medical Services Attn: WV Children's Health Insurance Program Room 251, 350 Capitol Street Charleston, West Virginia 25301

The Bureau for Medical Services/WVCHIP' decision will be written to the member.

THP will continue benefits during the time of a State Fair Hearing when:

- The member or provider on a member's behalf file an appeal on a timely basis
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired, and
- The member requests an extension of benefits within thirteen (13) days of The Health Plan determination.

To request an extension of benefits, call 1.888.613.8385. THP will pay for the services in question when the result of the appeal is to overturn the original decision. THP will pay for some or all the services as determined by the final appeal decision. If the result of the appeal is to uphold the original decision to deny, reduce, change, or end payment for services, THP may recoup reimbursement for those services while the appeal was in process, and the member will be responsible for paying for the services.

Grievances and Appeals Records

THP will maintain member grievance and appeals documents, records, and information for ten (10) years.

Provider Reconsideration (Appeal)

If a provider does not agree with a THP claim denial, then the provider has the right to file a reconsideration (appeal). THP's Provider Reconsideration is a one-level appeal. A provider has the greater of 180 days from THP's original denial or 180 days from the date of service to request a reconsideration (appeal). To file a provider reconsideration (appeal), provider can call 1.888.613.8385 or contact their Practice Management Consultant.

Mountain Health Trust Members' Rights

THP members have rights around their health care and to receive information according to contract standards. Annually on April 1, THP submits an annual report to the Bureau for Medical Services (BMS) and WVCHI. This annual report includes a description of THP's services, personnel, and the financial standing .

The annual report is available to members by request. To get a copy of the report, members can call Member Services at 1.888.613.8385**.** Members can also get a copy of the report from BMS/WVCHIP.

Members have the right to:

- Ask for and obtain all included information
- Be told about their rights and responsibilities
- Get information about THP's services, providers, and their rights
- Be treated with respect and dignity
- Not be discriminated against by THP
- Access all services that THP must provide
- Choose a provider in THP's network
- Take part in decisions about their health care
- Refuse treatment and choose a different provider
- Get information on available treatment options or alternative courses of care,
- Get information presented in a manner appropriate to the their condition and ability to understand, regardless of cost or benefit coverage
- Have their privacy respected
- Ask for and to get their medical records within 30 days of request
- Ask that their medical records be changed or corrected if needed within 60 days of request
- Be sure their medical records will be kept private
- Recommend changes in policies and procedures, including, but not limited to, member rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are experiencing homelessness
- Refer themselves to in-network and out-of-network family planning providers

- Access certified nurse midwife services and certified pediatric or family nurse practitioner services

- Get emergency post-stabilization services
- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have their parent or a representative make treatment decisions when they can't
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of their member handbook annually after initial enrollment
- Disenroll from their health plan
- To exercise their rights. Exercising their rights does not adversely affect THP's treatment of the member
- Ask us about THP's quality improvement program and tell THP how they would like to see changes made
- Ask us about THP's utilization review process and tell us how you would like to see changes made
- Know the date they joined THP
- Know that THP only cover health care services that are part of their plan
- Know that THP can make changes to their health plan benefits after THP informs about those changes in writing
- Get news on how providers are paid
- Find out how THP decides if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost
- Use interpreters who are not your family members or friends
- Know they will not be held liable if THP insolvent
- Know their provider can challenge the denial of service with your permission

MHT Member Responsibilities

- Read through and follow the instructions in THP's member handbook
- Work with their PCP to manage and improve your health
- Ask their PCP any questions
- Call their PCP at any time when you need health care
- Give information about your health to THP and your PCP
- Always remember to carry your member ID card

- Only use the emergency room for real emergencies
- Keep their appointments
- If they must cancel an appointment, call their PCP as soon as possible to let him or her know
- Follow their PCPs recommendations about appointments and medicine
- Go back to their PCP or ask for a second opinion if they do not get better
- Call Member Services at 1-888-613-8385 whenever anything is unclear
- Treat health care staff and others with respect
- Tell THP right away if they get a bill they should not have gotten or if they have a complaint
- Tell THP and their Department of Health and Human Resources (DHHR) caseworker right away if they had a transplant or if they are told they need a transplant
- Tell THP and DHHR when they change your address, family status or other health care coverage
- Know that THP does not take the place of workers' compensation insurance

Provider Reporting Requirements

Reporting of Required Reportable Diseases

State law requires health care providers are required to report certain diseases. This is to allow for both disease surveillance and appropriate case investigation/public follow-up. THP may be responsible for (1) further screening, diagnosis, and treatment reportable diseases, as necessary to protect the public's health, or (2) screening, diagnosis and treatment of case contacts who are THP members. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health within the Department of Health and Human Resources.

The three primary types of diseases that must be reported are:

1. Division of Surveillance and Disease Control, Sexually Transmitted Disease Program.

   According to WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, sexually transmitted diseases (STDs) are required to be reported for disease surveillance purposes and for appropriate case investigation and follow-up. For contact notification, THP must refer case information to the Division of Surveillance and Disease Control. The Division has an established program for notifying partners of persons with infectious conditions. This includes follow-up of contacts to individuals with HIV and AIDS. Once notified, contacts who are members with THP may be referred for appropriate screening and treatment, if necessary.

2. Division of Surveillance and Disease Control, Tuberculosis Program.

   As per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, individuals with diseases caused by M. tuberculosis must be reported to the WV Bureau for Public Health, DSDC, TB Program for appropriate identification, screening, treatment and treatment monitoring of their contacts.

3. Division of Surveillance and Disease Control, Communicable Disease Program.

   As per WV Legislative Rules Title 6-4, Series 7, cases of communicable disease noted as reportable in West Virginia must be reported to the local health departments in the appropriate time frame and method outlined in legislative rules. This both provides for disease surveillance and allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc. (Note: Per legislative rule, reports of category IV diseases [including HIV and AIDS] are submitted directly to the state health department, not to local jurisdictions.)

Federal Reporting Requirements

THP must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to BMS/WVCHIP. (See BMS Physician Provider Manual for state requirements and procedures):

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F –Sterilizations. This includes completion of the consent form. Under WV 2020 Senate Bill 716 tubal ligation (or sterilization) may be provided without waiting 30 days after informed consent.

- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

Provider Reimbursement

Providers must inform members non-covered services costs prior to rendering non-covered services.

Providers are prohibited from collecting copays for missed appointments. Please remember that members are held harmless for the costs of all MHT-covered services provided, except for any cost-sharing obligations.

Providers are required to treat all information obtained through the performance of the services in THP contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations.

THP does not discriminate against providers acting within the scope of their license. Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of a member's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the member needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.

THP may not make specific payments, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular member. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

THP will provide information to members regarding their rights and responsibilities and any changes upon enrollment, annually, and at least 30 days prior to any change in their benefits.

Provider Fee Schedule Changes

In accordance with THP's contract with BMS, THP will update provider fee schedules as follows:

Federally Qualified Health Center / Rural Health Center (FQHC/RHC)

Upon BMS/WVCHIP notification to THP of any changes to the FQHC/RHC reimbursement rates, THP must update payment rates to FQHC/RHCs to the effective date in the notification by BMS/WVCHIP. THP must pay the new rate for any claims not yet paid with a date of service on or after the effective date of change. If payment has already been made for a claim within the current state fiscal year with a date of service on or after the effective date of the rate change, THP must reprocess the claim to reimburse at the new rate. The new payment rate must be loaded into The Health Plan's claims payment system within thirty (30) calendar days of notification of the payment rate change.

THP must offer FQHCs and RHCs terms and conditions, including reimbursement, which are at least equal to those offered to other providers of comparable services.

Critical Access Hospital (CAH)

Upon BMS/WVCHIP notification to THP of any changes to the CAH reimbursement rates, THP must update payment rates to CAH effective from the designated CMS effective date. THP must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The new payment rate must be loaded into THP's claims payment system within thirty (30) days of notification of the payment rate change.

Other Fee Schedules

THP is required to implement any rate changes adopted by BMS/WVCHIP within thirty (30) calendar days of notification of the rate change. THP must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. THP must reprocess any claims paid between the notification date and the system load date to the updated rate.

Provider Overpayments

THP is responsible to recovery all overpayments, including those due to fraud, waste, and abuse. In the event THP makes an overpayment to a provider, THP must recover the full amount of the overpayment from the provider. This recovery will be administered through the claims system by offsetting the overpayment against future claims payments.

Providers are required to notify THP in writing of self-identified overpayment and return the full amount to THP within 60 calendar days of when the overpayment was identified.

In some situations, BMS/WVCHIP reserves the right to collect overpayments. If this were to occur, BMS/WVCHIP will directly notify the provider. The provider's appeal rights in the event of BMS collecting an overpayment directly from the provider are outlined in the BMS Policy Manual, chapter 800(B).

Alternative Payment Models (APMs)

THP collaborates with providers to develop APMs to best fit for the providers and members needs.

THP's APM include:

- Care coordination payments
- Pay for quality
- Pay for reporting
- Shared savings, upside only

THP will consider other APMs in the future, such as shared savings, upside and downside, or full risk, based on provider readiness.

Marketing Guidelines

THP may conduct general advertising that does not specifically solicit the MHT population. THP must submit marketing plans to BMS/WVCHIP for prior written approval.

Prohibited Marketing Practices

The following prohibitions are applicable to The Health Plan, its agents, subcontractors, and The Health Plan providers:

1. Distributing Marketing materials without prior BMS approval;
2. Distributing Marketing materials written above the sixth (6th) grade reading level (Grade 6.9 or below), unless approved by BMS;
3. Making any assertion or statement (orally or in writing) that the MCO is endorsed by CMS, a federal or state government agency, or similar entity;
4. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO's plan or the Medicaid and WVCHIP program, services, or benefits;
5. Making false, misleading, or inaccurate statements relating to services or benefits of the MCO or Medicaid and WVCHIP program, or relating to the providers or potential providers contracting with the MCO;
6. Using the word, "Mountain," or phrase, "Mountain Health," except when referring to Mountain Health Trust or other State programs;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Direct Mail Marketing to potential enrollees.
9. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities;
10. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
11. Inducing or accepting an enrollee's MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential enrollees to contact the MCO, rather than the Enrollment Broker, for enrollment;
13. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to BMS;
14. Portraying competitors in a negative manner;
15. Referencing the commercial component of the MCO in any Marketing materials;
16. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone, or electronic means of communication;
17. Influencing enrollment in conjunction with the sale or offering of any private insurance;

18. Tying enrollment in the Medicaid/WVCHIP MCO with purchasing (or the provision of) other types of private insurance;

19. Charging enrollees for goods or services distributed at MCO or Medicaid/WVCHIP events;
20. Charging enrollees a fee for accessing the MCO's website;
21. Using marketing agents who are paid solely by commission;
22. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying BMS' contractors or Subcontractors to send plan specific materials to potential enrollees;
23. Assisting with Medicaid/WVCHIP MCO enrollment form;
24. Conducting potential enrollee orientation in common areas of providers' offices;
25. Posting MCO-specific, non-health related materials or banners in provider offices;
26. Allowing providers to solicit enrollment or disenrollment in an MCO or distribute MCO-specific materials at a Marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);
27. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential or current enrollees;
28. Offering gifts valued over $15 or $75 annually to potential enrollees;
29. Making potential enrollee gifts conditional based on enrollment with the MCO;
30. Discriminating against an enrollee or potential enrollee because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to enrollees with certain diagnoses;
31. Failing to provide an opt-out option in SMS/text message materials.

Social Media Marketing Guidelines

THP must comply with the following social media marketing guidelines: p

The following list is applicable to THP, its agents, subcontractors, and providers:

1. Upon BMS/WVCHIP approval, THP may engage in forms of social media advertising (i.e. Twitter, Facebook, Instagram)
2. Upon BMS/WVCHIP approval, THP may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution
3. THP may post Medicaid/WVCHIP events on social media sources. The content of such posts must be approved by BMS/WVCHIP approval prior to posting
4. THP may post general non-advertising information regarding The Health Plan activities. The content of such posts does not require BMS/WVCHIP prior approval, and

5. Any member complaints received through social media sources must be processed and resolved through the general complaint intake system.

Social Media Prohibitions

The following prohibitions are applicable to THP , its agents, subcontractors, and providers:

1. Posting or sending personal or protected private health information on social media
2. Advertising on social media platforms that entail direct communication with potential members. This list includes, but is not limited to: Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services
3. Responding to any comments on social media posts from potential members except when to provide a general response, such as giving a phone number or link to a website or the enrollment broker phone number
4. Partaking in individual communication on social media outlets
5. Requesting followers or adding individuals as friends or tagging individuals on social media sources (i.e., Facebook, Instagram, Twitter)
6. Tagging individuals on social media

Reporting and Investigating MCO Marketing Violations

THP's process to ensure fair and consistent investigation of alleged violations of BMS/WVCHIP marketing policies is:

Upon written receipt of any alleged violation(s) from BMS/WVCHIP, THP must:

1. Acknowledge receipt, in writing, within one (1) business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to BMS/WVCHIP.

West Virginia MHT Provider Required Provisions

THP is contracted with West Virginia Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (CHIP). The West Virginia Mountain Health Trust Program requires specific contractual provisions for all contracted providers that participate with the West Virginia Mountain Health Trust program or choose to provide services to West Virginia Medicaid and WVCHIP recipients on an intermittent basis. In addition to the terms contained within the Agreement, the following provisions are applicable specifically to Facility, Physician, Practitioner, and Ancillary Medical Care Providers that provide services to West Virginia MHT recipients.

A. Obligations of Emergency Care Providers

- Emergency Care Providers must provide education to MHT members regarding the cost of their copay for non-emergency services received in the Emergency Department, including alternate locations where non-emergency can be obtained.

B. Obligations of Providers with Respect to Member Copays

- Enrollees will be held harmless for the costs of all MHT-covered services provided except for applicable cost-sharing obligations. Providers must inform members of the costs or non-covered services prior to rendering such services.
- Providers agree that THP's members may not be held liable for THP's debts in the event of THP's insolvency.
- In accordance with the regulatory requirements promulgated by BMS, providers may not routinely waive required copays.
- Providers may not charge a copay for the following services:
  - Family Planning Services
  - Emergency Services
  - Behavioral Health Services
  - Members under age 21
  - Pregnant women (including postpartum visit)
  - American Indians and Alaska Natives
  - Members receiving hospice care
  - Members in nursing homes
  - Other services excluded under State Plan Authority
  - Members who have met their maximum cost sharing obligation per quarter; or
  - Missed appointments.

- Providers must charge a copay for the following:
  - Inpatient and Outpatient Services
  - Physician office visits
  - Non-emergency use of an Emergency Department
  - Caretaker relatives age 21 and above
  - Transitional Medicaid members age 21 and above; and
  - Other members identified by THP not specifically exempt.

C. Other Obligations of Provider

- Physician may not refuse to furnish covered services to the eligible member on account of a third party's potential liability for the service(s).
- Physician agrees to comply with THP's Quality Assurance/Performance Improvement (QAPI) Program requirements.
- Providers that order, refer, or render covered services must enroll with BMS/WVCHIP, through the fiscal agent, as a Medicaid/CHIP provider, as required by 42 CFR 438.602(b). Enrollment with BMS does not obligate provider to offer services under the BMS fee-for-service delivery system. THP is not required to contract with a provider enrolled with the West Virginia Bureau for Medical Services/CHIP that does not meet THP's credentialing or other requirements.
- Provider must attest to the following certification for claims for MHT goods and services:
  - All statements are true, accurate, and complete
  - No material fact has been omitted
  - All services will be medically necessary to the health of the specific patient; and
  - The provider understands that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.
- Providers shall maintain malpractice insurance with minimum coverage requirements of $1 million per episode and $1 million in aggregate.
- Provider shall supply a certification that neither provider nor provider's director(s), officer(s), principal(s), partner(s), managing employee(s), or other person(s) with ownership or control interest of five percent (5%) or more in provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement. This certification shall state that all persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program.

Provider shall notify THP immediately at the time it receives notice that any action is being taken against a physician or any other person above, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

- Primary Care Physicians must comply with timeliness of access standards as defined by BMS/WVCHIP.

D. THP's Reimbursement Responsibilities

- THP is solely responsible for payment of covered and authorized services to West Virginia MHT recipients as long as the member is eligible for services on the date of service. Provider shall not seek reimbursement directly from West Virginia Bureau for Medical Services.
- The reimbursement terms for West Virginia MHT recipients are set forth in the Provider's Master Agreement.
- THP will not make specific payment, directly or indirectly, to provider as an inducement to reduce or limit medically necessary services furnished to any particular member.

E. Reporting Actions against Physician, Owners, or Others

- Provider must notify THP immediately after it receives notice that any action is being taken against provider or any physician, owners, persons with control interest, managing employees, partners, directors, and officers, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. The provider must agree to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

F. Compliance with Health Insurance Portability and Accountability Act

- Provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931, et. seq. Provider must treat all information that is obtained through the performance of the services contemplated by the agreement, including this amendment, as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This expectation of confidentiality shall include, but is not limited to, information relating to applicants or members of BMS/WVCHIP programs.

G. Compliance with Deficit Reduction Act Requirements

- Provider must comply with the Section 6032 of the Deficit Reduction Act of 2005 and the SMDL 06-024. If provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the provider must:
    - Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of physician. The policies must provide detailed information

about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

- Include as part of such written policies detailed provisions regarding the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

H. Required Disclosures by Provider

- Provider shall provide THP and BMS/WVCHIP with all information requested of provider, including required disclosures regarding ownership and control, in accordance with 42 CFR § 455.104. In addition to any other information requested by THP or BMS/WVCHIP, provider shall disclose the name and address of any person (individual or corporation) with an ownership or control interest in provider. In the case of individuals, such required information shall include date of birth and Social Security number for each individual having an ownership or controlling interest in Provider.

  Consistent with 42 CFR § 455.101, THP defines "ownership interest" and "ownership" as follows:

  - Ownership interest means the possession of equity in the capital, the stock, or the profits of provider.
  - Person with an ownership or control interest means a person or corporation that:
    - Has an ownership interest totaling 5 percent or more in a disclosing entity;
    - Has an indirect ownership interest equal to 5 percent or more in provider;
    - Has a combination of direct and indirect ownership interests equal to 5 percent or more in provider;
    - Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
    - Is an officer or director of a provider practice that is organized as a corporation; or
    - Is a partner in a provider practice that is organized as a partnership.
- In addition to the required ownership and control disclosures required by 42 CFR 455.101, provider shall disclose the name of any other Medicaid-recipient organizations in which any of its owners have an ownership or controlling interest, as required by 42 CFR 455.104(b)(3).

- A provider that is a business entity, corporation, or a partnership must disclose the name, date of birth, Social Security number, and address of each person who is provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider or in the provider's subcontractor.

  The address for corporate entities must include, as applicable, primary business address, every business location, P.O. Box address, and tax identification number.

- Provider must provide information on the interrelationships of persons disclosed per 42 CFR § 455.104(b). This required information includes whether the person (individual or corporation) with an ownership or control interest in provider is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which provider has a 5 percent or more interest is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling.

- Provider agrees to keep its disclosed information regarding ownership and control current at all times by informing THP, in writing, within thirty-five (35) calendar days of any ownership or control changes.

- Provider must disclose any significant business transactions, in accordance with 42 CFR § 455.105. Provider is required to disclose full and complete information about the following information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS or BMS/WVCHIP:

  - The ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during the previous 12-month period; and

  - Any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor, during the previous five (5) years.

- Provider must disclose any healthcare-related criminal convictions, in accordance with 42 CFR § 455.106, of any physician or provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in provider, relating to Medicare, Medicaid, or Title XX programs. These disclosures are required at the time that provider applies or renews its applications for Medicaid participation or at any time on request. Provider must notify THP immediately at the time provider receives notice of any such conviction. For purposes of this amendment and the underlying agreement, and consistent with 42 CFR § 1001.2, "Convicted" shall mean:

  A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

  - There is a post-trial motion or an appeal pending, or

  - The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

  - A Federal, State or local court has made a finding of guilt against an individual;

- A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
- An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

- Provider shall report to THP all provider-preventable conditions associated with claims.

I. Maintenance and Access of Records

- If provider places required records in another legal entity's records, such as a hospital, the provider shall be responsible for obtaining a copy of these records for use by the government entities or their representative.
- Provider must provide to BMS/WVCHIP:
  - All information required under THP's managed care contract with BMS/WVCHIP, including but not limited to the reporting requirements and other information related to a provider's performance of its obligations under its provider contract with THP; and
  - Any information in provider's possession sufficient to permit BMS/WVCHIP to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. If provider places required records in another legal entity's records, such as a hospital, provider is responsible for obtaining a copy of these records for use by the above-named entities or their representative.

J. Use of Information Obtained Through Agreement

- The provider shall not use information obtained through the performance of THP agreement, or this amendment, in any manner except as is necessary for the proper discharge of obligations and securing of rights under the agreement.

K. Prohibition against Direct Marketing

- Provider is prohibited from engaging in direct marketing to members that is designed to increase enrollment in THP. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

L. Non-Interference with Rights of THP and the State

- Provider shall take no actions that interfere with or place any liens upon the State's right or THP's right, acting as the State's agent, to recovery from third-party resources.

M. Compliance with Advance Directives Requirements

- Provider shall comply with 42 CFR § 422.128 and West Virginia Health Care Decisions Act relating to advance directives.

N. Right to Recover Overpayments from Provider

- Provider shall notify THP, in writing, of any overpayment discovered by Provider. This required notification shall include the reason for any overpayment. Provider shall return the full amount of the overpayment to THP within sixty (60) calendar days after the date on which the overpayment was identified.
- BMS/WVCHIP has the right to recover provider overpayments, including those overpayments due to Fraud, Waste, and Abuse, from provider if:
  - BMS/WVCHIP or its contractor identifies an overpayment made by THP to provider
  - The payment occurred outside the grace period, as defined by BMS/WVCHIP
  - THP has not previously identified the overpayment via the deconfliction process outlined herein
  - The Medicaid Fraud Control Unit (MFCU) or other law enforcement entity is not pursuing provider, and
  - BMS/WVCHIP, in its sole discretion, determines it is unable to collect from THP.
- THP may seek recoupment of payments for up to twenty-four (24) months from the date of service of the claim, per its agreement with BMS. For fraud, waste or abuse claims, there is no time limit on recoveries.
- In the event the State collects overpayments directly from provider, provider's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.

Medicaid Drug Testing Policy

THP's policies regarding drug testing are guided by the American Society for Addiction Medicine. Please consult the ASAM White Paper on drug screening on the THP website at www.healthplan.org for further clinical guidelines on use of definitive/definitive drug testing.

- WV Medicaid coverage will be based on WV Bureau of Medical Services (BMS) Policy and Medical Review Criteria. https://dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx
- WV BMS has established specific limitations on number of services that may be covered for specific timeframes of treatment without further authorization. For additional information go to: https://dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx
- THP's prior authorization form must be completed to assist in reviewing the indication and medical necessity of the testing requested.
- Limitations in number of services during management of both addiction treatment and pain management will be based on the guidelines as cited above. Additionally, to assure medically appropriate services are provided, prior authorization will be required as follows:

- Presumptive tests - more than 24 in a contract year require prior authorization. Please note the minimum eight required panels delineated in Chapter 503 of the BMS manual;
- Definitive tests, –are limited to twelve (12) per calendar year without authorization.
- Effective January 1, 2023, HCPCS codes G0481, G0482, G0483 and G0659 definitive tests will require prior authorization and medical necessity review from the initial service.

All drug testing as part of pain management and/or substance use treatment/recovery is a clinical determination and should influence the treatment plan, be based on the stage of treatment and patient presentation, and the medical necessity should be supported in the clinical record.

Medical Necessity Documentation Guidelines

All Drug screenings must be ordered by the treating practitioner operating within his/her scope of practice.

Presumptive testing (CPT codes 80305-80307) is a routine part of initial and ongoing patient assessment.

- Phase of treatment
    - beginning or induction phase - usually less than 30 days of abstinence
    - middle or stabilization phase – usually 31 – 90 days of abstinence
    - maintenance phase - > 90 consecutive days of abstinence
- Baseline screening before initiating treatment or at the time treatment is initiated (i.e., induction phase), once per program entry when the following are met:
    - A clinical assessment of member history and risk of substance abuse is performed;
    - The clinician has a working knowledge of basic test interpretation and
    - There is a plan in place regarding how to use test findings clinically.
- Additional presumptive testing throughout the Stabilization phase and Maintenance phase may be appropriate to monitor adherence and progression.
- Documentation must support how results will have an impact upon treatment.

Definitive testing techniques (HCPCS codes G0480-G0483, G0659) are intended to be used when a provider wants to detect specific substances not identified by presumptive methods and quantify levels of the substance present.

Definitive testing techniques may be indicated in the following clinical situations:

- When the results inform clinical decisions with major clinical or non-clinical implications for the patient (e.g., treatment transition, changes in medication therapies, changes in legal status).
- If a patient disputes the findings of a presumptive test
- When ordering a definitive test, providers should advise the testing laboratory if the presence of any particular substance or group of substances is suspected or expected. Not all laboratories

automatically perform a definitive test of positive presumptive results (the common term for this is "reflex" testing); providers should be aware that laboratories may require a specific order for definitive testing.

- Definitive testing should not be performed to confirm substances that are expected to be present on a presumptive test that would provide limited clinical value (e.g., testing for THC levels after a member admits to regular cannabis use.)

Documentation of medical necessity for definitive drug testing should be individualized. Medical necessity of definitive drug testing used in treatment of substance use disorder is based on the following information that should be clearly evident in the medical record.

Stage of treatment

- beginning or induction phase - usually less than 30 days of abstinence
- middle or stabilization phase – usually 31 – 90 days of abstinence
- maintenance phase - > 90 consecutive days of abstinence

Unusual circumstance such as initial treatment or relapse;

Exam findings, including the following:

- Documented recent substance use

- Patient disclosed use
- Identification of whether the testing was random or scheduled
  - Presumptive test findings
  - If the presumptive test is negative, what signs and symptoms are present during the visit that raise suspicions to justify definitive testing
  - List of the medications and herbal products the patient is taking that may lead to "false positives" on the presumptive tests.

A description of how the results will modify the treatment plan as follows, including:

- Impact on level of care
- Continuation / discontinuation from treatment program
  - Of note, if the definitive test results will not impact the treatment plan, the ordering of the expanded testing is questionable.

Number of drug classes being assessed should correlate with regional exposure and known history of drugs of abuse

Limitations and Exclusions:

Limitations and exclusions in coverage are based on CMS and/or West Virginia BMS established guidelines.

Standardized statements of need for definitive testing in the file/electronic health record are not acceptably individualized clinical justification for the tests.

THP does not reimburse testing ordered for the purpose of employment screening or satisfaction of a court order.

Participation in an OBMAT or other substance use treatment program is not in and of itself justification for ordering definitive tests.

"History of SUD/OUD" is not in and of itself justification for ordering definitive tests (exception being the initial testing done when the member enters the program).

Pregnancy Testing

Participation in an office-based Medication Assisted Treatment (OBMAT) program is not in and of itself sufficient justification for frequent pregnancy screening. THP defines frequent pregnancy screening as more than once per month.

Medical necessity criteria for pregnancy testing in an OBMAT program for substance use disorder (SUD) includes:

- The patient is female, not postmenopausal nor has a confirmed pregnancy
- The visit is an initial screen for entry into the practice; and/or
- The patient has a history of engaging in high-risk heterosexual behavior (claim billed with ICD-10 diagnosis code Z72.51 and the provider has documented high-risk behavior in the medical record); and/or
- The patient is complaining of symptoms possibly suggestive of pregnancy; and/or
- The patient has reason to express concerns that she may be pregnant; and/or
- The patient requires medical clearance for some type of procedure or medication which may be potentially harmful to the fetus; and/or
- The patient requests pregnancy testing

Providers should judge for themselves their degree of comfort with treatment agents containing both Naloxone and Buprenorphine and order testing, accordingly, documenting the need for such testing in the clinical record.

Breathalyzer

THP will deny all breath alcohol testing (82075) performed in conjunction with any urine drug screen other than dipstick point of care testing (POCT) (80305). Providers using more complex urine drug testing such as 80307 or a definitive screen are encouraged to include alcohol as a screened substance. Breathalyzer testing should be performed only if the member:

- Has a history of alcohol use that is not currently controlled; or
- The member appears intoxicated or smells of alcohol and denies alcohol use.

Automatic use of breathalyzer testing without justification may be reviewed and denied if not deemed medically necessary.

Oral Fluid Testing

According to Medicare guidance on drug screening, "Urine or oral fluid is the preferred biologic specimen for testing because of the ease of collection, storage, and cost-effectiveness."

Oral fluid methods of point of care testing have proven to be 97 to 99% effective in detection of most drugs utilized within 5 to 48 hours of the test. Oral fluid testing has, in some research, proven to produce fewer false positive results than similar urine point of care testing. The methodology is painless and non-invasive, respecting the member's right to privacy while honoring the provider's need for accurate, observed samples. Oral fluids have reliably proven to be harder to tamper with than similar urine point of care testing. Positive results will appear immediately after use whereas urine tests require that the body metabolize the substance prior to becoming evident in urine POC sampling.

Providers electing to utilize the oral fluid method of drug screening must comply with the following:

- Members must be continuously observed for 10 minutes prior to the sample collection.
- The member may not consume any fluid or food during that time, nor may the member chew gum, smoke, rub tobacco, or introduce any foreign material into their mouth during the 10-minute observation.
- The provider must document the methodology utilized for the screen (oral vs urine).
- Only FDA approved equipment/tests may be utilized.
- Breathalyzer (82075) may not be billed at the same date of service as the oral fluid panel.
- Billing code 80305 (Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges), includes sample validation when performed, per date of service) is to be used for this point of care screening.

Transplant Services

Members receiving transplant services, with the exception of retinal transplants, are exempt from managed care.

Prior Authorization

Effective January 1, 2017, all providers are required to request prior authorization before a service is rendered. This requirement includes both outpatient and inpatient services. If service is rendered after hours, over the weekend or on a holiday, providers are required to request authorization the next business day. Prior authorization requests received after the next business day will not be processed. Failure to follow prior authorization guidelines will result in denied claims.

Medicaid Chiropractic Service

Manipulation and X-ray procedure codes along with 99201, 99202, and 99203 will be covered per contract. Effective April 1, 2020, physical therapy codes have been added as a covered service. Benefit limits are still in effect.

Physical and Occupational Therapy

Therapy codes are not payable without one of these modifiers to distinguish the discipline of the plan of care under which the service is delivered.

- **GO**: Indicates services delivered under an outpatient **occupational** therapy plan of care
- **GP**: Indicates services delivered under an outpatient **physical** therapy plan of care

Inpatient Claims

Effective July 1, 2017, THP began processing payments for inpatient admissions based on the discharge date of the inpatient stay. This affects any claim for an inpatient admission where the reimbursement terms of our contract are based upon a DRG, case rate, per diem or percent of billed charges methodology.

Medicaid NDC Rebate Eligible Drugs

THP will not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the department's outpatient drug pharmacy program.

In accordance with 42 U.S.C. § 1396r-8, THP must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. THP is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The Medicaid drug rebate program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) which added Section 1927 to the Social Security Act and became effective on January 1, 1991. The law requires that drug manufacturers enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

Drugs administered by the physician and billed with an NDC must be rebateable to be eligible for payment, otherwise the drug will be denied. Providers can refer to the CMS website to determine if an NDC is manufactured by a company that participates in the federal drug rebate program or consult your wholesaler for assistance. Failure to submit all required information such as NDC code, unit of measurement and quantity will result in a complete claim denial (see provider billing instructions for requirements).

Unit of Measurement codes are:

- F2 -International Unit
- GR-Gram
- ML-Milliliter
- UN- Unit

340b providers are required to use modifier "UD" when submitting claims.

FAQs related to this requirement can be found on the Bureau for Medical Services website (https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/FAQsNDC_HCPCS_012712_v.%208.pdf).

Medicaid Substance Use Disorder (SUD) Goals

THP supports the following goals related to SUD:

1. Improve the quality of care and population health outcomes for Medicaid members with SUD
2. Increase member access to, and utilization of, appropriate SUD treatment services based on the American Society of Addiction Medicine (ASAM®) Criteria
3. Decrease medically inappropriate and avoidable utilization of high-cost emergency department and hospital services by members with SUD
4. Improve care coordination and care transitions for Medicaid members with SUD and
5. Follow the CMS standards and guidelines as stated in the Special Teams and Conditions of the West Virginia approved 1115 SUD Waiver

SUD Provider Training and Education Requirements

SUD providers are responsible for providing training and education to their staff on the ASAM® Level of Care criteria and the application of the ASAM® Criteria in the assessment process. As part of BMS' quality monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM® Levels of Care and the Medicaid Provider Manual. THP will perform these retro reviews of providers to ensure SUD program providers are consistently applying ASAM® Criteria throughout an individual's stay and that documentation and personnel records meet established Medicaid standards.

Peer Recovery Support Services

Beginning October 1, 2022, the Bureau for Medical Services (BMS) requires board certification for all new and existing Peer Recovery Support Services personnel (PRSS) through the West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP). WVCBAPP certification requirements, applications and manuals may be accessed online at https://www.wvcbapp.org/applications THP will not reimburse services provided by a non-WVCBAPP certified PRSS.

Medicaid Emergency Room (ER) All-Inclusive Reimbursement Rate

THP follows BMS' reimbursement policy for ER all-inclusive reimbursement rates.

The ER all-inclusive reimbursement rate includes
- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies - routine EKG monitoring
- Oxygen administration and O_2 saturation monitoring

Diagnostic procedures including lab and radiology performed during an ER visit may be billed separately and in addition to the emergency room services

Outpatient Services for Acute and Critical Access Hospitals

Effective January 1, 2020, CPT/HCPCS codes are required to be submitted with the applicable revenue code for all outpatient services. Revenue codes submitted without the corresponding procedure code will be denied.

Surgical procedures must be billed with the appropriate CPT or HCPCS code and revenue code. Units are reported in fifteen (15) minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. If you wish to report multiple procedures, bill all additional lines with zero units and zero charges.

Indian Health Care Providers Disclosure

THP follows the requirements related to Indians, Indian Health Care Providers, and Indian Managed Care Entities in accordance with the terms of 42 Code of Federal Regulations (CFR) 438.14.

THP permits any Indian who is enrolled in THP and eligible to receive services from a participating Indian Health Service, Tribes and Tribal Organizations, or Urban Indian Health Program (I/T/U) provider to choose to receive covered services from that I/T/U provide

Member Incentives (Value Added Services)

Members may qualify for incentives by completing health activities. By helping members complete these activities, providers can help THP reward patients who receive needed services.

THP's 2023 member incentives include:

Value-Added Services

- **Annual well visits:** Ages 3-21 - Receive a $25 gift card.
- **Maternity:** $100 gift card for six prenatal visits and $50 for post-partum visit between 7-84 days of delivery.
- **Diabetes:** $25 gift card for completion of an HbA1c blood test and $25 gift card for a diabetic eye exam for ages 18-75.
- **Dental:** $25 gift card for dental exams for children up to age 21.
- **Mammogram:** $50 gift card for completion of a mammogram, ages 40+.
- **Pap Smear:** $25 gift card for completion of a Pap smear.
- **Colorectal Screening:** $25 gift card for men and women aged 45-64 for completing an exam.
- **Free Cell Phone:** Free cell phone with free minutes for text and voice, unlimited calls to Member Services and free wellness and appointment reminder texts. (Medicaid-only)
- **Boy and Girl Scouts** annual membership fee for ages 5-18.
- **Participation in Member Advisory Committee:** Assist THP with better understanding how to meet your needs
- **Jobs and Hope West Virginia Assistance:** Assist members in referral program.
- **Teladoc**: 24/7/365 access to providers for non-emergent treatment.
- **Meals for Moms**: New moms may receive a week's worth of meals following discharge from hospital after newborn delivery.
- **COVID Vaccine**: $25 gift card for completing COVID vaccine (limited to 1 gift card)
- **Life Coach:** Available to assist with resume development, interview skills and job searches.
- **Smoking Cessation:** $25 gift card for completing THP smoking cessation course (effective 1/1/2022)
- **Health Risk Assessment:** $25 gift card for members up to age 21 for completing a Health Risk Assessment (effective 1/1/2022)

These incentives are subject to change January 1 and July 1 each year. Please contact Member Services to verify most current value adds. Please allow up to six (6) months to receive gift card funds.