16.1 INTRODUCTION

The West Virginia Medicaid Program provides payment for covered medical services to certified medical providers for eligible individuals who are aged, blind or disabled and to eligible members of families with dependent children.

The determination of which medical services are covered under Medicaid and which medical providers are certified to accept Medicaid patients is the responsibility of the Bureau for Medical Services and is not addressed in this Manual. Unless otherwise specified, the coverage group receives all services covered under Medicaid.

For eligibility for nursing care services and MR/DD and HCB Waiver coverage groups, refer to Chapter 17.

This Chapter provides an overview of the Medicaid Program. In addition, each coverage group has specific requirements which must be met and procedures to follow that may not apply to other Income Maintenance programs or other Medicaid coverage groups. These are contained in this Chapter.

Certain programs, such as CDCS, MR/DD and HCB Waiver, require a medical and/or other determination by a community agency or government organization other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

NOTE: Children determined eligible for QC or PL Medicaid remain eligible for 12 continuous months, regardless of any changes after approval, except those specified in Section 2.8.

In addition to the coverage groups described in this Chapter which make up the Medicaid Program, the Department has special procedures in place to pay for certain necessary drugs for individuals not eligible for Medicaid. See Chapter 28.

A. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS

Provided they are legally able to do so, all adult Medicaid applicants and recipients must assign to the department any rights to medical support and to payments for medical care from any third party.

When the adult receives Medicaid under any coverage group, under any case number, the assignment of medical support rights is a condition of eligibility and he must cooperate in identifying and providing information to use in pursuing third parties, unless good cause is established for not cooperating. This includes

providing accurate health insurance information at application and redetermination. See Section 4.2,H for verification requirements. Good cause is determined by DFA, based on written information obtained by the Worker.

NOTE: All other adults who have the legal ability to do so, but who are not Medicaid recipients, must assign medical support rights as well.

When an otherwise eligible individual cannot legally assign his own rights, and the person legally able to do so does not cooperate, the individual remains eligible.

EXAMPLE: A mother refuses to assign benefits for herself and her children, for whom she can legally make an assignment. The mother is ineligible and the children remain eligible for Medicaid.

NOTE: Poverty-Level Pregnant Women are not penalized for failure to cooperate with this requirement until the expiration of the postpartum period.

An applicant for SSI is required to assign third-party rights to the Department as part of his application for SSI. If he refuses to assign these rights, he is ineligible for Medicaid.

B. DATA SYSTEM INTERACTION

When health insurance information is entered by BCSE, RAPIDS alert 191 “Ins. Info. Check OSCAR’S INSU”, is sent to the Worker. Since BCSE and BMS data systems do not interface, the Worker must enter the health insurance information on RAPIDS screen AFMC which will interface with BMS.

The Bureau for Medical Services must verify health insurance with the carrier before entering it in the BMS data system. The Worker is notified by RAPIDS alerts when BMS updates Third-Party Liability (TPL) information, there is an insurance carrier or policy number mismatch or the TPL information is not verified. See the RAPIDS User Guide for specific Worker actions required. If the Worker has any information which conflicts with the BMS-verified information, he must provide the information to the Third-Party Liability (TPL) Unit by e-mail or fax so that BMS can clear up any discrepancy. This insures accurate information is entered in both data systems.

C. CERTIFICATE OF COVERAGE WHEN MEDICAID COVERAGE ENDS

All Medicaid recipients who so request, must be issued a Certificate of Coverage DFA-HIP-1, when Medicaid benefits stop.

This applies to all individuals whose Medicaid benefits stopped on or after July 1, 1996. See Section 2.1,B.