State West Virginia

3.1 AMOUNT, DURATION, AND SCOPE OF ASSISTANCE

ATTACHMENT 3.1-A AND 3.1-B

Amount, duration and scope of medical and remedial care and services provided.

1. Inpatient Hospital Services

Effective 4-1-90 coverage for medically necessary inpatient hospital services for recipients age 21 and older in a Medicare approved general hospital is limited to 25 days in a fiscal year, July 1 through June 30.

Preadmission review of medical necessity and prior authorization required except for normal deliveries and newborn care.

2. a. Outpatient Hospital Services

Outpatient hospital services include laboratory and radiological services, emergency room services, ambulatory surgical services, and other items and services generally furnished by hospitals in the State. These services may be limited in frequency/duration, or may require prior approval by the State.

2. c. Federally Qualified Health Center Services

Other ambulatory services furnished by a FQHC may be limited in frequency/duration or by prior authorization as is applied to that service when furnished by other Medicaid providers.

4. a. Nursing Facility Services

Pre-certification to determine the medical necessity for inpatient services prior to authorization of benefits.

4. b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

Vision Services - diagnosis and treatment for defects in vision including eyeglasses.

Dental Services - palliative treatment to relieve pain, eliminate infections, or reduce fractures; restorations to preserve dentition of the teeth; x-ray studies; preventative services; endodontics; periodontics; prosthodontics; oral surgery; orthodontics.

Hearing Services - diagnosis and treatment for defects in hearing including hearing aids.

Other Services - services described in Section 1905(a) necessary to correct or ameliorate defects and conditions identified by the screening services.

(i) Rehabilitation Hospital Services

(ii) Organ Transplant Services

(iii) Crisis Support (Residential Setting) - is a structured program which is provided in community-based, small residential settings licensed pursuant to West Virginia Code, Chapter 49, Section 3, Article 2B. The purpose of this service is to provide a supportive environment designed to minimize stress and emotional instability which has resulted from family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support systems or the abrupt removal of a recipient from a failed placement or other current living situation. Crisis support services must be available 24 hours a day, seven days a week and consist of an array of services including individual and group counseling, intensive therapy, behavior management, clinical evaluation/assessment, treatment planning and health maintenance/ monitoring.

(iv) Early Intervention (Rehabilitation Services) - are Medicaid rehabilitation services recommended by a physician or other licensed practitioner of the healing arts within their scope of practice, provided to EPSDT-eligible children who are eligible for IDEA, Part C services. Rehabilitation services will be provided to recipients who demonstrate handicapping conditions or who are at risk for developmental delays due to biological or other factors identified in an EPSDT screen and set forth in a recipient's Title V approved Individual Family Service Plan (IFSP). Services are provided in settings determined by the treatment team to ensure that individuals and their families have access to needed services and resources and that necessary evaluations are conducted and treatment plans are developed and implemented by the family/professional. The state assures that all rehabilitation services provided to the family are directed exclusively to the effective treatment of the Medicaid eligible child based on the child's IFSP.. The reassessment of a recipient's needs occurs on an ongoing basis and at regularly scheduled intervals to facilitate the developmental progress.

In addition to state plan services, IDEA, Part C early intervention services are:

Evaluation/Assessment is assessment of the child's development and the family's needs related to the child's development. Includes appropriate developmental and functional evaluation measures, observational assessment, medical history review and family interview

Therapeutic Interventions are interventions and research based strategies designed to achieve the integrated outcomes of the child's IFSP, through Part C, IDEA services such as speech therapy, physical therapy and occupational therapy.

Teaming/Treatment Planning is a meeting/planning session with the family for the purpose of planning assessments, designing outcomes and interventions or periodic review of the objective and strategies of the child's IFSP. This service is intended to reduce duplication of services and promote a collaborative service delivery process.

Providers will be credentialed through Title V to assure they meet all relevant licensing requirements and possess suitable qualifications to serve infants and toddlers who are eligible for Part C, IDEA services.

The above referenced therapy providers shall meet the requirements as set forth in 42 C.F.R. §440.110

(v) Private duty nursing. Prior Authorization is required.

5. a. **Physicians' Services**

Services may be limited by specialty, e.g., pathology, radiology, or by frequency/duration by prior authorization.

b. **Medical and Surgical Services Provided by a Dentist**

Limitations placed on the procedure for physicians apply when that service is provided by a dentist. Dental coverage for individuals age 21 and over will be limited to repair of fractures of the maxilla and mandible and certain surgical procedures which can be performed by a physician or oral surgeon.

6. a. **Podiatrists' Services**

Services may be limited in amount/duration, or by prior authorization. Limitations placed on the service (procedure) for other qualified practitioners apply when the services is provided by a podiatrist.

b. **Optometrists' Services**

Coverage will consist of one pair of eyeglasses for adults following cataract surgery.

c. **Chiropractors' Services**

Services consist of manual manipulation of the spine to correct a subluxation and radiological examinations related to the service. Coverage is limited to twelve (12) treatments in a twelve (12) month period. Additional treatments require prior authorization.

d. **Other-practitioners' Services**

Psychologists: Prior authorization is required for psychotherapy after initial ten (10) sessions.

6. d.2 Gerontological Nurse Practitioner Services
Adult Nurse Practitioner Services
Women's Health Nurse Practitioner Services
Psychiatric Nurse Practitioner Services

Coverage of Nurse Practitioner Services is limited to the scope of practice as defined in state law or the state licensure or regulatory authority with any limitations that apply to all providers qualified to provide service. Services to be covered will be defined by the State agency in accordance with scope of practice considerations and site of service – outpatient only.

d.3. Other Licensed Practitioners

Vaccines may be administered by currently licensed pharmacists in the pharmacy setting in compliance with West Virginia Board of Pharmacy rules and regulations. Pharmacies must assure that pharmacists possess and keep current licenses and registration to administer immunizations and work only within their scope of license and registration. Administration records must be kept in accordance with West Virginia Board of Pharmacy rules and regulations.

Medicaid covers selected active pharmaceutical ingredients (API) and excipients used in extemporaneously compounded prescriptions and selected over-the-counter vitamin and mineral supplements when dispensed by a participating pharmacy provider pursuant to a prescription issued by a licensed prescriber following all state and federal laws.

7. **Home Health Services**

a. / b. Prior authorization is required after sixty (60) units of all home health services per individual in a calendar year. One visit equals one unit. A unit includes a skilled nursing visit, or a home health aide visit, or a physical therapy services visit, or an occupational therapy services visit or a speech-language pathology services visit.

c. Medical equipment (ME) is equipment that generally:
1. Withstands repeated use;
2. Is primarily used to serve a medical purpose;
3. Is not useful in the absence of illness or injury;
4. Is appropriate for use in the beneficiary's home.

The medical supplies that are covered are listed in the Durable Medical Equipment (DME) Manual. Coverage of medical supplies does not generally include beneficiaries residing in long term care facilities or Intermediate Care Facilities for the Mentally Retarded (ICF/MRs).

Orthotic devices are covered when medically necessary, prescribed in accordance with program guidelines, and are utilized to support or correct a weak or deformed body part, and/or to restrict or eliminate motion in a diseased or injured body part.

Prosthetic devices are covered when medically necessary, prescribed in accordance with program guidelines, and are utilized as an artificial appliance or device to replace all or part of a permanently inoperative or missing body part.

The fee schedule and any published annual/periodic adjustments to the schedule are the same for both public and private providers of those 1905(a) services to which they apply. The fee schedule and any annual/periodic adjustments to the fee schedule are to be published.

Prior authorization is required prior to placement of an equipment/item as outlined in the DME Manual.

A certificate of medical necessity (CMN) or medical documentation must be provided by the prescribing practitioner as outlined in the DME Manual.

Supplies and equipment that are not covered include personal care and items/equipment for personal convenience. Excluded from coverage under medical supplies, equipment, prosthetics, and orthotics are items that are covered through other State Plan sections.

Each provider desiring to participate as a medical equipment, prosthetic, orthotic or medical supply provider must be enrolled as a Medicaid provider, employ or have the appropriate licensed or credentialed individuals on staff, depending on type of service provided, and follow all enrollment policies required by the Bureau for Medical Services.

The Bureau does not enroll as medical equipment, prosthetic, orthotic or medical supply providers the following: hospitals; hospital pharmacies, long term care facilities; physicians; physical, speech or occupational therapists. Home Health agencies can supply only medical supplies not equipment and appliances.

Medical equipment, prosthetic, orthotic or medical supplies must be prescribed by a physician or a medical practitioner authorized to prescribe said items.

8. **Private Duty Nursing**

EPSDT service. Prior authorization is required.

9. **Clinic Services**

Services may be limited by prior authorization.

10. **Dental Services**

Prior Authorization may be required for restorative/replacement procedures. For prior authorization criteria see generally www.wvdhhr/bms/manuals Chapter 505: Dental: sections 505.8, 505.10 and Attachments 1,2 and 3. Dental service limits provided under EPSDT can be exceeded based on medical necessity. Certain emergency dental services are covered for adults, see section 505.7

11. a. Physical Therapy

Physical Therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. A "qualified physical therapist" is an individual who meets qualifications specified in regulations at 42 CFR 440.110 and is licensed pursuant to West Virginia State law.

Prior authorization required. See Manual Chapter 515, section 515.4 and Attachment 2 at www.wvdhhr.org/bms

b. Occupational Therapy

Occupational Therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. An "occupational therapist" is an individual who meets qualifications specified in regulations at 42 CFR 440.110 and is licensed pursuant to West Virginia State law.

Prior authorization required. See Manual Chapter 515, section 515.4 and Attachment 2 at www.wvdhhr.org/bms.

All of the following must be met before an augmentative/alternative communication device can be considered for approval. The communication device must be:

- A reasonable and necessary part of the beneficiary's treatment plan.
- Consistent with the symptoms, diagnosis or medical condition being treated.
- Not furnished for the convenience of the beneficiary, the family, the attending practitioner or other practitioner or supplier.
- Necessary and consistent with generally accepted professional medical standards of care; i.e., not experimental or investigational.
- Established as safe and effective for the beneficiary's treatment protocol.
- Furnished at the most appropriate level which is suitable for use in the beneficiary's home environment.

Requests for augmentative/alternative communication devices must be accompanied by a systematic and comprehensive augmentative evaluation completed by a qualified speech/language pathologist trained in augmentative communication devices and services. Where appropriate, other evaluation team members may include an occupational therapist, physical therapist, psychologist, or rehabilitation engineer. The qualified speech/language pathologist will be directly responsible for management of the communication plan; and for training of any other service provider (which may include a support person such as a parent, guardian, teacher, or occupational therapist) to promote functional use of the augmentative/assistive communication device. The qualified speech/language pathologist shall also be responsible for determining specifications for the device based on outcome of the comprehensive assessment. Training services may be limited in amount, duration and scope.

Coverage of Augmentative/Alternative Communication Devices and Related Equipment

Covered Augmentative/Alternative Communications device equipment includes the items listed below:

(a) Operational Software

(b) Speech synthesizer

(c) Printer (if built in)

(d) Battery Packs

(e) Carrying Case

(f) Purchase of a less costly device to communicate basic needs will be considered before consideration of adapted access software and speech synthesizer, and any other accessories necessary to adapt a pre-owned computer for use as an augmentative/assistive communication device if the device is a computer-based system. The most economical device that meets the individual basic medical needs will be purchased.

(g) Basic vocabulary application package that will communicate the client's needs.

(h) Access Device:

1. Switch

2. Switch mount

3. Scanning indicator, optical indicator, head pointer, etc.

(i) Mounting device to suspend system for use either on wheelchair or desktop

(j) Overlay/multiple location configuration (plastic overlays used for training purposes)

12. a. Prescribed Drugs

All covered outpatient drugs, whether legend or non-legend, must be prescribed by a physician, or other practitioner qualified under State law. Applicable State and Federal law governing dispensing of drugs and biological must be followed.

The prescribed use of the covered outpatient drug must be for a medically accepted indication as defined in Social Security Act §1927(k)(6).

b. Coverage of Smoking/Tobacco Cessation products

(1) The Medicaid agency provides coverage of selected prescription tobacco/smoking cessation covered outpatient drugs, bupropion and legend nicotine replacement therapy, for all Medicaid recipients except for full benefit dual eligible beneficiaries who receive this coverage under the Medicare Prescription Drug Benefit-Part D.

(2) The Medicaid agency provides coverage of over-the-counter (OTC) tobacco/smoking cessation covered outpatient drugs for all Medicaid recipients except for beneficiaries residing in skilled and intermediate nursing facilities.

(3) The Medicaid agency provides coverage of prescription tobacco/smoking cessation covered outpatient drugs, bupropion and legend nicotine replacement therapy, and over-the-counter (OTC) tobacco/smoking cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence: 2008 Update: a Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

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Covered outpatient drugs are those produced by any manufacturer, which has entered into and complied with a rebate agreement under Social Security Act § 1927(a), which are prescribed for a medically accepted indication. A covered outpatient drug does not include any drug, biological product or insulin provided as part of or incident to and in the same setting as defined in Social Security Act § 1927(k)(3) for which payment includes drugs, biological products and insulin. Medicaid will not cover Part D drugs for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

Limitations in Coverage

A. Exclusions and restrictions on certain drugs or classes of drugs:

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

The following marked excluded drugs are covered:

□ (a) Agents when used for anorexia, weight loss, weight gain.

□ (b) Agents when used to promote fertility.

□ (c) Agents when used for cosmetic purposes or hair growth.

■ (d) Selected agents when used for the symptomatic relief of cough and colds which appear on West Virginia Medicaid's approved coverage list which is updated periodically. This includes drugs such as guaifenesin, guifenesin/dextromethorphan combination, antihistamine/decongestant combinations, nasal decongestants. See drug list at www.wvdhhr.org/medicalservices.

■ (e) Selected prescription vitamins and mineral products which appear on West Virginia Medicaid's approved coverage list which is updated periodically. See drug list at www.wvdhhr.org/medicalservices Legend vitamins A, D, K and niacin. Minerals include calcium, iron, magnesium, and additional mineral requirements for the treatment of ESRD. Legend prenatal vitamins are covered for women through age 45. All legend vitamins are covered for recipients in the End Stage Renal Disease (ESRD) Program.

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_X_ f. Nonprescription drugs: Nonprescription (over-the-counter or "OTC") drug coverage is limited to: Analgesics/antipyretics, antidiarrheals, antitussives, laxatives, hemorrhoidal preparations, topical antibacterial agents, topical and intravaginal antifungal agents, cough and cold preparations, contraceptives, topical acne agents, topical analgesics, antihistamines, topical antiviral agents, topical glucocorticoids, insulin, ophthalmic agents for allergic conjunctivitis, and pediculicides/scabicides. Residents in skilled and intermediate nursing facilities are excluded.

___ g. Drugs described in §107(c)(3) of the drug Amendments of 1962 and identical, similar or related drugs (within the meaning of §310.6(b)(1) of Title 21 of the Code of Federal Regulations ("DESI" drugs).

___ h. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services will be purchased exclusively from the manufacturer or its designee.

B. Drugs covered with limitation (applicable to all covered drug categories)

a. Certain drugs identified by high cost, high risk or high use are subject to limitations through prior authorizations as to units or coverage periods.

b. Certain drugs are limited by gender or age according to FDA approved indications. Prior authorization is available for on a case-by-case basis for exceptions with medical necessity justification.

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C. Quantities and Duration

1. Covered outpatient drugs are reimbursed up to 34-day supply per prescription. The number of refills per prescription will be in accordance with state and federal law and regulations.

2. Certain drugs are limited by quantity, number of allowable refills of duration or use.

D. Drug Rebate Agreements

The State is in compliance with §1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufactures. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on January 1, 2008 and entitled "West Virginia Medicaid Supplemental Drug Rebate Agreement" has been authorized by CMS.

CMS has authorized the state of West Virginia to enter into the Sovereign States Drug Consortium (SSDC) multi-state pool. This Supplemental Drug Rebate Agreement was submitted to CMS in September 30, 2008 and has been authorized by CMS effective August 1, 2008. A revised SSDC Supplemental Rebate Agreement was authorized by CMS, effective January 1, 2015, for any renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid recipients.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provision of the national drug rebate agreement.

E. Preferred Drug List with Prior Authorization

1. Pursuant to 42 U.S.C.§1396r-8 and WV Code §9-5-15, the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency circumstances.

2. Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

3. The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with federal law.

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12. b. Dentures

Prior authorization may be required.

12. c. Prosthetic Devices

Prior authorization may be required for certain procedures.

12. d. Eyeglasses

Certain procedures require narrative description of the service provided or laboratory invoice, or prior authorization.

13. c Preventive Services

Disease State Management

Disease State Management (DSM) will provide certain health care services by a licensed practitioner in a coordinated approach seeking to prevent serious complications to Medicaid eligible individuals who are determined to have Type 1, Type 2 or gestational diabetes mellitus. Licensed practitioners, operating within the scope of their licenses, will provide diabetics with an interdisciplinary support team formed around the recipients' primary care provider. The team may be based on community resources; hospitals, pharmacies, rural health clinics (RHC), federally qualified health centers (FQHC), independent certified diabetic educators (CDE), along with other resources that are within each community. The primary care provider will agree to manage the recipient and will be expected to either provide or refer the patients for diabetic disease state management services.

People with diabetes in this group will benefit from a patient-centered health care approach that is responsive to the unique needs and conditions of people living with diabetes to produce the best treatment outcomes in a cost-effective manner by demonstrating quantifiable and measurable results. A patient evaluation instrument will be used for initial and ongoing screening for patients, including a flow sheet evaluation form and a diabetic educational assessment form. These forms, which are completed by the patient's primary care provider, will define the health care and health related support needs of the patient.

Components of Disease State Management

The health care related needs of diabetics recipients will be determined through comprehensive diabetes assessments.

Components will include:

- Diabetic assessment and education which will include a comprehensive assessment of the diabetic's status and health care needs, risk assessment, hygiene, and diet, etc.
- Drug Therapy will include evaluation of the diabetic's medication requirements, oral or injectable, self monitoring of blood glucose, recognition of emergency conditions, etc.
- Diet Management/Education will include education on diet restriction, eating patterns, diet and medication interaction, etc.
- Referral to other providers to meet identified health care needs, such as skin and/or wound care, eye or renal care, etc.

Licensed practitioners who are also CDEs and not subject to independent enrollment will be enrolled solely to provide diabetic disease state management services as herein provided. Providers who are enrolled in Medicaid must be certified as CDEs prior to billing. Providers will be certified through a process in conjunction with the Bureau for Medical Services. Providers must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria below.

Demonstrate a capacity to provide all core elements of disease state management services including:

- Comprehensive client assessment and service plan development.
- Assist the client to access needed services, i.e., assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.
- Monitor and periodically reassess the client's status and needs.
- Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.
- Demonstrate ability to assure referral processes consistent with 1902 (a) (23), freedom of choice for providers.
- Demonstrate financial management capacity and system that provides documentation of services and cost.
- Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.
- Provide for certified diabetic educator services.

Certified Diabetic Educators (CDE) must be licensed practitioners and credentialed as a Certified Diabetes Educator by the National Certification Board for Diabetes Educators. This certification shows the applicant holds a current unrestricted state license as a registered nurse, an advanced nurse practitioner, pharmacist, physician, physician assistant, podiatrist, physical therapist, occupational therapist, clinical psychologist, social worker, or is registered as a dietician by the Commission on Dietetic Registration.

Disease State Management services are reimbursed on a fee-for service basis with certain limitations:

Description	Services Limits
Extended Provider's Office Visit	2 visits/year
Enrolled providers may also bill for the following:	
Outpatient self-management training visit -individual	8.5 hours/year
Outpatient self-management training visit - group session	8.5 hours/year
Follow-up visits/reassessment with CDE	2 visits/year

The outpatient self-management training sessions can be a combination of individual and group sessions, not exceeding 8.5 hours / year.

Number of total hours involving CDE education cannot exceed 10 hours / year per recipient.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13(d). Rehabilitative services.

B. Behavioral Health Services

Behavioral Health Services under the Rehabilitation option CFR 440:130(d) include any medical or remedial service recommended by a physician or licensed practitioner of the healing arts, for the purpose of reducing physical or mental disability and restoration of a recipient to his/her best possible functional level. These services are designed for all individuals with conditions associated with mental illness, substance abuse and/or drug dependency. The need for these services will be certified by a physician or licensed practitioner of the healing arts.

The providers are agencies or individuals licensed by the State and certified by the Bureau for Medical Services in accordance with West Virginia Code Chapter 27, Article 9, Section 1 and Chapter 49 of the Public Welfare Law Section 3, Article 2B to verify that the provider agency has employed qualified staff to provide the service. Any person or entity meeting requirements for the provision of Rehabilitation services will be given the opportunity to do so. The provider agencies are responsible for an internal credentialing process which maintains and monitors documentation in personnel records that substantiate the current licensure and training status of all employees providing these services which includes licensed social workers, WV State Board of Social Workers, West Virginia Code Chapter 30, Article 30, licensed counselors in Chapter 30, Article 31 and State certified addiction counselors and other qualified staff who perform duties under the direct clinical supervision a licensed practitioner as described in State Health Department Regulation 88-05.

1. **Crisis Services**

Crisis Services are based on a continuum of care ranging from the less restrictive setting which is crisis intervention in the home/community to a more restrictive setting which is treatment in a residential facility. If these interventions do not work, then the most restrictive would be a referral for inpatient psychiatric hospital services which is a separate state plan amendment and does not apply in this section.

(a) Crisis Intervention:

Unscheduled, face-to-face intervention with a recipient in need of emergency or psychiatric interventions in order to resolve an acute crisis. Depending on the specific type of crisis, an array of treatment modalities are available. These include but are not limited to individual intervention, and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation and stabilize as quickly as possible. Once the crisis is stabilized it would then be appropriate to initiate crisis stabilization services as described in this section.

(b) Crisis Stabilization:

An organized program of services designed to ameliorate or stabilize the conditions of acute or severe psychiatric signs and symptoms. This service is intended for any recipient who requires intensive crisis services without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community while resolving the crisis. Crisis stabilization services must be provided on the written order of a physician or licensed practitioner of the healing arts. Each recipient must have a psychiatric evaluation and an initial crisis stabilization plan developed within 24 hours of service initiation.

2. Rehabilitative Supportive Services

Supportive services are face-to-face interventions which are intended to provide support to the recipient in order to maintain or enhance levels of functioning and to assist in day-to-day management and problem solving. These services include counseling, specially designed behavior plans with scheduled direct intervention, and basic living skills development.

(a) Counseling:

A face-to-face scheduled supportive treatment modality which includes investigation, decision making, assessment and insight development in a group setting, individually, or conjointly.

(b) Behavior Management Services:

Behavioral management services consist of a two-step approach in order to change or modify maladaptive behaviors. The first step is development of a behavioral plan which specifically addresses behaviors to be extinguished. The plan must include specific objectives, criteria, methods of implementation, schedule and method of reinforcements, projected achievement dates and person (s) responsible to implement the plan. The process for development consists of assessment, data collection, observation of client and testing. The process determines the continuation, modification or termination of the plan. The second step is the hands-on, face-to- face contact intervention with the client. A specific intervention written in the plan must be provided in order for this service to be acceptable. General observations and monitoring alone are not acceptable methods of implementing the plan.

(c) Basic Living Skills Development:

Basic living skills development is a combination of structured individual and group activities offered to recipients who have basic skill deficits. These skills may be lost due to different factors such as history of abuse or neglect, years spent in institutional settings or supervised living arrangements that did not allow growth and development in the areas of daily living skills. The purpose of this service is to provide therapeutic activities focused upon basic living skills services which are elementary, basic and fundamental to higher level skills and are designed to restore or preserve a recipient's level of functioning. Services include but are not limited to learning and demonstrating personal hygiene skills, learning to responsibly manage sexual behavior, managing living space, social appropriateness and learning skills of daily living. These same services may be provided to an individual in his/her natural environment through a structured program as identified in the goals and objectives.

(d) Evaluations and Treatment Plan Development:

1. Clinical Evaluations:

Clinical evaluations are professional evaluations conducted to determine needs, strengths, levels of functioning, developmental level, functional behaviors, mental status, chemical dependency, social and/or life skill deficits; to assess physical or mental disabilities; and/or to develop the social history. Such evaluations are focused on the individual and may be conducted in the individual's natural environment in order that the environmental context may be considered in the assessment process.

((e) Community Focused Treatment

1. Definition:

Community-Focused Treatment is a long term preventive and rehabilitation service designed to serve clients with ~~a~~ severe and persistent mental illness whose quality of life and level of functioning would be negatively impacted without structured ongoing skill maintenance and/or enhancement activities.

This is a structured program of ongoing regularly scheduled day activities designed to enhance or maintain a client's level of functioning and to prevent a client's deterioration which could result in the need for institutionalization. This may be accomplished through skill maintenance and/or development and behavioral programming designed to maintain or improve adaptive functioning. This service emphasizes community based activities. Problem solving, disability specific awareness and community awareness groups are examples of activities that may be utilized to enhance or maintain functional levels. These services are to be provided in accordance with the client's potential and interests as reflected in the master treatment/service plan. Critical skills identified as essential to maintain placement in the community and preventing hospitalization will also be targeted for skill maintenance/enhancement. This service has a minimum staff to client ratio of one staff member per 12 clients when provided at a licensed site and a minimum staff to client ratio of 1 to 8 when provided in natural community settings.

2. Service Scope and Site:

Scope - Community Focused Treatment must be appropriate to the clients' needs and if necessary be available to the client five (5) days a week for a minimum of four (4) hours each day. The amount and/or combination of services approved for each client will be based on their specific needs as demonstrated by a comprehensive assessment and be clearly identified in their master treatment/service plan.

Site - Community Focused Treatment Services shall be based from a site listed on the agency's behavioral health license. Training may occur on site or in natural community settings.

3. **Description**

Community Focused Treatment services include activities occurring in a therapeutic environment and are designed to maintain or enhance the client's current abilities in various areas. These activities may consist of group activities using training modules, structured exercise which present the opportunities for clients to practice and use developing or existing skills or participate in client meetings designed to enhance social skills, improve insight into specific illnesses/disabilities, enhance coping skills, etc. The intensity, frequency, and type of Community Focused Treatment activities must be appropriate to the age and functional level of the participant and individualized to meet their own specific needs. Community Focused Treatment services must be reviewed at 90-day intervals and adjusted to the changing needs of the recipient.

Examples of skill areas include:

Health Education - first aid, pedestrian and passenger safety, home safety
Meal Preparation -nutrition, menu planning, cooking
Personal Hygiene - grooming, oral and general body care
Utilization of Community Resources - church groups, clubs, volunteer work, getting and keeping entitlements, learning to access recreational opportunities, etc.
Interpersonal Skills -
Problem Solving -
Communications - assertiveness, correspondence, initiating conversation, giving and taking Compliments and criticism, body language, active listening, etc.
Stress Reduction - relaxation techniques, biofeedback, etc.
Peer Relationship -
Interpersonal relationship with peers, caregivers, family, etc. -
Interactions with strangers -
Social Skill Development and Coping Skills
Social Competence - social skill training, presenting opportunities for social interaction
Understanding Mental Illness - medication usage, course of the illness, symptom management, coping mechanisms, normalization, etc.

All treatment objectives provided in a Community Focused Treatment Program must be included on the client's individual master treatment plan. A daily attendance roster reflecting all participants in the service that is signed and dated by participating staff must be maintained and available for review at the community treatment site. The attendance roster is not required to be maintained in the master clinical record.

4. **Staff Qualifications**

The site shall be supervised by a qualified mental health professional (QMHP) with a minimum of a bachelor degree and experience working with individuals with serious and persistent mental illness.

Paraprofessional staff shall possess a high school education and have verified training, experience and skills specific to working with individuals with serious and persistent mental illness. Staff to client ratio shall be one (1) staff to twelve (12) clients per site.

5. Community Focused Treatment Program Certification Process:

All Community Focused Treatment programs require approval through the completion of the Community Focused Treatment Program Certification form, which is then reviewed and approved by the Bureau for Medical Services.

Any changes from an approved original certification must be submitted with corresponding rationale for the changes. This assessment also includes a summary of utilization for the past year. Specific content is described in the application for Community Focused Treatment Program Certification used by the Bureau for Medical Services.

Assertive Community Treatment (ACT)

ACT is a multi-disciplinary approach to providing an inclusive array of community-based rehabilitation services to individuals that are to be provided by multi-disciplinary professional teams certified by the Department.

Eligibility Criteria:

Eligibility criteria for an ACT program is specific to a target population comprised of those members who are most in need and most suitable for the ACT services. The individual must:

A. Be an adult, eighteen (18) years of age or older who has been diagnosed with a severe and persistent mental illness as described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, and

B. Be in an eligible Disability group defined as one of the following: MH (Mental Health); MH & SA (Mental Health & Substance Abuse); or, MH & MR/DD (Mental Health & Mental Retardation/Developmental Disability) for those individuals who have a mental illness as the primary diagnosis and a secondary or co-occurring diagnosis of Mild Mental Retardation. The secondary or co-occurring diagnosis is limited to Mild Mental Retardation. Those individuals who have a primary Mental Retardation/Developmental Disability diagnosis are not eligible to participate in the ACT program. ACT is furnished to all individuals who are determined to meet the medical necessity criteria for the service.

C. ACT Services Team Composition and Staff Qualifications:

The ACT team shall be comprised of a multi-disciplinary, multi-functional professional staff, specializing in mental health, substance abuse treatment, and vocational rehabilitation. Minimum services included in ACT are: Psychiatrist services, counseling, medication management, care coordination of mental health services, community focused treatment, basic living skills, behavioral management, clinical evaluation and crisis services and treatment planning.

At a minimum, the team shall include staff with the following qualifications:

1. one (1) licensed physician/psychiatrist who is board certified;
2. one (1) full-time Team Leader/Supervisor with three (3) years experience in behavioral health services, two (2) of which must be in a supervisory capacity, and a Master's degree and valid West Virginia license in either Counseling, Nursing, Social Work, Psychology or be a Psychologist under Supervision for Licensure (formally enrolled in the WV Board of Examiners of Psychologist Supervision Program);
3. one (1) full-time Registered Nurse with one (1) year psychiatric experience;
4. two (2) full-time staff at the Master's level in Counseling, Nursing, Social Work, or Psychology and two (2) years experience in behavioral health services, specializing in substance abuse assessment/treatment and/or vocational rehabilitation; and,
5. one (1) full-time staff at the Bachelor's level in Social Work or the Behavioral Sciences with behavioral health services experience.

The psychiatrist shall be actively involved with clients and the team for a minimum of sixteen (16) hours a week, and will physically attend/participate in one (1) or more team meetings a week. The ACT team must meet daily to review cases in their caseload; the psychiatrist must also participate in the daily team meeting either in person or by means of video conferencing when unable to be physically present. The team may participate via teleconferencing with the exception of one (1) day per week when the team must meet face-to-face. The psychiatrist must physically participate in the annual service planning session. The psychiatrist and/or physician assistant and/or a psychiatric nurse practitioner may substitute for the psychiatrist as long as they are under the direct clinical supervision of the psychiatrist (except for his/her attendance at the annual service planning session) and the psychiatrist evidences direct clinical involvement with the ACT team and members.

D. ACT Discharge Criteria:

The member may be discharged from the ACT program for any of the following reasons:

1. Member no longer meets eligibility criteria;
2. Member has met all program goals and is at maximum level of functioning;
3. Member has moved outside of the ACT team's geographic area;
4. Member is no longer participating or refuses services regardless of ACT team's efforts at engagement;
5. By virtue of diagnosis or intensity of service needs, member would be better served by an alternative program of care.

E. Caseload Mix and Ratios:

ACT Teams may serve fifty (50) members per team at a minimum and may increase to one hundred and twenty (120) members at a maximum as long as the staff to member ratio remains 1:10. As additional members are added to the ACT team, the number of staff will increase to maintain the 1:10 staff to member ratio (the ratio may not include the psychiatrist). ***Note: The ACT Team shall not serve non-ACT members.***

F. ACT Service Elements and Fidelity Indicators:

The ACT Team is required to provide a combination of long-term services designed to meet national fidelity standards and individualized to the member. If necessary, services are provided twenty-four (24) hours a day, seven (7) days a week with seventy-five percent (75%) being community-based and delivered directly to the member outside of program offices.

Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

Preadmission review of medical necessity and prior authorization required.

A psychiatric hospital or an inpatient psychiatric program in a hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Services are covered in Medicare certified psychiatric hospitals, or distinct psychiatric inpatient units of acute care general hospitals.

Inpatient Psychiatric Services for Individuals Under Age 22 may also be provided in free-standing or distinct part Psychiatric Residential Treatment Facilities (PRTFs) which hold licensure as a behavioral health agency pursuant to 27-9-1 or 27-2A-1 of the West Virginia Code and licensure as a child care agency pursuant to 49-3B-2 of the West Virginia Code. Facilities located outside the State of West Virginia must meet all licensing requirements for Psychiatric Residential Treatment Facilities in the state where the facility is located and be certified to serve Title XIX recipients in that state. Inpatient Psychiatric Facilities for Individuals Under Age 22 and Psychiatric Residential Treatment Facilities must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or the Council on Accreditation of Services for Families and Children, or the Commission of Accreditation of Rehabilitation Facilities, or any other accrediting body with comparable standards that is recognized by the State.

Facilities may be freestanding or a distinct part of an acute care general, or psychiatric hospital. Psychiatric Residential Treatment Facilities are limited in size to 30 beds.

3.1 AMOUNT, DURATION AND SCOPE OF SERVICES

18. Hospice Care (in accordance with §1905(o) of the Act.

A participating hospice meets the Medicare conditions of participation for hospices and has a valid provider agreement. Hospice services are those services defined in Medicare law and regulations and as specified in the Code of Federal Regulations, Title 42, Part 418.

A. Covered Services

1. As required under Medicare and applicable to Medicaid, the hospice itself must provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

a. **Nursing Care:** Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. **Physician Services:** Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

c. **Medical Social Services:** Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

d. **Counseling Services**: Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

2. Other services applicable for the terminal illness that must be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services. These services may be arranged, such as by contractual agreement, or provided directly by the hospice.

a. **Short-term Inpatient Care**: Short-term inpatient care may be provided in a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

b. **Durable Medical Equipment and Supplies**: Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

c. **Drugs and Biologicals**: Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

d. **Home Health Aide and Homemaker Services:** Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

e. **Rehabilitation Services:** Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

3. To be covered, a certification that the individual is terminally ill must have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

B. Special Coverage Requirements

1. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of 8 hours of care during a 24-hour day must be provided to qualify as continuous home care.

2. Routine home care is covered when less skilled care is needed on a continuous basis to enable the person to remain at home.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home are for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Eligible Groups

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certification within two calendar days, it must obtain oral certifications within two calendar days, and written certification no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

20. c. Expanded Prenatal Care Services

A. Comparability of Services:

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B).

B. Definition of Services:

Expanded prenatal care services will offer a more comprehensive prenatal and postpartum care services package to improve pregnancy outcome. The expended prenatal care services provider may perform the following services:

1. Patient Health Education including:

Preventive Self Care instruction up to 32 15-minute sessions during the prenatal period and up to 60 days postpartum and should include but not be limited to topics such as, 1) Physical and emotional changes during pregnancy and postpartum, 2) Warning signs of pregnancy complications, and 3) Healthful behaviors.

Instruction must be rendered by Medicaid certified providers who have appropriate education, license, or certification.

Childbirth Classes up to 7 sessions, through group classes or through individual sessions, totalling 14 hours to be offered during the prenatal period to include but not be limited to topics such as 1) Maternal and fetal development, 2) Nutrition, fitness and drugs, 3) Physiology of labor and delivery, 4) Relaxation and breathing techniques for labor, 5) Postpartum care and family planning, and 6) Newborn care and feeding.

Instruction must be rendered by Medicaid certified providers who have appropriate education, license, or certification.

Parenting Education up to 32 15-minute sessions to be offered during the prenatal period and up to 60 days postpartum and should include but not be limited to topics such as 1) Feeding, bathing, dressing of infant, 2) Recognition of preventive health needs, 3) Recognition of acute care needs, 4) Newborn/child development, and 5) Child Safety. Instruction must be rendered by Medicaid certified providers who have appropriate education, license, or certification.

2. Nutritional Evaluation and Counseling Services to include up to 32 15-minute sessions during the prenatal period and up to 32 15-minute sessions during 60 days postpartum to provide specialized nutrition education and counseling for highly complicated medically related conditions occurring during pregnancy, postpartum or to the infant.

   Qualified provider of these specialized nutrition services must be a registered dietitian (R.D.) in accordance with the Commission on Dietetic Registration.

C. The State assures that the provision of expanded prenatal care services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

   1. Eligible recipient will have free choice of the providers of expanded prenatal care services.

   2. Eligible recipients will have free choice of the providers of other medical care under the plan.

   Payment for expanded prenatal care services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

22. Respiratory Care Services

Prior authorization is required.

23. Pediatric or Family Nurse Practitioner Services

Coverage limited to the scope of practice as defined in state law or the state regulatory authority, with any limitations that apply to all providers qualified to provide the service.

PERSONAL CARE

24. a. **Transportation**
Prior authorization may be required for transportation by ambulance, common carrier or other appropriate means.

d. **Nursing Facility Services Under 21 Years**
Precertification required prior to authorization of benefits.

e. **Emergency Hospital Services**
Limited to Medicare deductible

26. **Personal Care Services**
Personal care services are available to assist an eligible individual to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the individual's home or community. The following family relationships, spouse of a member or parents of a minor child, are excluded from providing personal care services for reimbursement by Medicaid.

Personal care services are services provided in the recipient's home or in the community. Personal care services in the form of assistance with ADLs and IADLs also are available outside the home to eligible disabled individuals who require assistance to obtain and retain competitive employment of at least 40 hours a month. Assistance outside the home may be provided as necessary to assist the individual to and from work, at the work site and in locations for obtaining employment such as employment agencies, human resources offices, accommodation preparation appointments and job interview sites. Personal care services provided outside the home to individuals, for other than employment, may not exceed twenty (20) hours per month. A registered nurse currently licensed in West Virginia provides supervision of direct-care staff and develops the plan of care. All direct-care staff must be certified by an approved training program. Direct-care staff must receive basic training of at least eight (8) hours prior to rendering care. Curricula topics must include CPR, First Aide, Abuse, Neglect and Exploitation topics, Within twelve (12) months of the beginning date of employment, these individuals must receive at least twenty-four (24) hours of additional training. All direct-care staff must have initial and continuing approved training. See Personal Care Services Manual, 517 at: www.wvdhhr.org then medical services/Manual.

Initial determination of need criteria for personal care services shall be based on the West Virginia Department of Health and Human Resources Pre-Admission Screening for Nursing Facility and Community Based Services. The Pre-Admission screen must be signed by a physician indicating level of care required and be accompanied by a registered nurse's plan of care. A personal care nursing assessment must be completed at least once every six months.

For individuals receiving personal care services on an on-going basis, recertification through completion of the screen requiring physician authorization and signature must be completed at least annually.

Personal care services are limited on a per unit, per month basis (15 minutes per unit) with all services subject to prior authorization. Individuals can receive up to a maximum of 840 units (210) hours) each month.

PERSONAL CARE

Personal Care agencies must be certified for the provision of personal care prior to initiating services. The West Virginia Specialized Family Care Program may provide personal care services to members who meet the requirements of its program. All providers agree to abide by applicable federal and state laws, policy manuals, policy changes and other documents that govern this program. Agencies must be certified by the Medicaid agency in order to serve as personal care providers. Agencies must perform, but are not limited to the following activities:

1. Complete criminal background checks on all employees which are to be maintained in the individual's personnel file;
2. Conduct initial and on-going in-home aide training;
3. Monitor quality of care;
4. Ensure that direct care staff work under the supervision of a registered nurse
5. Agree to subject themselves, their staff, and all records that pertain to member services to audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.