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

# CHAPTER 521 BEHAVIORAL HEALTH OUTPATIENT SERVICES

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## BACKGROUND

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

This chapter sets forth BMS's requirements for reimbursement of Behavioral Health Outpatient Services provided to eligible West Virginia Medicaid members by a:

- Physician
- Physician Extender
- Licensed Psychologist (LP)
- Supervised Psychologist (SP)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW); and
- Licensed Graduate Social Worker (LGSW).

Provider entities may enroll to render services as outlined in this chapter if they employ any of the above stated credentials. Examples of these entities are group practices, Day Report Centers, Child Advocacy Centers, or other identified and approved entities per BMS.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Behavioral Health Outpatient Services in the Medicaid Program, administered by the West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia. BMS has a joint goal with Medicaid enrolled providers to ensure effective services are provided to Medicaid Members.

Medicaid enrolled providers should give priority to children that have been identified as being in the foster care system. To uphold our responsibility to children in foster care, addressing foster children's needs must begin at entry and by making these foster children a priority especially with the assessment services stated in *Section 521.11, Assessment Services* and *Section 521.12, Testing Services* of this chapter. Medicaid enrolled providers should make a good faith effort to complete assessments in a timely manner as well as work with the Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

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

All Medicaid enrolled providers should coordinate care if a Medicaid member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety

is the forefront of the Member's treatment. Appropriate Releases of Information should be signed in order that Health Insurance Portability and Accountability Act (HIPAA) Compliant Coordination of Care takes place.

## *POLICY*

### 521.1 MEMBER ELIGIBILITY

Behavioral Health Outpatient Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when prior authorization for services is requested from the agency authorized by BMS to perform administrative review. The Prior Authorization process is explained in *Section 521.16, Prior Authorization* of this chapter.

### 521.2 MEDICAL NECESSITY

All Behavioral Health Outpatient Services covered in this chapter are subject to a determination of medical necessity. Services and Supplies must be:

1. appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
2. provided for the diagnosis or direct care of an illness;
3. within the standards of good practice;
4. not primarily for the convenience of the plan member or provider; and
5. the most appropriate level of care that can be safely provided.

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

- Diagnosis (as determined by an appropriate professional)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

Providers rendering services that require prior authorization must register with BMS's Utilization Management Contractor (UMC) and receive authorization before rendering such services. Prior authorization does not guarantee payment for services rendered. See Section 521.16, Prior Authorization.

### 521.3 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

#### 521.3.1 Enrollment Requirements: Staff Qualifications

Services may be rendered to Medicaid members by a physician; physician extender; licensed psychologist; supervised psychologist under the supervision of a licensed psychologist; LICSW; LPC;

LCSW; and LGSW. Documentation including required licenses, certifications, and proof of completion of training must be kept on file at the practice where the services are rendered.

WV Board of Psychology approved supervisors may only bill services for a maximum of four supervised psychologists that they are supervising. WV Board of Psychology approved supervisors may not "trade" supervisees for billing Medicaid services.

All provider documentation, including college transcripts, certifications, credentials, background checks, and trainings, must be kept in their personnel file, and may be reviewed at any time by BMS, its contractors, or State and Federal auditors. Provisional Licensure is only accepted for newly enrolling physicians under certain restrictions. No other provisionally licensed providers will be accepted for enrollment and provisionally licensed individuals may not bill under an enrolled provider.

The licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW and LPC may elect to provide services under the auspices of a physician's practice without independently enrolling in WV Medicaid. A physician practice may also employ Licensed Clinical Social Workers (LCSW) and Licensed Graduate Social Workers (LGSW). In doing so, the services provided by these health professionals must include the AJ modifier. Eligible AJ codes can be found later in this chapter.

All further Staff Qualifications are indicated under the service codes.

## 521.4 FINGERPRINT-BASED BACKGROUND CHECKS

All providers of behavioral health outpatient services and their staff that have direct contact with Medicaid members or the Medicaid members' treatment information must, at a minimum, have results from a state level fingerprint-based background check. This check must be conducted initially and again every three years. If the current or prospective employee, within the past five years, has lived or worked out of state or currently lives or works out of state, the agency must conduct an additional federal background check through the West Virginia State Police upon hire and every three years of employment. Providers may do an on-line preliminary check and use these results for a period of three months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last five years. An individual who is providing services or is employed by a provider cannot be considered to provide services, nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including, but not limited to, rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;

- Hate crimes;
- Kidnapping;
- Murder/homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including, but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse, must be considered by the provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in conviction status of an agency staff member providing Behavioral Health Outpatient Services, the provider must take appropriate action, including notification to the BMS Program Manager for Behavioral Health Outpatient Services.

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) must be checked by the provider for every agency staff who provides Medicaid services prior to employment. Persons on the OIG Exclusion List cannot provide Medicaid services.

It is the responsibility of the employer to check the list of excluded individuals/entities at

- (LEIE) http://exclusions.oig.hhs.gov/
- (Formerly EPLS) https://www.sam.gov/

A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, upon hiring for employment. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at http://www.wvsp.gov
- National sex offender registry is at http://www.nsopw.gov/

## 521.5 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management

guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information* of the BMS Provider Manual and are subject to review by state and federal auditors.

## 521.6 PROVIDER REVIEWS

The primary means of monitoring the quality of Behavioral Health Outpatient Services is through provider reviews conducted by the contracted agent as determined by BMS by a defined cycle. The Contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards.

Targeted on-site provider reviews and/or desk reviews may be conducted by the Contracted Agent in follow up to receipt of Incident Management Reports, complaint data, Plan of Corrections (POC), etc.

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

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

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

**The letter must be addressed to the following:**

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

If no potential disallowances are identified during the Contracted Agent review, then the Provider will receive a final letter and a final report from BMS.

**Plan of Correction (POC)**

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

1. How the deficient practice for the members cited in the deficiency will be corrected;
2. What system will be put into place to prevent recurrence of the deficient practice;
3. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
4. The date the Plan of Correction will be completed; and
5. Any provider-specific training requests related to the deficiencies.

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

## 521.7 TRAINING AND TECHNICAL ASSISTANCE

The Contracted Agent develops and conducts training for Behavioral Health Outpatient Services providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

## 521.8 OTHER ADMINISTRATIVE REQUIREMENTS

The provider must assure implementation of BMS policies and procedures pertaining to documentation, and case record review.

- Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid Members records within one business day of the request.
- Provider must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, providers must comply with the documentation and maintenance of records requirements described in *Chapter 100,*

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

- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the members
- BMS Provider Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a provider and a member.

## 521.9 TELEHEALTH SERVICES

The West Virginia Bureau for Medical Services encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid Members. To utilize Telehealth, providers will need to document that the service was rendered under that modality. When filing a claim, the Provider must bill the service code with a **GT Modifier**. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some service codes give additional instruction and/or restriction for Telehealth as appropriate.

- Minimum equipment standards are transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used if the software is HIPAA Compliant and abides by a federal code pertaining to Telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making. The provider at the distant site is responsible to maintain standards of care within the scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary.
- Member's consent to receive treatment via Telehealth shall be obtained, and may be included in the member's initial general consent for treatment.
- Members may utilize Telehealth through their personal computer by utilizing a VPN established and maintained by the provider and meeting the equipment standards stated in this policy.
- Telehealth services are available via web based applications and/or smartphone applications (apps) as long as they are HIPAA compliant and utilize a VPN.

- If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.
- The provider who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:
    - The right to withdraw at any time
    - A description of the risks, benefits and consequences of telemedicine
    - Application of all existing confidentiality protections
    - Right of the patient to documentation regarding all transmitted medical information
    - Prohibition of dissemination of any patient images or information to other entities without further written consent.
- BMS Provider Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), third party applications that are not HIPAA compliant (i.e. Skype, FaceTime, etc.) or facsimile transmission (fax) between a provider and a member.

## 521.10 DOCUMENTATION

The WV Bureau for Medical Services recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system. When services require documentation, BMS will accept both types of documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. If the provider uses an electronic based system, a time-based stamp must be on documentation to ensure integrity of the document.

## 521.11 ASSESSMENT SERVICES

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff and credentialed by the internal credentialing policies and procedures of the agency. Assessment services are designed to make determinations concerning the mental, physical, and functional status of the member. Those identified as being in the Foster Care system should receive assessment as rapidly as possible.

### 521.11.1 Psychiatric Diagnostic Evaluation (No Medical Services)

**Procedure Code:** 90791
**Service Unit:** Event (completed evaluation)
**Telehealth:** Available – Must use GT Modifier
**Service Limits:** Two events per year
**Prior Authorization:** Refer to Utilization Management Guidelines.

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, or LPC.

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

**Documentation:** Documentation must contain all of the following and be completed in 15 calendar days from the date of service:

- Date of service
- Start and stop times
- Location of service
- Purpose of evaluation
- Signature with credentials
- Presenting problem
- History of Medicaid member's presenting illness
- Intensity, duration and frequency of symptoms
- Current and past medication efficacy and compliance
- Psychiatric history up to present day and compliance
- SBIRT for individuals age of 10 and older
- Medical history related to behavioral health condition
- Mental status exam - the mental status exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Member's diagnosis per current DSM or ICD methodology
- Member's prognosis for treatment
- Rationale for prognosis
- Rationale for diagnosis
- Appropriate recommendations consistent with the findings of the evaluation

## 521.11.2 Psychiatric Diagnostic Evaluation (With Medical Services)

**Procedure Code:** 90792
**Service Unit:** Event (completed evaluation)
**Telehealth:** Available – Must use GT Modifier
**Service Limits:** Two events per year
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine or a Physician Extender.

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

**Documentation:** Documentation/Report must contain the following and be completed within 15 calendar days from the date of service.

- Date of service
- Start and stop times
- Location of service
- Purpose of evaluation
- Time spent (start/stop times)
- Physician's signature with credentials
- Presenting problem
- History of Medicaid member's presenting illness
- Intensity, duration and frequency of symptoms
- Current and past medication efficacy and compliance
- Psychiatric history up to present day with treatment compliance
- SBIRT for individuals age of 10 and older
- Medical history related to behavioral health condition
- Medical systems review
- Mental status exam - the mental status exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Member's diagnosis per current DSM or ICD methodology
- Rationale for diagnosis
- Member's prognosis for treatment
- Rationale for prognosis
- Appropriate recommendations consistent with the findings of the evaluation

## 521.11.3 Mental Health Assessment by a Non-Physician

**Procedure Code:** H0031 AJ
**Service Unit:** Event
**Telehealth**: Available – Must use GT Modifier
**Service Limits:** Maximum of (two) 2 per year per member

**Staff Credentials:** Staff must have a minimum of a master's degree and be a licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LCSW, LGSW, or LPC and the AJ modifier is required.

**Definition:** Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

**Approved Causes For Utilization:**

1. Intake/Initial evaluation;
2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral health condition to a lesser level of care.
3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment;
   The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services.
5. No one under the age of three (3) will have a H0031 conducted on them. The Medicaid member under the age of the 3 should be referred to the Birth to Three Program.

**Documentation for initial/intake (may include use of standardized screening tools) must include:**

- Demographic data (name, age, date of birth, etc.);
- Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
- Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
- History of behavioral health and health treatment (recent and remote);
- History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
- Medical problems and medications currently prescribed;
- Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
- Analysis of available social support system at present;
- SBIRT for individuals age of 10 and older;
- Mental status examination;
- Recommended treatment (initial);
- Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice);

- Place of evaluation, date of evaluation, start and stop times, signature and credentials of evaluator;
- Efficacy of and compliance with past treatment. (If past treatment is reported); and
- Past treatment history and medication compliance (If past treatment is reported)

**Documentation for re-assessment must include:**

- Date of last comprehensive assessment;
- Current demographic data;
- Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such);
- Changes in situation, behavior, functioning since prior evaluation;
- Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
- Mental status examination;
- Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
- Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and
- Place of evaluation, date of evaluation, start and stop times, signature and credentials of evaluator.

**Note: H0031-AJ,** and **90791 or 90792** are not to be billed at the same initial intake or re-assessment unless the **H0031-AJ** is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using **90791 or 90792**.

## 521.12 TESTING SERVICES

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

**Documentation:** For all codes in this section, documentation/report must contain the following and be completed in 15 calendar days from the date of service:

- Date and location of service
- Purpose of evaluation
- Time spent (start/stop times)
- Signature with credentials
- Documentation that the Medicaid member was present for the evaluation
- Results (scores and category) of the administered tests/evaluations
- Interpretation, diagnosis, and recommendations consistent with the findings of the administered tests/evaluations
- Mental status exam - the mental status exam must include the following elements:

- Appearance
- Behavior
- Attitude
- Level of consciousness
- Orientation
- Speech
- Mood and affect
- Thought process/form and thought content
- Suicidality and homicidality
- Insight and judgment

- Rendering of the Medicaid member's diagnosis within the current DSM or ICD Methodology

## 521.12.1 Psychological Testing with Interpretation and Report

**Procedure Code:** 96101
**Service Unit:** 60 minutes
**Telehealth:** Not Available
**Prior Authorization:** Refer to Utilization Management Guidelines
**Service Exclusions:** Psychometrician/Technician Work; Computer Scoring or Interpretation; and Self-Administered Assessment

**Staff Credentials:** Must be performed by a West Virginia licensed psychologist or Supervised Psychologist who is supervised by Board approved Supervisor

**Definition:** Evaluation by a psychologist including psychological testing with interpretation and report. Psychological testing includes, but is not limited to standard psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. Academic assessment and assessment required to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual are also included. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations. 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously interpreted, completed and reported technician-and computer-administered tests.

**Note:** Interpretation and report of technician and computer-based tests may not be completed using this service. It is intended for the integration of previously interpreted and reported technician and computer-based tests.

## 521.12.2 Developmental Testing: Limited

**Procedure Code:** 96110
**Service Unit:** Event (completed interpretation and report)
**Telehealth:** Not Available
**Prior Authorization:** Refer to Utilization Management Guidelines
**Payment Limits:** This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96101) has been billed in the last six months.
**Service Exclusions:** Psychometrician/Technician Work; Computer Scoring or Interpretation; and Self-Administered Assessment

**Staff Credentials:** Must be performed by a West Virginia licensed psychologist or Supervised Psychologist who is supervised by Board approved Supervisor

**Definition:** This is limited to developmental testing (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.

## 521.12.3 Developmental Testing: Extended

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|---|---|
| **Procedure Code:** | 96111 |
| **Service Unit:** | Event (completed interpretation and report) |
| **Telehealth:** | Not Available |
| **Prior Authorization:** | Refer to Utilization Management Guidelines |
| **Payment Limits:** | This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96101) has been billed in the last six months. |
| **Service Exclusions:** | Psychometrician/Technician Work; Computer Scoring or Interpretation; and Self-Administered Assessment |

**Staff Credentials:** Must be performed by a West Virginia licensed psychologist or Supervised Psychologist who is supervised by a Board approved Supervisor

**Definition:** Developmental testing, (includes assessment of motor language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

## 521.12.4 Neurobehavioral Status Exam

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|---|---|
| **Procedure Code:** | 96116 |
| **Service Unit:** | Per hour (completed interpretation and report) |
| **Telehealth:** | Not Available |
| **Prior Authorization:** | Refer to Utilization Management Guidelines |
| **Payment Limits:** | This service cannot be billed in conjunction with 96101 and 96118. |

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, or Supervised Psychologist who is supervised by a Board approved Supervisor.

**Definition:** Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist or physician's time, both face-to face time with the patient, and time interpreting test results and preparing the report.

## 521.12.5 Neuropsychological Testing

| | |
|---|---|
| **Procedure Code:** | 96118 |
| **Service Unit:** | Per hour |
| **Telehealth:** | Not Available |
| **Prior Authorization:** | Refer to Utilization Management Guidelines |
| **Payment Limits:** | This service cannot be billed in conjunction with 96101. |

**Service Exclusions:** Psychometrician/Technician Work; Computer Scoring or Interpretation; and Self-Administered Assessment

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, or Supervised Psychologist who is supervised by a Board approved Supervisor.

**Definition:** A nationally accredited or standardized Nero psychological battery or test, per hour of the psychologist's or physician's time, both face to face times administering tests to the patent and time interpreting these test results and preparing the report.

### 521.12.6 Neuropsychological Testing by Computer

**Procedure Code:** 96120
**Service Unit:** Event (completed interpretation and report)
**Telehealth:** Not Available
**Prior Authorization:** Refer to Utilization Management Guidelines
**Payment Limits:** This service cannot be billed in conjunction with 96101 and 96118.
**Service Exclusions:** Psychometrician/Technician Work; Computer Scoring or Interpretation; and Self-Administered Assessment

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, or Supervised Psychologist who is supervised by a Board approved Supervisor.

**Definition:** A nationally accredited or standardized neuropsychological battery or test, administered by a computer, with interpretation and report completed by provider.

## 521.13 PSYCHOTHERAPY

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

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

Psychotherapy documentation must indicate how often the service is to be provided and must follow an identifiable therapeutic strategy. Member compliance with treatment and other information must be shared with the physician or physician extender as per the Coordination of Care Agreement. Additionally, progress notes must include the following components:

- Date of service
- Place of service

- Start and stop times
- Signature with credentials
- Reason/purpose for the service and relationship of the service to the member's identified mental health treatment needs
- Symptoms and functioning of the member
- Therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change
- Member's response to the intervention and/or treatment
- Plan for continued therapy
- Group therapy notes must also include group topic

## 521.13.1 Individual Psychotherapy

**Procedure Code:** 90832
**Modifier Availability**: AJ (See requirements below)
**Service Unit:** 1 unit = 16-37 minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC, LCSW, or LGSW.

**AJ Modifier**: Required when service is rendered by licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC, LCSW, or LGSW, if not independently enrolled.

**Procedure Code:** 90833 billed with appropriate E/M Code
**Service Unit:** One unit = 16-37 minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines
**Payment Limits:** This service must be billed in conjunction with an appropriate Evaluation and Management code.

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine or a Physician Extender.

**Procedure Code:** 90834
**Modifier Availability:** AJ (See requirements below)
**Service Unit:** 1 unit = 38-52 minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC, LCSW, or LGSW.

**AJ Modifier**: Required when service is rendered by licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC, LCSW, or LGSW, if not independently enrolled.

**Procedure Code:** 90836 billed with appropriate E/M Code
**Service Unit:** One unit = 38-52 minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines
**Payment Limits:** This service must be billed in conjunction with an appropriate Evaluation and Management code.

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine or a Physician Extender.

**Procedure Code:** 90837
**Service Unit:** 1 unit = 53 or more minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, or LPC.

## 536.13.2 Individual Psychotherapy Biofeedback

**Procedure Code:** 90875
**Service Unit:** One unit = 30 minutes
**Telehealth:** Not Available

**Procedure Code:** 90876
**Service Unit:** One unit = 45 minutes
**Telehealth:** Not Available

**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine or a Physician Extender.

**Definition:** Face-to-face structured intervention by a Physician or Physician Extender to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

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

**Procedure Code:** 90853

**Modifier Availability:** AJ (See requirements below)
**Service Unit:** 1 unit
**Telehealth:** Available – Must use GT Modifier
**Service Limits:** Maximum limit of 12 individuals in a group setting regardless of payer source
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC. LCSW, or LGSW.

**AJ Modifier:** Required when service is rendered by licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC, LCSW, or LGSW, if not independently enrolled.

**Definition:** The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

## 521.13.4 Medication Assisted Treatment Guidelines

West Virginia Medicaid covers Medication Assisted Treatment Services under the following circumstances.

Physicians or Physician extenders wanting to render Suboxone®/Subutex® services must send a request for review to the Medicaid enrollment contractor. The request must include the providers National Provider Identifier (NPI) number, a copy of the DEA-X certificate, and letter requesting to be enrolled as a Suboxone provider for WV Medicaid. MCO's will not reimburse for Suboxone services if the provider has not been approved by the WV Bureau of Medical Services. Reasons for denial of approval include, but are not limited to, a history of issues with the provider pertaining to the services they deliver, past history of disciplinary actions with the WV Board of Medicine or WV Board of Osteopathic Medicine, and current investigations concerning the prescribing methods of the provider, etc.

Individuals seeking opioid addiction treatment with Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician, Advance Practice Registered Nurse (APRN) or physician extender as specified below, before beginning medication assisted treatment.

- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.
- All physicians and/or physician extenders agree to adhere to the Coordination of Care Agreement (Please see Appendix 521A) which will be signed by the member, the treating physician, stafffphysician extender, and the treating therapist.
- Each member receiving medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician, physician extender, or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.

- The agreement is not required if the member is receiving services at an agency where both the physician, physician extender, and therapist are employed.

**Program Guidelines:**

**Note:** These are the minimum requirements that are set forth in this manual. Providers may have more stringent guidelines set forth in their internal policy.

**Phase 1:** Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of psychotherapy services per month. The four hours must contain a **minimum** of one (1) hour individual psychotherapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

**Phase 2:** Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of psychotherapy services per month with individual, family, or group modalities. Frequency of therapeutic services may increase based upon medical necessity.

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

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

The following providers do not require supervision*:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Board Supervised Psychologist
- Licensed Professional Counselor
- National Certified Addiction Counselor II
- Master Addiction Counselor
- Bachelor's Degree in Human Services with Alcohol and Drug Counselor Credential

*Certification requirements for West Virginia Association of Alcoholism and Drug Abuse Counselors, Inc. (WVAADC) may be different than those included above. This policy is not meant to circumvent any requirements as set forth by this organization.

**Drug Screens:** A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2.

A record of the results of these screens may be requested from the physician or physician extender. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

**Instructions for non-compliance with treatment:** Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician's or physician extender's discretion. The physician, physician extender and/or treatment program has the option to allow the patient to reapply to the program after 30 days with proven participation in professional therapies. With three violations within six months, the physician or physician extender will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician or physician extender discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

**Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.**

**Titration Policy:** Titration due to non-compliance is per Physician or Physician extender order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise.

## 521.13.5 Psychotherapy for Crisis

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy mobilization of resources to defuse the crisis and

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

**Procedure Code:** 90839
**Service Unit:** 60 Minutes
**Telehealth:** Unavailable

**Procedure Code:** 90840
**Service Unit:** Add on code for each additional 30 minutes of psychotherapy for crisis, used in conjunction with 90839
**Telehealth:** Unavailable

**Prior Authorization:** Refer to Utilization Management Guidelines

**Service Exclusions:**

- Response to a domestic violence situation
- Admission to a hospital
- Admission to a Crisis Stabilization Unit
- Time waiting for transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, or LPC.

**Documentation:** In addition to the requirements in *Section 521.13, Psychotherapy,* the documentation must also include a safety plan and mental status exam. The Mental Status Exam must include the following elements:

- Appearance
- Behavior
- Attitude
- Level of consciousness
- Orientation
- Speech
- Mood and affect
- Thought process/form and thought content
- Suicidality and homicidally
- Insight and judgment

### 521.13.6 Family Psychotherapy (without the patient present)

**Procedure Code:** 90846
**Service Unit:** 45-50 minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, or LPC.

**Definition:** This code is specific to family psychotherapy without the patient present in the therapeutic session.

### 521.13.7 Family Psychotherapy (with the patient present)

**Procedure Code:** 90847
**Modifier Availability:** AJ
**Service Unit:** 45-50 minutes
**Telehealth:** Available – Must use GT Modifier
**Prior Authorization:** Refer to Utilization Management Guidelines

**Staff Credentials:** Must be performed by a West Virginia licensed Physician in good standing with the WV Board of Medicine, Physician Extender, West Virginia licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, or LPC.

**AJ Modifier:** Required when service is rendered by licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LPC, LCSW, or LGSW, if not independently enrolled.

**Definition:** This code is specific to family psychotherapy with the patient present in the therapeutic session.

## 521.14 SERVICE LIMITATIONS

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

## 521.15 SERVICE EXCLUSIONS

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

- Individual and Group Psychotherapy services for beneficiaries with a diagnosis of dementia which has progressed to a severe cognitive deficit.
- Individual and Group Psychotherapy services for beneficiaries with a diagnosis of severe and profound intellectual disability.

- Group Psychotherapy services which only consist of activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, motion therapy, and non-directional play therapy.
- Services provided a Supervised Psychologist in a "satellite" office, which is not the primary site of the practice and the Board approved supervising Psychologist is not available for direct face-to-face supervision.
- Telephone consultations.
- Meeting with the Medicaid member or Medicaid member's family for the sole purpose of reviewing evaluation and/or results.
- Missed appointments, including but not limited to, canceled appointments and appointments not kept.
- Services not meeting the definition of medical necessity.
- Time spent in preparation of reports
- A copy of the psychological report when the Bureau paid for the original service.
- Experimental services or drugs.
- Services rendered outside the scope of a provider's license.
- Any activity provided for the purpose of leisure or recreation.
- Services completed by an employee other than those approved by WV Medicaid to provide services to its members.
- If a facility is reimbursed for behavioral health outpatient services, the professional cannot be reimbursed separately.
- Services provided by Supervised Psychologists is limited to the extent that billing for these services is restricted to four (4) individual supervised psychologists per Medicaid enrolled licensed board approved supervising psychologist.
- Family Psychotherapy services when the service constitutes taking a history or documenting evaluation and management services.
- Unlisted Psychiatric/Psychological Services are subject to review and pricing. The completed reports must be attached to the claim form and submitted for consideration to the Bureau.
- Developmental Testing (extended assessment) when Psychological Testing has been billed.
- Hypnotherapy
- Neurobehavioral Status Exam when Psychological Testing, Developmental Testing (limited or extended) and Neuropsychological Testing Battery have been billed.

## 521.16 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

## 521.17 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

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

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

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

## 521.18 BILLING PROCEDURES

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

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

## *GLOSSARY*

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

**Abuse and Neglect:** As defined in West Virginia Code §49-1-3

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

**Child Advocacy Centers:** Child Advocacy Centers or CAC's provide services to children in West Virginia per **WV State Code** §49-3-101

**Coordination of Care:** Sharing information between relevant parties to plan, arrange, implement, and monitor provision of services to a Medicaid Member.

**Day Report Center:** As governed under West Virginia State Code §62-11C-1 are responsible for carrying out the dual purpose of imposing sanctions on and providing services to offenders.

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

**Legal Representative:** Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

**Licensed Certified Social Worker:** An individual who has obtained Level C status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-11

**Licensed Graduate Social Worker:** An individual who has obtained Level B status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-13

**Licensed Independent Clinical Social Worker:** An individual who has obtained Level D status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-9

**Licensed Professional Counselor:** An individual who as has obtained full licensure as defined by the West Virginia Board of Examiners in Counseling and by West Virginia Code §30-31-8.

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

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

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

**Plan of Correction (POC):** A template form that will list the quality deficiencies that were identified during a retrospective review of a behavioral health outpatient practice.

**Supervised Psychologist:** An individual with a completed Master's degree and whose current status is a "Board-Approved Supervised Psychologist" as defined and granted by the WV Board of Examiners of Psychologists, and cited in this Board's current requirements for licensure.

**Utilization Management Contractor (UMC):** The contracted agent of BMS.

## *CHANGE LOG*

| REPLACE | TITLE | EFFECTIVE DATE |
|---|---|---|

| | | |
|---|---|---|
| Chapter 521 | Psychological Services | April 1, 2015 |
| Chapter 521 | Behavioral Health Outpatient Services | January 15, 2018 |