TheHealthPlan

Chapter 6

Mountain Health Trust (MHT)

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, and Supplemental Security (SSI), the West Virginia Children's Health Insurance Program (WVCHIP) membership.

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.

THP will notify practitioners at least thirty (30) days in advance of WV Bureau of Medical Services (BMS) and/or MHT program changes.

Mountain Health Trust Member ID Cards and Member Eligibility

The member is expected to present both their THP card and Medicaid card (8.5"x11" eligibility form) when receiving services. Each eligible individual family member will have a separate ID card with their own ID number. THP member ID card has the applicable program logo and important information including:

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

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 practitioner portal or call the Customer Service Department at 1.888.613.8385.

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

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

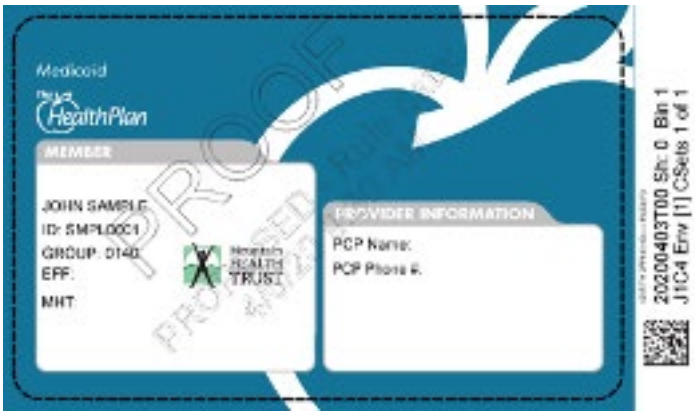
THP must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency and/or limited reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless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

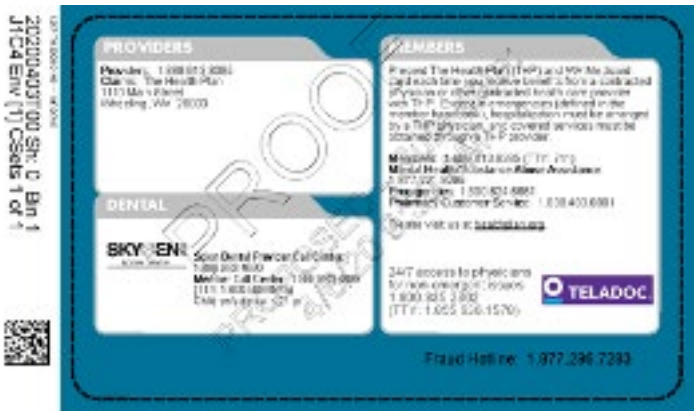
Sample Mountain Health Trust Member ID Cards

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

WV Medicaid

Group number: 0140, 0141 and 0142

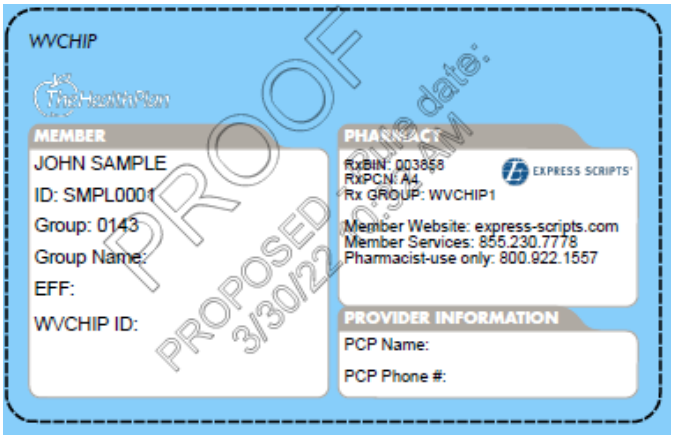




WV CHIP

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

Front:



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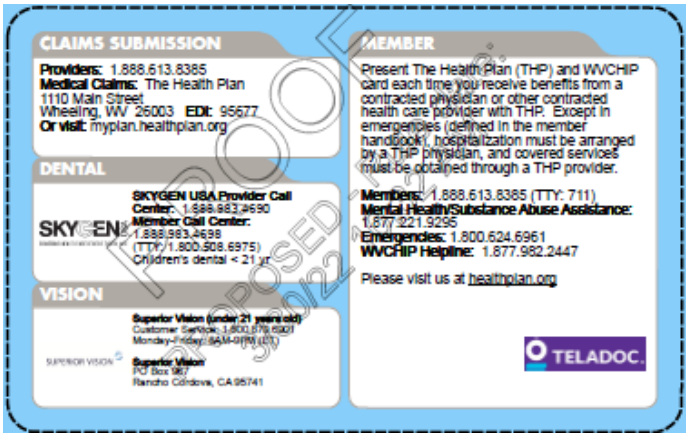

Medicaid Benefits and Exclusions at a Glance

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

Mountain Health Trust Covered Benefits
Medical • Primary Care/Specialist Office Visits/FQHC/RHC– Includes practitioner and nurse midwife services. • Practitioner 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 practitioner 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 and stem cell 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 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.

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. Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Services may be accessed by in network or out of network practitioners.
- Maternity Care—Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.

Mountain Health Trust Covered Benefits
Durable Medical Equipment, Orthotics and Prosthetics • Devices and medical equipment prescribed by a practitioner to ameliorate disease, illness or injury. Certain procedures have service limits or need prior authorization. Customized special equipment considered. • Requires prior authorization and must meet THP guidelines. • Limited replacements. • Other limitations may apply.
Hospice Requires prior authorization for inpatient hospice. 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 is not required.
Dental • For children (ages 0-21) o Must use participating practitioners (see practitioner directory or call Skygen Dental, 1.888.983.4698). o Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization. • For adults (21 and older) o Must use participating practitioners (see practitioner directory or call Skygen Dental, 1.888.983.4698). o Accident or injury, tumor removal, or emergency extraction o $2,000 benefit for preventive and restorative care, such as cleanings and crowns, every two years o TMJ is not covered for adults.
Vision • For children (ages 0–21) o Must use participating vision services practitioners. See practitioner directory or call Superior Vision. o Vision screening and therapy. o One eye exam covered once every 12 months. o Limited one frame per year. o Contact lenses covered for certain diagnoses. o Repairs. • For adults (21 and older) o Adults limited to medical treatment only. o Medical contact lenses for adults and children covered for certain diagnoses. o 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.

Mountain Health Trust Covered Benefits
Hearing • For children (ages 0–21) o Audiology screening/testing does not require authorization (only if referred by a PCP or ENT practitioner). o One hearing aid every five years. o Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures or devices 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) o Requires prior authorization for functional testing for specific medical conditions. o 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 and adults with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization. • Inpatient Psychiatric Services – Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed. o Under age 21 – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required. o Age 21 to 64 – Includes treatment at an Institution for Mental Diseases (IMD). • Outpatient – Includes services for individuals with mental illness and substance abuse. Some services may have frequency and unit limits that require authorization beyond initial service (e.g. Assertive Community Treatment[ACT]). ACT Team must be ACT certified. Certain services require pre-authorization. • Psychological Testing – Some psychological testing may be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization. • Drug Screening – Laboratory services to screen for presence of one or more drugs of use. Limits apply and pre-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. Some services may require an authorization once defined limit is reached.
Gender Affirmation Surgery • Procedure that aligns an individual's biological sex with their gender identity. Adults must be twenty-one (21) years or older prior to being considered for the procedure. Prior authorization is required.
Abortion • Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Practitioner certification required. All Federal and State laws regarding this benefit apply.

Benefits Under Fee-for-Service Medicaid *(For more information on fee-for-service benefits, visit https://bms.wv.gov)*
Early Intervention Services for Children Three and Under • Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
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 practitioner 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 practitioner order and nursing plan of care.
ICF/MR Intermediate Care Facility • Includes practitioner and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires practitioner 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. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call WVMMIS at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network. Access the WV Medicaid Preferred Drug List (PDL) by visiting: **https://bms.wv.gov/preferred-drug-list-and-coverage-details**. The PDL is subject to regular updates by the WV Medicaid program. THP covers medicines that you get during a hospital stay and in the emergency room. THP also covers medicine you get in the practitioner's office, such as injectable medicines i.e., vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by THP. Hemophilia blook factors and hepatitis C virus related drugs are covered by traditional Medicaid.
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. Corneal and stem cell transplants shall remain THP responsibility.
School-based Services • Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting. Limited to individuals under age twenty-one (21). Service limitations are listed in the fee for service Medicaid policy 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 five (5) business days in advance of the 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 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.

Mountain Health Trust (WV CHIP) 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 use disorder (SUD) treatment. Services must be ordered by a practitioner 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 0-20. Requires prior authorization, limits apply. • Vaccinations - Vaccinations are included for children and as approved for adults.
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. Requires prior authorization. • 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. Limited to 3 sessions per week for 12 weeks or 36 sessions per 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. • Physical Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy). • Occupational Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy). • Speech Therapy. Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval. • Chiropractor Services. Includes radiological exams and corrections to subluxation. Certain procedures have service limits.

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. Select procedures require prior authorization. Consult with your doctor before receiving services.
- 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 0-20) 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. The Health Plan (THP) has certified American Lung Association Freedom from Smoking facilitators to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to *quit*, not *why*. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. THP's program is 90 days. A facilitator will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our facilitators a call at 1-888-450-6023.
- Sexually Transmitted Disease Services—Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- Preventive Screenings—Annual pap smear for cervical cancer screening beginning at age 18, earlier if medical 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.

Maternity
- Right From The Start—Includes prenatal care and care coordination. Services covered through 12-months post-partum 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. Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Services may be accessed by in network or out of network practitioners.
- Maternity Care—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics, and Prosthetics
- Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered.
- Requires prior authorization and must meet THP guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice • Requires prior authorization for all visits. If you revoke three times, you are 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 to 2nd certification period.
Dental For children (ages 0-20) • Must use participating practitioners (see practitioner directory or call Skygen Dental at 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 practitioner directory or call Skygen Dental at 1-888-983-4698). • WVCHIP adult members have access to all age-appropriate services available under the WVCHIP children's benefit.
Vision For children (ages 0–20) • Must use participating vision services practitioners. See practitioner 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 diagnosis. • Repairs. For adults (21 and older) • Adults limited to medical treatment only. • Medical contact lenses for adults and children covered for certain diagnosis. • One pair of glasses up to 60 calendar 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.

Hearing

For children (ages 0–20)
- 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 devices may have service limits or require prior authorization. Augmentation communication devices are 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 (age 20 and under) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require prior authorization.
- Inpatient Psychiatric Services – Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
  - Under age 21 – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
  - Ages 21 to 64 – Includes treatment at an Institution for Mental Diseases (IMD).
- Outpatient – Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Practitioners must be ACT certified. Children's residential treatment is not covered. Certain services require prior authorization.
- Psychological Services – May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require prior authorization.
- Drug Screening – Laboratory services to screen for presence of one of more drugs of use. Limits apply and prior authorization is required for some testing.
- Substance Abuse Disorder (SUD) Services – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance abuse. Prior authorization is required.

Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.

Benefits Under Fee-for-Service WVCHIP *(For more information on fee-for-service benefits, visit: https://bms.wv.gov)*
Early Intervention Services for Children Three and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
Tubal Ligation – Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent and medical necessity.
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 – Includes dispensed drugs on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call the WVMMIS HelpDesk at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network. *You can also find this information at wvmmis.com. THP will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by THP. Hemophilia blood factors and hepatitis C virus related drugs are covered by WVCHIP FFS
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. Corneal and stem cell transplants shall remain THP's responsibility.
Transportation – WVCHIP 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

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

- All non-medically necessary services.
- Services from non-enrolled or non-participating practitioners.
- Services that require prior authorization but did not get a prior authorization.
- Sterilization of a mentally incompetent or institutionalized individual.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular member's condition.
- Treatment for infertility and the reversal of sterilization.
- All cosmetic services, except in the case of accidents or birth defects.
- Christian science nurses and sanitariums.

This is not a complete list of the services that are not covered by THP. If a service is not covered, not prior authorized, or is provided by an out-of-network practitioner, the member may be responsible. If you have a question about whether a service is covered, please call THP at 1-888-613-8385.

Additional Resources for Mountain Health Trust Members

Program	Description	MHT Population	Contact Information
Tobacco Cessation	THP'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
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
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 practitioners for non-emergent issues	All	1.800.TELADOC (1.800.835.2362)

Practitioner Hours of Operation

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. Practitioners must ensure that waiting time to be seen is minimal and that the MHT member waiting time standard is the same wait time standard for commercial members. Practitioners cannot discriminate against MHT members in the order that members are seen, or in the order that appointments are given (meaning, practitioners are not permitted to schedule "Medicaid-only" days).

Cultural Competency and Social Determinants of Health (SDoH)

Mountain Health Trust (WV Medicaid and WVCHIP) practitioners 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 practitioners provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) practitioner 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) are available for individualized education sessions. To request a training session, please contact your PMC.

Practice Training Guidelines

Practitioners should develop training program(s) for staff inclusive, but not limited to, member needs that can help with addressing physical, behavioral and environmental health e.g., Adverse Childhood Experiences (ACEs) and Motivational Interviewing.

THP can provide training materials on these topics, upon request.

Information regarding THP's clinical guidelines and policies is available at the following links:
https://www.healthplan.org/practitioners/resources/policies/medical-policies
https://www.healthplan.org/practitioners/resources/policies/payment-policies
https://www.healthplan.org/practitioners/prior-authorization-referrals/forms-prior-auth-list-notices

*Lists are not all-inclusive.

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 practitioner 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 encourage members to see their dental practitioner 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 practitioner should submit an 837P or 1500 claim form with the appropriate diagnosis codes, and procedure codes and modifiers. The EP modifier must be appended on all EPSDT service line(s).

EPSDT claims are paid without any coordination of benefits (COB). Further information including current EPSDT forms and periodicity guidelines is available at:

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

If the practitioner 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 (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 practitioner office, ASC or outpatient hospital, excluding emergency rooms	$0	$2	$4

Members and practitioners 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. Practitioners 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.

For prescribers issuing controlled substances, prescribers must review the WV PDMP in accordance with Section 5042 of the SUPPORT Act. In the case that a prescriber is not able to check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. Prescribers may be required to submit, upon request, such documentation to Medicaid.

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
Multisource Prescriptions	No copay	$10	$15
Primary Care Practitioner Medical Home Visit	No copay	No copay	No copay
Practitioner 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 PCP office visits.

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 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.

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

Effective August 1, 2019, services rendered by out-of-network non-patient facing practitioners 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 practitioners 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 practitioner will result in claim denial.

Under federal law and WV State code, the MHT program prohibits balance billing by all practitioners, regardless of location. Practitioners may not balance bill enrollees for covered services. More specifically, a participating practitioner cannot bill the difference between the practitioner's charge and the allowed amount. Practitioners must be compliant with Section 1902 (n)(3)(B) of the Social Security Act, and Section 1417 of the Balanced Budget Act of 1997. 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 existed.

THP 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 THP.

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.

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 practitioner, regardless that family planning practitioner'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 practitioner
- 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 practitioner.

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.

Vaccines For Children (VFC) Program

The Vaccines for Children (VFC) program is a federally funded program administered by the State Bureau's Public Health Immunization Program, that helps provide immunizations to WV children younger than 19 years of age and is one of the following: Medicaid-eligible, Uninsured, Under-insured, American Indian, or Alaska Native. Vaccines available through the VFC program are those recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC).

For more information about the VFC program, visit: https://www.cdc.gov/vaccines/programs/vfc/index.html

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, but it must be kept with the member's medical records.

Surgical sterilization consent forms are available at healthplan.org.

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 practitioners 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. 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 Human Services' (DoHS) Office of Maternal, Child and Family Health website: dhhr.wv.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 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 encourage well-child visits and immunizations and will mail a newborn packet with 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 practitioner.

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 practitioner 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 practitioners, 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 THP's tobacco cessation classes which are free of charge. A THP staff member will provide the member with one-on-one personal support that can help the member with tobacco cessation. Members can qualify for THP's tobacco cessation incentive by completing THP's sponsored program. Practitioners can refer a member to this program and others on THP corporate website here.

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 practitioner writes the order, and the monitor is obtained from a participating practitioner. 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 THP.

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. THP 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) practitioner manual. BMS' practitioner manual may be accessed on the WV DHHR website.

The following BMS practitioner manual provides detailed information regarding services typically provided by behavioral health practitioners:

- 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 its prior authorization list.

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.

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 practitioners, or members locate behavioral health practitioners.

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 practitioners must be fully licensed and credentialed by THP before providing services.

Services may require prior authorization. Please visit THP's prior authorization requirement list **here**.

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 THP. 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 practitioner's practice. WV Medicaid and WVCHIP credentialing and billing rules are aligned.

Unlicensed personnel may not bill for behavioral health services within a practitioner's practice except for supervised psychologists officially approved by the WV Board of Examiners of Psychology and for select exceptions related to OBMAT programs that are defined within THP payment and medical policies. A supervised psychologist must appear in the directory of the West Virginia Board of Examiners of Psychologists at psychbd.wv.gov/license-info/license-search.

This guideline does not apply to practitioner'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 those 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 Practitioners" section.

For additional information regarding behavioral health billing, please refer to THP's medical and payment guidelines at the following links:

https://www.healthplan.org/practitioners/resources/policies/medical-policies
https://www.healthplan.org/practitioners/resources/policies/payment-policies

Medicaid Adult Dental

Dental Services: Adults age 21 and over

West Virginia Medicaid members aged 21 and over qualify for $2,000 in preventive and restorative dental care. Any amount over $2,000 is the responsibility of the member. Practitioners may only bill members using the Medicaid fee schedule for any services rendered that exceed $2,000. The $2,000 is over a two-year period, effective July 1, 2024, and then resets every two (2) years thereafter.

Skygen USA is THP's dental benefit administrator. Practitioners must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website and Practitioner Manual at skygenusa.com.

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' Practitioner Manual Chapter 505 (Oral Health Services) section located at dhhr.wv.gov, then "Practitioners", 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. Practitioners must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website and Practitioner Manual at skygenusa.com.

Children's (up to age 21) dental services rendered in hospital setting require the dental practitioner to obtain a prior authorization from Skygen USA. Skygen issues prior authorization, the dental practitioner 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 practitioners may receive reimbursement for fluoride varnish application.

- Fluoride varnish is reimbursable to both medical and dental practitioners:
  - May be billed two times/year for each type of practitioner = four fluoride varnish treatments/year
  - Member must be under 21 years old
  - Code may only be billed once within a six-month period per each type of practitioner
- Medical Practitioners
  - 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 Practitioners
  - 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 practitioners which fragment the immunization record, causing missed doses or over immunization. The benefits of this registry are access to a current immunization record, better member 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

- Members, or their representative with written consent, 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 feels he or she was not treated with respect
  - The member is not satisfied with the health care received
  - It took too long to get an appointment
  - The member does not agree with a decision that we made
- To file a complaint or grievance, the member should call THP at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, the member may fax it to THP 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:
  - Member's Name
  - Member's Mailing address
  - The reason why the member is filing the complaint and what the member wants THP to do
  - When and where the issue took place

The member's doctor or authorized representative can also file a complaint or grievance on his or her behalf.

If filing a written grievance, THP will send the member an acknowledgement letter within five (5) calendar days. Verbal grievances are acknowledged when we take the member's call. The member can file a complaint or grievance at any time after the event about which they are unhappy. THP will conduct a full investigation after THP receives the complaint or grievance. THP will respond within thirty (30) calendar days and no later than ninety (90) days but may ask for extra time to give an answer.

THP will provide translation services, as needed, at no cost.

Member Appeals

If a member believes their benefits were unfairly denied, reduced, delayed, or stopped, the member has the right to file an appeal with THP. The member also has the right to appeal any adverse decision. The member has the right to be represented by anyone he or she chooses, such as an attorney, healthcare practitioner or a family member, with written consent.

- 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's name
    - Practitioner's name
    - The date of service
    - Member's mailing address
    - The reason why THP should change our decision
    - A copy of any information that the member think supports the appeal, such as written comments, additional documents, records or information related to the appeal

If a member calls and gives an appeal over the phone, THP will acknowledge the appeal verbally at the time of receipt and in a letter within five (5) calendar days. Be sure to read the letter carefully and keep it.

The member must file an appeal verbally or in writing within sixty (60) calendar days from the date of the adverse benefit determination or adverse decision by THP.

THP will send the member a letter to let him or her know when THP has received the appeal. The member has the right to give proof, or claims of fact or law, for the appeal either orally, in person, or in writing. The member has the right to see and get copies of documents that have to do with the appeal, records, the benefits, documents explaining how THP made our decision and any other related information to the appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits.

THP will review the member's appeal. None of the people reviewing it will have been involved in the initial decision to not authorize or pay for the health services being appealed. If the appeal involves a medical issue, reviewer will be a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. THP will provide the titles and qualifications of individuals who participate in the appeal decision review.

THP must process and provide notice to the member regarding the appeal within thirty (30) calendar days.

If THP needs more information for the appeal, or if the member wants to provide more information, 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 that he or she has the right to file a grievance if you disagree with the extension.

Fast (Expedited) Appeals

If the member appeal is about our decision to not approve or pay for some or all of his or her health care services, and the member needs an appeal decision fast because he or she has not gotten the health care services, the member can ask for a fast appeal by calling THP at 1.888.613.8385 or by submitting the request in writing within sixty (60) calendar days of the adverse decision. THP will give a decision notice to the member about the fast appeal within 72 hours after THP receives the appeal.

If the member calls and gives the fast appeal over the phone, THP will acknowledge the appeal verbally at the time of receipt and in a letter. Be sure to read the letter carefully and keep it.

If more information is needed to decide the appeal, THP can ask for fourteen (14) more calendar days to finish the appeal. THP will send a letter within two (2) calendar days telling the member why more time is needed. The member may file a grievance if he or she is unhappy with THP's request for more time. The member may also ask for fourteen (14) more days if he or she needs more time to provide information about the appeal.

To file a fast appeal, the member will need to provide us with:
- Member's name
- Practitioner's name
- Date of service
- Member's mailing address
- The reason why THP should change our decision
- A copy of any information that the member thinks support 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
Fax Number: 1.888.450.6025

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 they are unhappy with the decision to deny the fast appeal.

The member has the right to give proof, or claims of fact or law, for the appeal either orally, in person or in writing, but the member must provide this information more quickly under a fast appeal process. Upon receipt of the fast appeal request, the member will also have access to copies of all materials at no cost.

State Fair Hearing Process

If a member is not happy with THP's appeal decision, and the appeal is about THP's decision to deny, reduce, change, or terminate payment for health care services, a member can request a State Fair Hearing. A member, or practitioner on behalf of a member with written consent, 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 ten (10) 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
Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301-3708

The Bureau for Medical Services/WVCHIP' decision will be written to the member within 90 days of the hearing.

Continuation of Benefits During Appeal or State Fair Hearing Process

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

- The member or practitioner 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 practitioner
- The original period covered by the original authorization has not expired, and
- The member requests an extension of benefits within ten (10) calendar days of THP determination.

To request an extension of benefits, call 1.888.613.8385. THP will reimburse 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.

Mountain Health Trust Members' Rights

THP members have rights around their health care and to receive information according to contract standards. These rights and responsibilities are available at healthplan.org/legal/member- rights-and-responsibilities.

Annually on April 1, THP submits an annual report to the Bureau for Medical Services (BMS) and WVCHIP. 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 THP at 1.888.613.8385. Members can also get a copy of the report from BMS.

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, practitioners, and their rights
- Be treated with respect and dignity
- Not be discriminated against by THP
- Access all services that THP must provide
- Choose a practitioner in THP's network
- Take part in decisions about their health care
- Refuse treatment and choose a different practitioner
- Get information on available treatment options or alternative courses of care,
- Get information presented in a manner appropriate to 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 practitioners
- 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 practitioners 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 practitioner can challenge the denial of service with your permission
- Be provided with informed consent

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 Human Services (DoHS) caseworker right away if they had a transplant or if they are told they need a transplant
- Tell THP and DoHS when they change your address, family status or other health care coverage
- Know that THP does not take the place of workers' compensation insurance

Practitioner Reporting Requirements

Reporting of Required Reportable Diseases

State law requires health care practitioner 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—member 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. (See BMS 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.

Practitioner Fee Schedule Changes

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

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

Upon BMS 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. 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 THP'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 practitioners of comparable services.

Critical Access Hospital (CAH)

Upon BMS 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 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.

Practitioner Overpayments

In some situations, BMS reserves the right to collect overpayments. If this were to occur, BMS will directly notify the practitioner. The practitioner's appeal rights in the event of BMS collecting an overpayment directly from the practitioner are outlined in the BMS Policy Manual, chapter 800(B). See **Chapter 3 – Claims** for additional practitioner overpayment information.

Alternative Payment Models (APMs)

THP collaborates with practitioners to develop APMs to best fit for the practitioners 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.

Marketing Guidelines

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

Prohibited Marketing Practices

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

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 THP 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 THP's plan or the Medicaid and WVCHIP program, services, or benefits;
5. Making false, misleading, or inaccurate statements relating to services or benefits of THP or Medicaid and WVCHIP program, or relating to the practitioners or potential practitioners contracting with THP;
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 member's THP enrollment or THP disenrollment;
12. Using terms that would influence, mislead, or cause potential enrollees to contact THP, 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 THP 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 members for goods or services distributed at THP or Medicaid/WVCHIP events;
20. Charging enrollees a fee for accessing THP'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 members;
23. Assisting with Medicaid/WVCHIP MCO enrollment form;
24. Conducting potential enrollee orientation in common areas of practitioners' offices;
25. Posting THP-specific, non-health related materials or banners in practitioner offices;
26. Allowing practitioners to solicit enrollment or disenrollment in THP or distribute THP-specific materials at a Marketing activity (This does not apply to health fairs where practitioners do immunizations, blood pressure checks, etc. as long as the practitioner is not soliciting enrollment or distributing plan specific THP materials.);
27. Providing gifts to practitioners for the purpose of distributing them directly to the MCO's potential or current members;
28. Offering gifts valued over $15 or $75 annually to potential members;
29. Making potential enrollee gifts conditional based on enrollment with THP;
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:

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

1. Upon BMS approval, THP may engage in forms of social media advertising (e.g., Facebook, Instagram)
2. Upon BMS 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 approval prior to posting
4. THP may post general non-advertising information regarding THP activities. The content of such posts does not require BMS 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 practitioners:

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 (e.g., 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 marketing policies is:

Upon written receipt of any alleged violation(s) from BMS, 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.

West Virginia MHT Practitioner 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 practitioners 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, Practitioner, and Ancillary Medical Care Practitioners that provide services to West Virginia MHT recipients.

A. Obligations of Emergency Care Practitioners

- Emergency Care practitioners 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 Practitioners 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. Practitioners must inform members of the costs or non-covered services prior to rendering such services.
- Practitioners 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, practitioners may not routinely waive required copays.
- Practitioners 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.
- Practitioners must charge a copay for the following:
  - Inpatient and Outpatient Services

- Practitioner 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 Practitioner

- Practitioner may not refuse to furnish covered services to the eligible member on account of a third party's potential liability for the service(s).
- Practitioner agrees to comply with THP's Quality Assurance/Performance Improvement (QAPI) Program requirements.
- Practitioners that order, refer, or render covered services must enroll with BMS, through the fiscal agent, as a Medicaid/CHIP practitioner, as required by 42 CFR 438.602(b). Enrollment with BMS does not obligate practitioner to offer services under the BMS fee-for-service delivery system. THP is not required to contract with a practitioner enrolled with the West Virginia Bureau for Medical Services/CHIP that does not meet THP's credentialing or other requirements.
- Practitioner 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 member; and
  - The practitioner 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.
- Practitioner shall maintain malpractice insurance with minimum coverage requirements of $1 million per episode and $1 million in aggregate.
- Practitioner shall supply a certification that neither practitioner nor practitioner'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 practitioner 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. Practitioner shall notify THP immediately at the time it receives notice that any action is being taken against a practitioner 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. Practitioner 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 Practitioners must comply with timeliness of access standards as defined by BMS.

D. THP's Reimbursement Responsibilities

- THP is solely responsible for payment of covered and authorized services to West Virginia MHT recipients if the member is eligible for services on the date of service. Practitioner 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 Practitioner's Master Agreement.
- THP will not make specific payment, directly or indirectly, to practitioner as an inducement to reduce or limit medically necessary services furnished to any member.
- Members may not be held liable for covered services, for which 1) the State or THP does not pay the individual or health care practitioner that furnished the services under a contractual, referral, or other arrangement; or 2) payments for covered services furnished under a contract, referral, or other arrangement to the extent those payments are in excess of the amount that the enrollee would owe if THP covered the services directly.

E. Reporting Actions against Practitioners, Owners, or Others

- Practitioner must notify THP immediately after it receives notice that any action is being taken against practitioner or any practitioner, 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 practitioner 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

- Practitioner 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. Practitioner 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 programs.

G. Compliance with Deficit Reduction Act Requirements

- Practitioner must comply with the Section 6032 of the Deficit Reduction Act of 2005 and the SMDL 06-024. If practitioner receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the practitioner must:
    - Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of practitioner. 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 practitioner'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 practitioner's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

H. Required Disclosures by Practitioner

- Practitioner shall provide THP and BMS with all information requested of practitioner, 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, practitioner shall disclose the name and address of any person (individual or corporation) with an ownership or control interest in practitioner. 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 Practitioner.

  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 practitioner.
  - 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 practitioner;
    - Has a combination of direct and indirect ownership interests equal to 5 percent or more in practitioner;
    - 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 practitioner practice that is organized as a corporation; or
    - Is a partner in a practitioner practice that is organized as a partnership.
- In addition to the required ownership and control disclosures required by 42 CFR 455.101, practitioner 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 practitioner 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 practitioner's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the practitioner or in the practitioner'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.

- Practitioner 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 practitioner is related to another person with ownership or control interest in practitioner 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 practitioner has a 5 percent or more interest is related to another person with ownership or control interest in practitioner as a spouse, parent, child, or sibling.
- Practitioner 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.
- Practitioner must disclose any significant business transactions, in accordance with 42 CFR § 455.105. Practitioner 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:
    - The ownership of any subcontractor with whom practitioner has had business transactions totaling more than $25,000 during the previous 12-month period; and
    - Any significant business transactions between practitioner and any wholly owned supplier, or between practitioner and any subcontractor, during the previous five (5) years.
- Practitioner must disclose any healthcare-related criminal convictions, in accordance with 42 CFR § 455.106, of any practitioner's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in practitioner, relating to Medicare, Medicaid, or Title XX programs. These disclosures are required at the time that practitioner applies or renews its applications for Medicaid participation or at any time on request. Practitioner must notify THP immediately at the time practitioner 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.
- Practitioner shall report to THP all practitioner-preventable conditions associated with claims.

I. Maintenance and Access of Records

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

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

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

- Practitioner 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

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

N. Right to Recover Overpayments from Practitioner

- Practitioner shall notify THP, in writing, of any overpayment discovered by Practitioner. This required notification shall include the reason for any overpayment. Practitioner 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 has the right to recover practitioner overpayments, including those overpayments due to Fraud, Waste, and Abuse, from practitioner if:
  - BMS or its contractor identifies an overpayment made by THP to practitioner

- The payment occurred outside the grace period, as defined by BMS
- 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 practitioner, and
- BMS, 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 practitioner, practitioner's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.

MHT Drug Testing Policies

THP's policies regarding drug testing are guided by the American Society for Addiction Medicine (ASAM), however, may be more stringent or clearly delineated in some cases. Please consult the ASAM White Paper on drug screening on THP website at www.healthplan.org for further clinical guidelines on use of definitive/definitive drug testing. Please note BMS Chapter 529.2 outlines drug testing availability and limits.

For additional information regarding behavioral health billing for MHT, please refer to THP's clinical and payment guidelines at the following links:
https://www.healthplan.org/practitioners/resources/policies/payment-policies
https://www.healthplan.org/practitioners/resources/policies/medical-policies

Transplant Services

Members receiving transplant services, with the exception of Corneal and stem cell transplants, are exempt from managed care. Members that have received transplant services or are under evaluation for transplant services shall be disenrolled from THP and placed under fee-for-service coverage for all services.

Inpatient Claims

THP processes claims 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 practitioners dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include practitioner -administered drugs.

Drugs administered by the practitioner and billed with an NDC must be rebateable to be eligible for payment, otherwise the drug will be denied. Practitioners 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 practitioner billing instructions for requirements).

Unit of Measurement codes are:

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

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

FAQs related to this requirement can be found on the BMS website at https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/FAQsNDC_HCPCS_012712_v.%208.pdf.

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 (e.g., 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 one (1) unit and $0.01 charges.

Indian Health Care Practitioners Disclosure

THP follows the requirements related to Indians, Indian Health Care Practitioners, 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) practitioner 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, practitioners can help THP reward members who receive needed services.

THP's member incentives include:

Value-Added Services
• Annual well visits: Members up to age 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+. • Cervical Cancer Screening: $25 gift card for completion of a cervical cancer screening. • Colorectal Screening: $25 gift card for men and women aged 45-64 for completing an exam. • Boy and Girl Scouts annual membership fee for ages 5-18. • Participation in Member Advisory Committee: Assist THP with better understanding of how to meet your needs • Jobs and Hope West Virginia Assistance: Assist members in referral program. • Teladoc: 24/7/365 access to practitioners for non-emergent treatment. • Meals for Moms: New moms may receive a week's worth of meals following discharge from hospital after newborn delivery. 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 These incentives are subject to change January 1 and July 1 each year. Please contact Customer Service to verify most current value adds. Please allow up to six (6) months for members to receive gift card funds due to claim submission process.