TABLE OF CONTENTS

SECTION **PAGE NUMBER**

Background 5

Policy 5

538.1 Member Eligibility 5

538.2 Medical Necessity 6

538.3 Provider Enrollment 6

538.3.1 Enrollment Requirements: Staff Qualifications 7

538.4 Fingerprint-Based Background Checks 7

538.5 Methods of Verifying Bureau for Medical Services' Requirements 8

538.6 School-Based Health Services Provider Reviews 8

538.7 Training and Technical Assistance 9

538.8 Other Administrative Requirements 10

538.9 Telehealth Services 10

538.10 Documentation 12

538.11 Nursing Services 12

538.11.1 Anaphylactic Reaction – Assessment/Evaluation 12

538.11.2 Anaphylactic Reaction – Individual 13

538.11.3 Manual Resuscitator 13

538.11.4 Postural Drainage and Percussion 14

538.11.5 Catheterization 14

538.11.6 Mechanical Ventilator 15

538.11.7 Seizure Management 15

538.11.8 Subcutaneous Insulin Infusion-by Pump 16

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.11.9 Measurement of Blood Sugar 16
538.11.10 Emergency Medication Administration 16
538.11.11 Oral Suctioning 17
538.11.12 Subcutaneous Insulin Infusion By Injection 17
538.11.13 Enteral Feeding 18
538.11.14 Ostomy Care 18
538.11.15 Tracheostomy Care 19
538.11.16 Oxygen Administration 19
538.11.17 Inhalation Therapy 20
538.11.18 Peak Flow Meter 20
538.12 Speech, Language and Audiology Services 21
538.12.1 Individual - Speech, Language, Voice, Communication, Auditory Processing 23
538.12.2 Group - Speech, Language, Voice, Communication, Auditory Processing 23
538.12.3 Evaluation of Speech Fluency 24
538.12.4 Evaluation of Speech Sound Production 25
538.12.5 Evaluation of Speech Sound Production with Evaluation of Language Comprehension 25
538.12.6 Behavioral and Qualitative Analysis 26
538.12.7 Basic Vestibular Evaluation 26
538.12.8 Speech Auditory Threshold 27
538.12.9 Speech Audiometry with Speech Recognition 28
538.12.10 Comprehensive Audiometry Threshold Evaluation with Speech Recognition 28
538.12.11 Bekesy: Diagnostic 29
538.12.12 Loudness Balance Test 29
538.12.13 Tympanometry 30

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.12.14 Acoustic Reflex Testing 31
538.12.15 Acoustic Immitance Testing 31
538.12.16 Filtered Speech Test 32
538.12.17 Conditioning Play Audiometry 32
538.12.18 Select Picture Audiometry 33
538.12.19 Distortion Product Evoked Otoacoustic Emission 33
538.12.20 Hearing Aid Examination - Monaural 34
538.12.21 Hearing Aid Examination - Binaural 35
538.12.22 Hearing Aid Check- Monaural 35
538.12.23 Hearing Aid Check - Binaural 36
538.12.24 Electroacoustic Evaluation for Hearing Aid - Monaural 36
538.12.25 Ear Protector Attenuation Measurements 37
538.13 Psychological Services 37
538.13.1 Assessment Services 37
538.13.1.1 Psychiatric Diagnostic Evaluation (No Medical Services) 37
538.13.2 Testing Services 38
538.13.2.1 Psychological Testing with Interpretation and Report 38
538.13.2.2 Developmental Testing: Limited 40
538.13.3 Psychotherapy Services 41
538.13.3.1 Family Psychotherapy (without the patient present) 43
538.13.3.2 Family Psychotherapy (with the patient present) 44
538.13.3.3 Psychotherapy for Crisis 44
538.14 Personal Care Services (One-on-One Aide) 47
538.15 Occupational and Physical Therapy 48

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.15.1 Physical Therapy Evaluation 49
538.15.2 Occupational Therapy Evaluation 49
538.15.3 Physical Therapy Re-Evaluation 50
538.15.4 Occupational Therapy Re-Evaluation 50
538.15.5 Occupational/Physical Therapy Services 51
538.16 Targeted Case Management (TCM) Services 55
538.17 Transportation Services 58
538.17.1 Non-Emergency Medical Transportation- with Bus Aide 58
538.17.2 Non-Emergency Transportation 59
538.18 Service Limitations 59
538.19 Service Exclusions 59
538.20 Rounding Units of Service 59
538.21 Documentation and Record Retention Requirements 60
538.22 Billing Procedures 60
Glossary 61
Change Log 65

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

POLICY METADATA

Policy ID = 538
Policy Author = Home and Community Based Services
Policy Status = Pending
Creation Date = New

Initial Approval Date = TBD
Initial Effective Date = 7/1/2015
Last Revised Date = 6/5/2015
Revision Approval Date = TBD
Next Review Date = TBD

BACKGROUND

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary 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 the manual 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 payment of School-Based Health Services.

The policies and procedures set forth herein are promulgated as regulations governing the provision of School-Based Health Services in the Medicaid Program as approved by the Centers of Medicaid and Medicare (CMS) and administered by the West Virginia Department of Health and Human Resources (WVDHHR). As set forth in this chapter students are referred to as Medicaid members.

The Bureau for Medical Services has a joint goal with Medicaid enrolled providers to ensure effective services are provided to Medicaid members.

All School-Based Health Providers must cooperate fully 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 Medicaid members 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

538.1 MEMBER ELIGIBILITY

School-Based Health Services program includes medically necessary covered health care services

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

pursuant to an Individualized Education Program (IEP) Plan provided by or through the West Virginia Department of Education (DOE) or a Local Education Agency (LEA). These medically necessary health care services must be ordered by a physician or other licensed practitioners of the healing arts within the scope of license as defined under the West Virginia Code to eligible special education members from age 3 to age 21.

538.2 MEDICAL NECESSITY

All Services covered in this chapter are subject to a determination of medical necessity. In the managed care position paper published in 1999 by the State of WV, medical necessity was defined as:

Services and Supplies that are:

1. appropriate and medically 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 a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

538.3 PROVIDER ENROLLMENT

All LEA's must follow this policy chapter as well as *Chapter 100, General Administration and Information*, *Chapter 200, Definitions and Acronyms*, *Chapter 300, Provider Participation Requirements*, *Chapter 800, Program Integrity* and *Chapter 900, Estate Recovery* of the West Virginia BMS Provider Manual.

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

- Review all documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the committee. Based on this review, the committee must determine which services staff are qualified to provide.
- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Participating providers must develop standards for staff training, supervision, and compliance monitoring in accordance with existing state policy and federal regulations.

538.3.1 Enrollment Requirements: Staff Qualifications

Documentation including required licenses, certifications, proof of completion of training, must be kept on file at the Central Office of the County Boards of Education.

All further staff qualifications will be indicated under the services identified in this Chapter. All documentation for staff including college transcripts, certifications, credentials, background checks, and trainings should be kept in the staff's personnel file and may be reviewed at any time by BMS or BMS' contractors or state and federal auditors.

538.4 FINGERPRINT-BASED BACKGROUND CHECKS

All provider staff, having direct contact with members must, at a minimum, have results from a state level fingerprint-based background check. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must request an additional federal background check through the West Virginia State Police also upon hire and every 3 years of employment. Providers may do an on-line preliminary check and use these results for a period of 3 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 5 years. An individual who is convicted of one or more of the following crimes listed below may not bill or provide services to a Medicaid member or have access to a Medicaid member's information at any time:

- 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 sexually 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;

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- 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 services, the provider must take appropriate action, including notification to the BMS Program Manager for School-Based Health 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 and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.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.

538.5 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.

538.6 SCHOOL-BASED HEALTH SERVICES PROVIDER REVIEWS

The primary means of monitoring the quality of 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 LEA to attend. Following the exit summation, the contracted agent will make available to the provider a draft exit report and a POC 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. 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 of

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Services. A cover letter to the provider's Executive Director will outline the following options to effectuate repayment:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
- 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
- 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 West Virginia Medicaid 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 services 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 POC 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.

538.7 TRAINING AND TECHNICAL ASSISTANCE

The contracted agent develops and conducts training for providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

compliance. Training is available through both face-to-face and web-based venues.

538.8 OTHER ADMINISTRATIVE REQUIREMENTS

Other administrative requirements that must be met by the LEA include but are not limited to the following:

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning, 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 contain completed member identifying information.
- 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.
- Providers 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, Service 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 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 member.
- BMS 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), except for services billed under the T1017 Code for Targeted Case Management.

538.9 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 will bill the service code with a GT Modifier. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services 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 as long as the software is HIPAA Compliant and abides by a federal code pertaining to Telehealth.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- 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 or HCPCS 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 identified scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- The provider must have an appropriately trained employee of the facility available in the building at all Telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation that involves patient management.
- The health care agency or entity that has the ultimate responsibility for the care of the patient must be enrolled as a WV Medicaid provider. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within this manual.
- Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.
- 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, a contracted employee, 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.
- 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 health care practitioner 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 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.

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.10 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. Electronic signatures are accepted when an electronic time stamp is included. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Please refer to the following:

- Appendix 538A – Private Duty Nursing Billing Form
- Appendix 538B – Audiological Billing Form
- Appendix 538C – Speech Therapy Billing Form
- Appendix 538D – Psychological Billing Form
- Appendix 538E – Personal Care Medicaid Log
- Appendix 538F – Occupational Therapy Billing Form
- Appendix 538G – Physical Therapy Billing Form
- Appendix 538H – Targeted Case Management Form
- Appendix 538I – Transportation Billing Form

538.11 NURSING SERVICES

School-Based Nursing Services are face-to-face skilled nursing services that enable a Medicaid member to receive medical monitoring, interventions, and nursing services in their educational setting. Please see Appendix 538A – Private Duty Nursing Billing Form.

538.11.1 Anaphylactic Reaction – Assessment/Evaluation

Procedure Code: T1001
Service Unit: Event
Telehealth: Not Available
Service Limits: Two per calendar year

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: An assessment or evaluation used to develop a written emergency plan for members with a documented history of anaphylactic reaction or potential for anaphylaxis in conjunction with member, parent/guardian and principal. Plan should include step-by-step instructions to follow and emergency phone numbers.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Appropriate Recommendations consistent with the findings of the assessment/evaluation

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

538.11.2 Anaphylactic Reaction – Individual

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Ten per calendar year

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: In cases of known allergies, designated trained personnel will give appropriate amount of medication ordered by the licensed prescriber.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.3 Manual Resuscitator

Procedure Code: 92950
Service Unit: Event
Telehealth: Not Available
Service Limits: Ten per Calendar Year

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: The use of a manual resuscitator in the school setting and during co-curricular events. Includes hyperventilation, oxygenation, ventilator failure with physician order.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.11.4 Postural Drainage and Percussion

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Two units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Performing percussion and/or postural drainage in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.5 Catheterization

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: The performance of cleaning and sterilization of intermittent catheterization in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.11.6 Mechanical Ventilator

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Six units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Mechanical ventilation of the member in the school setting and during co-curricular events. Hands on management included.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.7 Seizure Management

Procedure Code: T1001
Service Unit: Event
Telehealth: Not Available
Service Limits: Two per calendar year

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Seizure management in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service
- Emergency Health Care Plan

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.11.8 Subcutaneous Insulin Infusion-by Pump

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Six units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of insulin by pump in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.9 Measurement of Blood Sugar

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Six units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Measurement of member's blood glucose levels in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.10 Emergency Medication Administration

Procedure Code: T1000

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Two units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of emergency medication in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.11 Oral Suctioning

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Oral suctioning and nasopharyngeal suctioning in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.12 Subcutaneous Insulin Infusion By Injection

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Six units per instructional day

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of insulin by injection in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.13 Enteral Feeding

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of medication via a gastric tube in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.14 Ostomy Care

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

Definition: Management of emptying or changing an ostomy system in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.15 Tracheostomy Care

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Six units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Emergency care and cleaning of a tracheostomy tube and stoma in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.16 Oxygen Administration

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration and safe use of oxygen in the school setting and during co-curricular events.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.17 Inhalation Therapy

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Administration of inhalation therapy by machine in the school setting and during co-curricular events.

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

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.11.18 Peak Flow Meter

Procedure Code: T1000
Service Unit: 15 minute unit
Telehealth: Not Available
Service Limits: Four units per instructional day

Staff Credentials: Must be performed by a Registered Nurse under the employment of an LEA, or a nurse under the supervision of a certified school nurse.

Definition: Use of a peak flow meter in the school setting and during co-curricular events.

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

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Date of Service
- Location of Service
- Nurse's signature with credentials
- Member's health care plan
- Documentation of Individual Service
- Appropriate Recommendations consistent with the findings of the individual service.

538.12 SPEECH, LANGUAGE AND AUDIOLOGY SERVICES

Speech and audiology services must be ordered by a physician, PA or APRN and provided by or under the direction of an enrolled licensed speech therapist or audiologist.

Speech Language Pathologist (SLP)

To render speech language pathology services to Medicaid members under School-Based Health Services the SLP must be licensed by the West Virginia Board of Speech-Language Pathology and Audiologist and must comply with all rules and regulations under WV Code §30-32-1 thru §30-32-23.

Speech Language Pathology Assistants (SLPA)

To render speech language pathology services to Medicaid members under School-Based Health Services the SLPA must have an associate's degree, bachelor's degree or master's degree in speech pathology. The SLPA will be supervised by an SLP associated with the LEA that they are employed with. The SLP is not required to directly supervise the SLPA but must be available in case of any emergent issues.

Non- Covered Services for Speech, Language and Audiology Services include but are not limited to:

- Evaluations by the Speech-Language Pathology Assistant (SLPA)
- Experimental/investigative services/procedures for research purposes
- Evaluations provided by an employee or an individual that has a financial interest with providers of devices
- Speech therapy services provided:
  - to individuals who are not Medicaid eligible on the date of service
  - by persons not duly certified to provide the services
  - to members showing no progress in treatment/therapy
- Upgrades to, or subsequent versions of the speech generating device software program or memory modules that may include enhanced features or other improvements
- Any device that is not a dedicated augmentative communication/speech generating device or can run software for purposes other than speech generating device (e.g., word processing application, accounting program, or other non-medical functions)
- Augmentative communication (AC)/speech generating systems or devices intended to meet social, educational, vocational or non-medical needs
- Any device that allows input of information via a pen-based system using a stylus and handwriting recognition software, keyboard, or downloaded from a personal computer using special cables and software
- Multiple AC's or software programs that perform the same essential function are considered a

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

duplication of services and are not medically necessary
- Laptop computers or desktop computers which may be programmed to perform the same function as a speech generating device
- Printers (which are not a built-in component of a augmentative communication/speech generating device), printer paper, printer cables
- Environmental control devices which are not a built in component
- Purchase of a new personal computer, repair or replacement of a previously owned personal computer, repair or replacement of a previously owned PC or any related hardware
- Extended vocabulary software packages
- An AC device provided without severe speech impairment
- Rental of hearing aids
- Hearing aids, hearing aid evaluations and fittings for members 21 years and older
- Personal FM Systems
- Assistive technology devices that are maintained at a school facility for the general use of disabled members and assistive technology services related to the use of such devices
- Upgrading of hearing aids to accommodate school facility FM systems

Speech therapy is deemed not medically necessary when the member has:

- Reached the highest level of functioning and is no longer progressing; OR
- The established plan of care goals and objectives are met; OR
- The established plan of care does not require the skills of a speech-language therapist/pathologist; OR
- The member or his/her legal representative has demonstrated the knowledge and skill of providing the speech therapy regime themselves.

Non-covered services are not eligible for a DHHR fair hearing or document/desk review.

Required Documentation

A written referral from the treating/prescribing practitioner with pertinent clinical documentation for service(s) requested. The referral must include, but is not limited to, the member's name, date of referral, type of service requested, frequency and duration of treatment, diagnosis, and physician's, PA's, or APRN's signature. Supporting documentation must not be more than 6 months old.

- The plan of care which must include, but is not limited to, the date the plan was developed, diagnosis, short and long-term functional goals, measurable treatment objectives, frequency and duration of treatment, education/training in speech therapy or hearing devices for the member or their legal representative to attain maximum rehabilitation, prognosis, date discussed with member or legal representative, signature and date of the member or legal representative agreeing to the treatment, date, and signature and title of the individual providing treatment. The plan of care may be developed from information found in the IEP.
- An audiology evaluation with audiometric results which cannot be more than 6 months old prior to dispensing the hearing aid.

Please see Appendix 538B Audiological Therapy Form or Appendix 538C Speech Therapy Billing Form.

Codes 92521, 92522, 92523 and 92524 are used to report evaluation of speech production, receptive

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

language, and expressive language abilities. Tests may examine speech sound production, articulatory movements of oral musculature, the patient's ability to understand the meaning and intent of written and verbal expressions, and the appropriate formulation and utterance of expressive thought.

538.12.1 Individual - Speech, Language, Voice, Communication, Auditory Processing

Procedure Code: 92507
Service Unit: 15 minute unit
Telehealth: Available
Service Limits: Eight units per calendar month

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Treatment of Speech, language, voice, communication, and/or auditory processing disorder; individual

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified speech therapy needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Documentation must also include the following:

- Member Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.12.2 Group - Speech, Language, Voice, Communication, Auditory Processing

Procedure Code: 92508
Service Unit: 15 minute unit
Telehealth: Available
Service Limits: Eight units per calendar month

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Treatment of Speech, language, voice, communication, and/or auditory processing disorder;

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

individual

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified speech therapy needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Documentation must also include the following:

- Member Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.12.3 Evaluation of Speech Fluency

Procedure Code: 92521
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology.

Definition: An integrated evaluation to determine speech fluency e.g. stuttering, cluttering etc.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.12.4 Evaluation of Speech Sound Production

Procedure Code: 92522
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
Cannot be billed the same day as 92523
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: An integrated evaluation to determine speech sound production (e.g. articulation, phonological process, apraxia, and dysarthria.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.5 Evaluation of Speech Sound Production with Evaluation of Language Comprehension

Procedure Code: 92523
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
Cannot be billed the same day as 92522
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: An integrated evaluation to determine speech sound production (e.g. articulation, phonological process, apraxia, and dysarthria with evaluation of language comprehension and expression (e.g.) receptive and expressive language)

Documentation: Documentation must contain the following and be completed within 30 calendar days from

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.6 Behavioral and Qualitative Analysis

Procedure Code: 92524
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: An integrated evaluation to determine behavioral and qualitative analysis of voice and resonance.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.7 Basic Vestibular Evaluation

Procedure Code: 92540
Service Unit: Event (completed evaluation)
Telehealth: Not Available

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Service Limits: Two Events per Year
Cannot be billed in conjunction with 92541, 92542, 92544 or 92545

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Basic vestibular Evaluation includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording positional hystagmus test, minimum of 4 positions, with recording optokinetic nystagmus test bidirectional foveal and peri [heral stimulation, with recording and oscillating tracking test, with recording.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.8 Speech Auditory Threshold

Procedure Code: 92555
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: An integrated evaluation to determine speech audiometry threshold

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.9 Speech Audiometry with Speech Recognition

Procedure Code: 92556
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year
Cannot be billed the same date of service as 92555

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: A comprehensive audiometry threshold evaluation and speech evaluation.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.10 Comprehensive Audiometry Threshold Evaluation with Speech Recognition

Procedure Code: 92557
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
Cannot be billed the same date of service as 92552, 92533, 92555, or 92556

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: A comprehensive audiometry threshold evaluation and speech recognition.

Documentation: Documentation must contain the following and be completed within 30 calendar days from

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.11 Bekesy: Diagnostic

Procedure Code: 92561
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One Event per Year
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Bekesy Diagnostic Test

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.12 Loudness Balance Test

Procedure Code: 92562
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Staff Credentials: Must be performed by a West Virginia licensed or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Loudness Balance Test, alternate binaural or monaural

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.13 Tympanometry

Procedure Code: 92567
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia, licensed registered nurse licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Tympanometry (impedance testing)

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Appropriate Recommendations consistent with the findings of the evaluation

538.12.14 Acoustic Reflex Testing

Procedure Code: 92568
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Acoustic Reflex Testing; threshold

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.15 Acoustic Immitance Testing

Procedure Code: 92570
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year
SLPA cannot render this service

Staff Credentials: Must be performed by a West Virginia, licensed registered nurse licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Acoustic Immittance testing includes tympanometry (impedance testing) acoustic reflex threshold.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.16 Filtered Speech Test

Procedure Code: 92571
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event Per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Filtered Speech Test

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service

- Date of Service
- Location of Service
- Physician, PA or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.17 Conditioning Play Audiometry

Procedure Code: 92582
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: Four Events Per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Definition: Conditioning Play Audiometry

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.18 Select Picture Audiometry

Procedure Code: 92583
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Select Picture Audiometry

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.19 Distortion Product Evoked Otoacoustic Emission

Procedure Code: 92587
Service Unit: Event (completed evaluation)

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Distortion Product Evoked Otoacoustic Emission; Limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.20 Hearing Aid Examination - Monaural

Procedure Code: 92590
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Two Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Hearing Aid Examination and selection; monaural.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

- Appropriate Recommendations consistent with the findings of the evaluation

538.12.21 Hearing Aid Examination - Binaural

Procedure Code: 92591
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Two Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Hearing Aid Examination and selection; binaural.

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.12.22 Hearing Aid Check- Monaural

Procedure Code: 92592
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Hearing Aid Check; monaural

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Provider's signature with credentials
- Documentation with results of check
- Appropriate Recommendations consistent with the findings of the check.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

538.12.23 Hearing Aid Check - Binaural

Procedure Code: 92593
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed speech pathologist or audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Hearing Aid Check; binaural

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Provider's signature with credentials
- Documentation with results of check
- Appropriate Recommendations consistent with the findings of the check

538.12.24 Electroacoustic Evaluation for Hearing Aid - Monaural

Procedure Code: 92594
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: Four Events per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Electroacoustic Evaluation for Hearing Aid; monaural

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service.

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Evaluation
- Evaluator's signature with credentials
- Presenting Problem
- Duration and Frequency of Symptoms
- Members diagnosis per current ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.12.25 Ear Protector Attenuation Measurements

Procedure Code: 92595
Service Unit: Event (completed evaluation)
Telehealth: Not Available
Service Limits: One Event per Year

Staff Credentials: Must be performed by a West Virginia licensed audiologist in good standing with the West Virginia Board of Examiners for Speech-Language Pathology & Audiology

Definition: Ear Protector Attenuation measurements

Documentation: Documentation must contain the following and be completed within 30 calendar days from the date of service:

- Date of Service
- Location of Service
- Physician, PA, or APRN order for the evaluation
- Purpose of Measurements
- Evaluator's signature with credentials
- Presenting Problem
- Members diagnosis per current ICD methodology
- Documentation of Measurements

538.13 PSYCHOLOGICAL SERVICES

Psychological Services includes assessments, testing, and therapeutic services that are used to diagnose and treat individuals with suspected or identified diagnosis of emotional, developmental or substance abuse issues. Please see Appendix 538D Psychological Billing Form.

538.13.1 Assessment Services

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff 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.

538.13.1.1 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: 90791
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: Two events per year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

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 the following and be completed within 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Purpose of Evaluation
- Psychiatrist's/Psychologist's signature with credentials
- Presenting Problem
- History of Medicaid Member's presenting illness
- Duration and Frequency of Symptoms
- Current and Past Medication efficacy and compliance
- Psychiatric History up to Present Day
- 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 Homicidally
    - Insight and Judgment
- Members diagnosis per current DSM or ICD methodology
- Medicaid Member's prognosis and rationale
- Rationale for Diagnosis
- Appropriate Recommendations consistent with the findings of the evaluation

538.13.2 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 material 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.

538.13.2.1 Psychological Testing With Interpretation and Report

Procedure Code: 96101
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: Two units per calendar year

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

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.

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

- Date of Service
- Location of Service
- Time Spent (Start/Stop Times)
- Signature with Credentials
- Purpose of the Evaluation
- Documentation that Medicaid Member was present for the evaluation
- Report must contain results (score and category) of the administered tests/evaluations
- Report must contain interpretation 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 Homicidally
    - Insight and Judgment
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology.
- Recommendations consistent with the findings of administered tests/evaluations

Service Exclusions:

- Psychometrician/Technician Work
- Computer - Scoring

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Self-Administered Assessments
- Computer – Interpretation
- Interns may not bill for this service

538.13.2.2 Developmental Testing: Limited

Procedure Code: 96110
Service Unit: Event (completed interpretation and report)
Telehealth: Not Available
Service Limits: Two Events per calendar year

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.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education.

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

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

- Date of Service
- Location of Service
- Purpose of Evaluation
- Time Spent (start/stop times)
- Signature with credentials
- Documentation that the member was present for the evaluation
- Documentation must contain the results (scores and category) of the administered tests/evaluations
- Documentation must contain interpretation, diagnosis, and recommendations.
- 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
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology
- Recommendations consistent with the findings of the administered tests/evaluations.

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.13.3 Psychotherapy Services

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist 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).

Procedure Code: 90832
Service Unit: 1 unit = 16-37 minutes
Telehealth: Available
Service Limits: Ten units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist 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, 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.

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

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Documentation must also include the following:

- Member Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 90834

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Service Unit: 1 unit = 38-52 minutes
Telehealth: Available
Service Limits: Ten units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist 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, 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.

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

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Member Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 90837
Service Unit: 1 unit = 53 or more minutes
Telehealth: Available
Service Limits: Ten units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist 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, 90837, and 90853 include ongoing assessment

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

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

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Member Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.13.3.1 Family Psychotherapy (without the patient present)

Procedure Code: 90846
Service Unit: 1 unit =45-50 minutes
Telehealth: Available
Service Limits: Ten units per Calendar Year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy without the patient present in the therapeutic session.

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

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

The documentation must also include the following:

- Member's Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.13.3.2 Family Psychotherapy (with the patient present)

Procedure Code: 90847
Service Unit: 45-50 minutes
Telehealth: Available
Service Limits: Ten Units per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy with the patient present in the therapeutic session.

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

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Member's Service Plan
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.13.3.3 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

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

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 psychologist 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 psychologist 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 patient must be present for all or some of the service. Do not report with 90791.

Procedure Code: 90839
Service Unit: 60 Minutes
Telehealth: Not Available
Service Limits: Four per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education

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

There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis

The documentation must also include the following:

- Signature with credentials
- Safety Plan
- Place of service
- Date of service
- Start-and-Stop times
- 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

Service Exclusions:

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Response to a Domestic Violence Situation
- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting 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.

Procedure Code:	90840
Service Unit:	Add on code for each additional 30 minutes of psychotherapy for crisis, used in conjunction with 90839
Telehealth:	Not Available
Service Limits:	Four per calendar year

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a Supervised Psychologist who is supervised by a Board Approved Supervisor or a School Psychologist as deemed and approved by the West Virginia Department of Education.

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

There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis

The documentation must also include the following:

- Signature with credentials
- Safety Plan
- Place of service
- Date of service
- Start-and-Stop times
- 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

Service Exclusions:

- Response to a Domestic Violence Situation

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting 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.

538.14 PERSONAL CARE SERVICES (ONE-ON-ONE AIDE)

Procedure Code: T1019 SE
Service Unit: 15 Minute Unit
Telehealth: Not Available
Service Limits: 28 units per instructional day

Staff Credentials: Services are furnished by providers who have satisfactorily completed a program for home health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions. Providers must have completed a GED or High School Diploma. Providers must complete AND continue to have up to date training for the following:

- CPR/First Aid
- Abuse, Neglect, Exploitation and Mandatory Reporting Requirements Training
- HIPAA/ Confidentiality Training

The following are the positions that have been identified as providers of Personal Care Services by the West Virginia Department of Education:

- Aide I
- Aide II
- Aide III
- Aide IV
- Paraprofessional
- Autism Mentor
- Early Childhood Classroom Assistant Teacher (ECCAT) I
- Early Childhood Classroom Assistant Teacher (ECCAT) II
- Early Childhood Classroom Assistant Teacher (ECCAT) III
- Braille Specialist
- Sign Support Specialist
- Educational Sign Language Interpreter I
- Educational Sign Language Interpreter II

Definition: Services related to a child's physical and behavioral health requirements, including assistance with eating, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, use of adaptive equipment, ambulation and exercise, behavior modification, and/or other remedial services necessary to promote a child's ability to participate in, and benefit from, the educational setting. Aide services can be shared across two staff. However each staff must document their service time with the member. Interpreters and autism mentors can serve as personal care aides. Parents cannot be counted as personal care aides.

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Documentation: Documentation must be completed within 15 calendar days from the date of service. Please see Appendix 538E – Personal Care Medicaid Log.

538.15 OCCUPATIONAL AND PHYSCIAL THERAPY

To be covered, occupational and physical therapy services must be ordered by a participating physician or nurse practitioner and provided by or under the direction of a registered licensed occupational /physical therapist on an outpatient basis.

"Under the direction of" means that the therapist is on the premises when the services are rendered and is available for any emergency or question that may arise. As circumstances permit, the therapist must be involved in patient education, including but not limited to, teaching the patient exercise, manipulation, and how to use devices for their own rehabilitation.

Documentation: Documentation must be completed within 15 calendar days from the date of service. Please see Appendix 538F Occupational Therapy Billing Form or Appendix 538G Physical Therapy Billing Form.

Continuous progress/improvement must be documented for coverage of therapy. The member must show compliance with therapy.

Continuation of services may be considered, when an exacerbated episode of a chronic condition is clearly documented.

A member's representative has the freedom to choose services from Medicaid providers outside the school system. However, West Virginia cannot cover this duplication of services, that is, pay claims for the same services provided in the school system and also outside the school system by private. The LEA is responsible to have the Medicaid member's representative sign consent for treatment form for any occupational or physical therapy services provided at a school that is intended to be billed to Medicaid.

When school is not in session, continuation of therapy services, if necessary, should be coordinated with a qualified therapist in private practice. The treatment plan established by the school system should be written in a way that the private practitioner can pick up where the school therapist ended.

Physical Therapy Assistant (PTA) Regulations to Bill under a Licensed Physical Therapist: All PTAs must meet and follow the regulations under WV State Code §16-1-1 thru 16-1-9.

Certified Occupational Therapy Assistant (COTA) Regulations to Bill under a Licensed Occupational Therapist: All COTAs must meet and follow the regulations under WV State Code §30-28-1 thru 30-28-21.

SERVICE EXCLUSIONS

- Occupational / physical therapy services that are rendered to an inpatient in a hospital, skilled nursing facility, or other facility.
- Occupational / physical therapy services furnished to persons who are not eligible for such services on the date the services are rendered
- Occupational / physical therapy services will not be authorized for members who have reached maximum rehabilitation potential
- Separate payment for hot or cold packs (CPT 97010). Payment for this code has been bundled into the payment for other services.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Experimental services or drugs.

538.15.1 Physical Therapy Evaluation

Procedure Code: 97001 GP
Service Unit: Event
Telehealth: Not Available
Service Limits: One per Calendar Year

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist

Definition: Physical Therapy Evaluation

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

The documentation must also include the following:

- PT Diagnosis
- Recent PT Therapy
- Prior Functional Status
- Plan of care
- PT Profile and Context
- Tolerance to IADLS
- Tolerance to Activities
- Current Splint and Orthoses
- Recommendations
- Prognosis for Treatment
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.15.2 Occupational Therapy Evaluation

Procedure Code: 97003 GO
Service Unit: Event
Telehealth: Not Available
Service Limits: One per Calendar Year

Staff Credentials: Must be performed by a West Virginia Licensed Occupational Therapist

Definition: Occupational Therapy Evaluation

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

The documentation must also include the following:

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- OT Diagnosis
- Recent OT Therapy
- Prior Functional Status
- Weight Bearing Activities
- OT Profile and Context
- Tolerance to IADLS
- Tolerance to Activities
- Current Splint and Orthoses
- Recommendation
- Prognosis for Treatment
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.15.3 Physical Therapy Re-Evaluation

Procedure Code: 97002 GP
Service Unit: Event
Telehealth: Not Available
Service Limits: Two per Calendar Year

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist

Definition: Physical Therapy Re-Evaluation

Documentation: Documentation of the Re-Evaluation must contain the following and be completed within 15 calendar days from the date of service.

The documentation must also include the following:

- Change or no Change of PT Diagnosis
- Frequency of PT
- Duration of PT
- Prognosis toward Established Goals
- Member Compliance to Treatment
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.15.4 Occupational Therapy Re-Evaluation

Procedure Code: 97004 GO
Service Unit: Event
Telehealth: Not Available
Service Limits: Two per Calendar Year

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

Staff Credentials: Must be performed by a West Virginia Licensed Occupational Therapist

Definition: Occupational Physical Therapy Re-Evaluation

Documentation: Documentation of the Re-Evaluation must contain the following and be completed within 15 calendar days from the date of service.

The documentation must also include the following:

- Change or no Change of OT Diagnosis
- Frequency of OT
- Duration of OT
- Prognosis toward Established Goals
- Member Compliance to Treatment
- Update to Tolerance to IADLS
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.15.5 Occupational/Physical Therapy Services

Procedure Code: 97032 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97110 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Therapeutic procedure 1 or more areas each 15 minutes therapeutic exercise to develop strength and endurance range of motion and flexibility.

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97112 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97113 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

Documentation: Documentation must include the following:

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97116 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Gait Training and Stair Climbing

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97140 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Manual therapy techniques (e.g. Mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97150 (GO for Occupational Therapy or GP for Physical Therapy)

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Therapeutic procedure(s), group (2 or more individuals)

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97530 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance)

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97532 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider,

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

each 15 minutes

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 97533 (GO for Occupational Therapy or GP for Physical Therapy)
Service Unit: 15 minute
Telehealth: Not Available
Service Limits: Ten per Calendar Month

Staff Credentials: Must be performed by a West Virginia Licensed Physical Therapist, PTA, Licensed Occupational Therapist, or COTA

Definition: Sensory integrative techniques to enhance sensory processing and promote adaptive response to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

Documentation: Documentation must include the following:

- Member Service Plan
- PT/OT Interventions utilized
- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

538.16 TARGETED CASE MANAGEMENT (TCM) SERVICES

Procedure Code: T1017 SE
Service Unit: 15 Minute Unit
Telehealth: Available
Service Limits: Three units per instructional day

Staff Credentials: The following credentials are accepted for a TCM Provider to render this Medicaid service:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
    - Psychology

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

DRAFT

  - Criminal Justice
  - Board of Regents with health specialization
  - Recreational Therapy
  - Political Science
  - Nursing
  - Sociology
  - Social Work
  - Counseling
  - Teacher Education
  - Behavioral Health Liberal Arts or;
- Other degrees approved by the West Virginia Department of Education.

TCM services are a component of the TCM Service Plan. TCM identifies and addresses special health problems and needs that affect the member's ability to learn, assist the child to gain and coordinate access to a broad range of medical, social, educational, and other services, and ensures that the member receives effective and timely services appropriate to their needs.

The relationship of the targeted case manager with a Medicaid member and his or her family should be one of a partnership. As such, members, parents, and families are not merely spectators of case management recommendations, but active participants in care planning throughout the case management process. This is a necessary perspective in order for the member's needs and/or preferences to be considered and addressed individually and within the environment in which the person resides.

Accordingly, organized strategies that empower members, parents, and families to assume and carry out their responsibilities must be included in this mutual planning process. It is very important that a targeted case manager is aware of and sensitive to the values, attitudes, and beliefs that are unique to each family. Values concerning approaches and styles of parenting and/or family life vary according to culture. The effectiveness of TCM is positively impacted by a demonstrated respect for cultural variations among families. Thus, it is critical that case managers be able to identify and understand cultural beliefs, values, attitudes, and morals by which beneficiaries and their families operate.

TCM effectiveness is further enhanced when integrated with other services and resources identified through a systems perspective, considering all active participants in the individual's life (including the individual's parents, family, and significant others and any involved service providers). Interschool collaboration is crucial to ensuring that a member's needs are adequately met without duplication of services. Thus, it is important for a system to exist within each school to ensure that targeted case managers are communicating with other professionals and involved parties, coordinating care and services and meeting the specific needs of each individual and, as appropriate, the needs of families.

TCM is the coordination of services to ensure that eligible Medicaid members have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying individual problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist beneficiaries and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid beneficiary are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

The LEA is required to have the Medicaid member's Targeted Case Management Form (Please see Appendix 538H Targeted Case Management Form) signed by the member's legal representative and kept in the member's file. LEA's may not bill for TCM Services until the form is completed and signed by the Member's representative.

TCM services must include any of the following activities:

- Needs Assessment and Reassessment;
- Development and Revision of Service Plan;
- Referral and Related Activities; or
- Monitoring and follow-up activities;

1. Needs Assessment and Reassessment: Reviewing of the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. Results of assessments and evaluations are reviewed and a meeting is held with the individual, his or her parent(s) and /or guardian, and the case manager to determine whether services are needed and, if so, to develop a service plan. At a minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed.

2. Development and Revision of the TCM Service Plan: Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parents(s) or legal guardian, and the case manager. Development (and periodic revision) of the TCM Service Plan will specify the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually. The IEP is not the TCM Service Plan.

3. Referral and Related Activities: Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the individual, his or her parent(s) or legal guardian and the case manager and between the individual, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual. This may also include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

4. Monitoring and Follow-up Activities: The case manager shall conduct regular monitoring and follow-up activities with the client, the client's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the individual's TCM Service Plan. Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of TCM services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties. The periodic reviews will be conducted as necessary but at least annually.

All services shall be fully documented in the member's record.

Non-Duplication of Services: If a Medicaid member chooses to have TCM services from another provider agency as a result of being members of other covered targeted groups such as foster children etc.; the School-Based Health Services providers will ensure that TCM activities are coordinated to avoid duplication of services.

TCM includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. TCM activities shall not restrict or be used as a condition to restrict a client's access to other services under the state plan.

538.17 TRANSPORTATION SERVICES

Transportation services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service. Transportation must only be provided to Medicaid members.

538.17.1 Non-Emergency Medical Transportation- with Bus Aide

Procedure Code: T2001
Service Unit: Trip
Service Limits: 4 One Way trips per instructional day

Definition: Non-emergency Medical Transportation with attendant is a service in which a one-way transport of a member by a vehicle other than an ambulance is provided. If more than one member is being transported, each member's transport to the Medicaid service is billable. Non-Emergency Transportation with an attendant may only be billed when a Medicaid covered service is billed for the same date of service and the attendant is present during the transport.

Documentation: Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times. Please see Appendix 538I Transportation Billing Form.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

538.17.2 Non-Emergency Transportation

Procedure Code: T2002
Service Unit: Per Diem
Service Limits: On instructional days where a Member does not receive a Medicaid Covered Service the LEA cannot bill for transportation

Definition: Non-Emergency Medical Transportation: Per Diem is a service in which the member's transportation by the provider is documented and subsequently billed at a per diem rate when a Medicaid Covered Service rendered the same date as the transportation.

Documentation: Documentation must consist an activity note describing the purpose for the transport, signed by the providing staff (along with their credentials), type of vehicle used for the transport, place of departure and arrival, actual billable mileage, and date of service. Please see Appendix 538I Transportation Billing Form.

538.18 SERVICE LIMITATIONS

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

538.19 SERVICE EXCLUSIONS

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

- Telephone consultations - excluding T1017
- 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 including IEP's
- A copy of medical report when the agency paid for the original service
- Experimental services or drugs
- Methadone administration or management
- Any activity provided for the purpose of leisure or recreation
- Services rendered outside the scope of a provider's license

538.20 ROUNDING UNITS OF SERVICE

- Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. **Units of service based on an episode or event cannot be rounded**.
- Many services are described as being "planned," "structured," or "scheduled." If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.
- The following services are eligible for rounding:
- T1017 –Targeted Case Management

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months. Only whole units of service may be billed.**

538.21 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 Provider Manual.

Providers of services 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, a current service plan signed by the provider, 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 at the Central Office of the County Boards of Education/LEA. These records are 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 of Services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

538.23 BILLING PROCEDURES

- Claims from providers must be submitted on the current BMS approved designated forms 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.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

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 WV Code §49-1-3

Audiologist: A person who practices audiology in accordance within their licensure, scope of practice and is licensed by the West Virginia Board of Examiners for Speech-Language Pathology & Audiology as defined in WV Code §30-32**.**

Augmentative Communication (AC)/Speech Generating Device: A speech aid that provides the ability to meet functional speaking needs of members with severe speech impairment.

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

Billing Agent: The party to whom Medicaid Program billing has been designated, a Regional Educational Service Agency.

Billing Tool: The form used for listing provider services so the billing agent can generate the CMS 1500 claim. Can be done electronically or manually.

Binaural: Pertaining to both ears. Only 1 unit and binaural procedure codes are to be billed when supplying hearing devices for both ears.

Bureau for Medical Services (BMS): The organizational entity in DHHR responsible for the administration of the Medicaid Program.

Certified Occupational Therapy Assistant (COTA): An Associate of Arts graduate employed by and under the direct supervision of an Occupational Therapist and is licensed by the Board of Occupational Therapy in West Virginia.

Certified School Nurse: A registered professional nurse, who is licensed by the West Virginia Board of Examiners for Registered Professional Nurses (W.Va. Code §30-7-1, et seq.), who has completed a West Virginia Department of Education approved program as defined in the WVBE Policy 5100: Approval of Educational Personnel Preparation Programs (W.Va. §126CSR114), and meets the requirements for certification contained in WVBE Policy 5202: Minimum Requirements for the Licensure of Professional/Paraprofessional Personnel and Advanced Salary Classifications (W.Va. 126CSR136) (hereinafter Policy 5202). The certified school nurse must be employed by the county board of education or the county health department as specified in W.Va. Code §18-5-22. These policies are located on the West Virginia Department of Education website at https://wvde.state.wv.us/policies/

Cochlear Implant: An implanted electronic hearing device, designed to produce useful hearing sensations to a member with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Communication Disorder: An impairment in a person's ability to receive, send, process, and comprehend concepts of verbal, nonverbal, and graphic symbol systems.

County School Districts: Any of the fifty-five (55) local school systems responsible for providing public education in West Virginia.

Covered Services: Medicaid reimbursable services provided to Medicaid eligible members by qualified providers employed by or contracted with a county school district, RESA, state operated or state supported program.

Designated Legal Representative (DLR): 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.

DHHR: The West Virginia Department of Health and Human Resources.

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.

Freedom of Choice: Unless formally waived by the federal government, state Medicaid programs must allow Medicaid recipients to obtain services from any institution, agency, person, pharmacy or organization that qualifies as a Medicaid provider. For school-based services, a member and/or his/her parents could elect to receive services either through the West Virginia Department of Education or through any other Medicaid provider. Freedom of choice for school-based services must be documented in the member's record and maintained for a five-year period.

Group Number: The number assigned to each district for billing Medicaid. The group number must be on all claims submitted. Individual providers for the following specialties: audiologists, occupational therapists, physical therapists, psychologists, registered nurses and speech language therapists must also provide their individual Medicaid provider number.

Health Care Plan: A written document developed by the certified school nurse which includes a nursing diagnosis, is individualized to the member's health needs and consists of specific goals and interventions delineating the school nursing actions, delegated procedures and member's role in self-care.

Hearing Aid: An electronic device that increases the loudness of sounds and speech for the hearing impaired.

Human Services Degree: A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Psychology
- Criminal Justice
- Board of Regents with health specialization
- Recreational Therapy
- Political Science
- Nursing
- Sociology
- Social Work
- Counseling
- Teacher Education
- Behavioral Health Liberal Arts or;
- Other degrees approved by the West Virginia Department of Education

(Note: Some services require specific degrees as listed in this manual. See specific services for detailed information on staff qualifications.)

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.

Local Education Agency (LEA): As defined in Elementary and Secondary Education Act (ESEA), a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools.

Medicaid: Created as Title XIX of the Social Security Act in 1965, Medicaid is a federal/state health insurance program for low-income individuals administered by the states and funded from federal and state revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. States have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery. In general, Medicaid covers low-income mothers and children, elderly people who need long-term care services and people with disabilities. Children make up about half of the Medicaid population.

Medicaid Eligible Member: Any student who has been determined by DHHR as eligible to receive Medicaid benefits.

Medical Necessity: Based upon the member's diagnosis (es), all service(s) provided to the member are medically necessary. Medical necessity for school-based services must be documented in the member's record and maintained for a five-year period.

Medicare: Created as Title XVIII of the Social Security Act, Medicare established a broad program of federally-funded health insurance coverage for individuals 65 years of age or older and certain disabled individuals.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Medicare/Medicaid Patient: An individual dually eligible for both the Medicare program (65 year of age or older, as well as certain other disabled individuals) and the Medicaid program (low-income individuals or families who qualify to receive medical and/or financial assistance).

Member ID Number: The eleven-digit number designated for each Medicaid recipient. This case number must be included on all claims.

Member Service Plan: A required written document developed by the service provider which is individualized to the member's health needs and consists of specific goals and objectives.

Monaural: Pertaining to one ear. Only 1 unit and the monaural procedure codes are to be billed when supplying a hearing device for 1 ear. Each ear cannot be billed separately.

Occupational Therapist: A graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association (AMA) and the American Occupational Therapy Association and is licensed or registered in West Virginia.

Physical Therapist: A graduate of a program of physical therapy approved by the American Physical Therapy Association and the Committee on Allied Health Education and Accreditation of the AMA, and is licensed or registered in the State in which he or she Practices

Physical Therapy Assistant (PTA): An Associates of Arts graduate under the direct supervision of a Physical Therapist and licensed by the Board of Physical Therapy in the State he/she practices. (PTA)

Physician: As defined in WV 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 WV Code §30-14-6.

Physician's Order: A written prescription from a licensed medical physician authorizing the provision of services. It contains the diagnosis, etc., to substantiate the medical necessity of the services.

Physician's Referral – A recommendation from a licensed physician for a member to receive services. The referral must be documented in the member's file with the name of the physician, date of the referral and the service(s) for which the member was referred, and the diagnosis to substantiate the medical necessity for the service(s).

Procedure Codes: The Medicaid Program uses the American Medical Association Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) as its base for identifying particular procedures.

Regional Educational Service Agency (RESA): One of eight regional multi-county agencies established pursuant to WV Code §18-2-26 whose purpose is to provide high quality, cost effective educational programs and services to the county school systems.

Registered Nurse (RN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse and in good standing with the West Virginia Board of Examiners for Registered

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Professional Nurses or a person who has completed a BA or BS in Nursing and is approved by the West Virginia Department of Education as a school nurse.

Related Services: Those services identified as but not limited to: audiology, speech/language therapy, occupational therapy, physical therapy, psychological services, and private duty nursing.

Speech-Language Pathologist: A person who practices speech language pathology in accordance within their licensure, scope of practice and is licensed by the West Virginia Board of Examiners for Speech-Language Pathology & Audiology as defined in WV Code §30-32**.**

Speech-Language Pathologist Assistant: A person who practices speech language pathology as an assistant in accordance within their licensure, scope of practice and is licensed by the West Virginia Board of Examiners for Speech-Language Pathology & Audiology defined in WV Code §30-32.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Utilization Management Contractor (UMC): The contracted agent of BMS who performs retrospective reviews on school-based services.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			8/1/2015

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.