West Virginia HealthCheck

Talking Points for HealthCheck Technical Assistance

Any treatment plan that requires service beyond the benefit package limitations must be documented during a HealthCheck initial, periodic or interperiodic screening.

It is required that the primary care provider obtain authorization for an item or service requiring prior authorization review for medical necessity by West Virginia Medical Institute (WVMI).

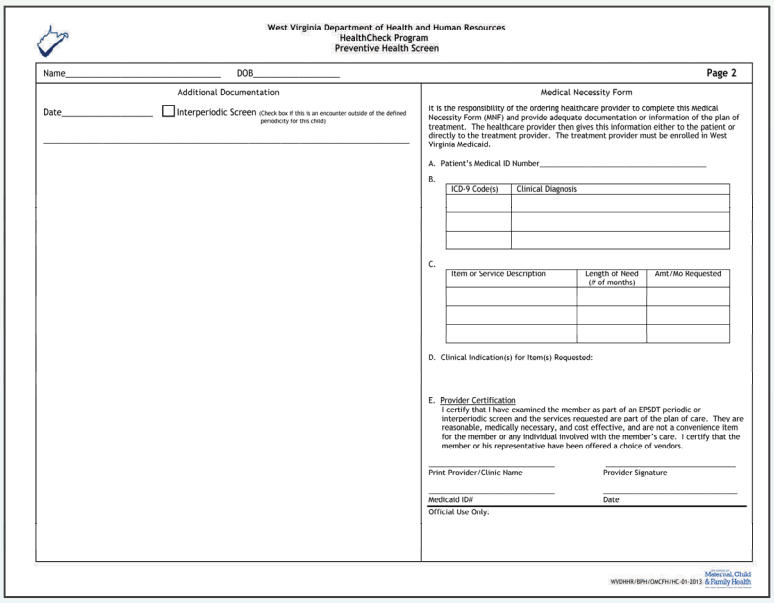
When requesting items or services requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing primary care provider to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the PHS page 2 along with corresponding documentation of the HealthCheck screening (initial, periodic or interperiodic) encounter, and other pertinent documentation from the preceding six (6) months.

"EP" is the required modifier for all HealthCheck claim details. Utilizing the appropriate evaluation and management (E/M) code with the "EP" modifier appended, the primary care provider designates all services related to early and periodic screening, diagnosis, and treatment (EPSDT) of the Medicaid eligible individual.

Requests for prior authorization review for medical necessity should be sent directly from the primary care provider to:

West Virginia Medical Institute (WVMI)
3001 Chesterfield Ave.
Charleston, WV 25311
Fax: 304-346-8185 or 1-877-762-4338

Page 2 of the Preventive Health Screen form is available on the HealthCheck website:
www.dhhr.wv.gov/healthcheck



West Virginia Department of Health and Human Resources
HealthCheck Program
Preventive Health Screen

Name_____ DOB_____ Page 2

Additional Documentation

Date_____ ☐ Interperiodic Screen (Check box if this is an encounter outside of the defined periodicity for this child)

Medical Necessity Form

It is the responsibility of the ordering healthcare provider to complete this Medical Necessity Form (MNF) and provide adequate documentation or information of the plan of treatment. The healthcare provider then gives this information either to the patient or directly to the treatment provider. The treatment provider must be enrolled in West Virginia Medicaid.

A. Patient's Medical ID Number_____

B.

ICD-9 Code(s)	Clinical Diagnosis

C.

Item or Service Description	Length of Need (# of months)	Amt/Mo Requested

D. Clinical Indication(s) for Item(s) Requested:

E. Provider Certification
I certify that I have examined the member as part of an EPSDT periodic or interperiodic screen and the services requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not a convenience item for the member or any individual involved with the member's care. I certify that the member or his representative have been offered a choice of vendors.

Print Provider/Clinic Name _____ Provider Signature _____

Medicaid ID# _____ Date _____

Official Use Only.

WVDHHR/BPH/OMCFH/HC-01-2013 Office of Maternal, Child & Family Health

West Virginia HealthCheck Program
1-800-642-9704

West Virginia Department of Health and Human Resources
EPSDT/HealthCheck Program
Preventive Health Screen

Name_____ DOB_____ **Page 2**

Additional Documentation

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Medicaid ID# Date

Official Use Only: