



## COVERED MEDICAL AND ANCILLARY SERVICES

The Children with Special Health Care Needs (CSHCN) Program provides medical and ancillary services to those children/youth that have specific chronic and/or congenital medical diagnoses or certain residual effects of acute or traumatic conditions and have met financial eligibility guidelines. **Benefits from other payment sources (i.e. Medicaid, CHIP or private insurance) must be used when available for coverage of medical and ancillary services.**

**A. Services that may be provided by the CSHCN Program include, but are not limited to:**

- Medical evaluations
- Medical treatment of program eligible diagnoses
- Hospitalizations
- Diagnostic procedures, i.e. laboratory testing, x-rays, echocardiograms, CT and MRI scans
- Medications
- Limited therapies, i.e. occupational, physical and speech
- Surgeries
- Equipment and supplies
- Care coordination
- Transition services

**B. Food and Drug Administration Approval**

All procedures, treatments and medications must be approved by the Food and Drug Administration (FDA) and/or accepted as standard medical practice by the American Medical Association to be considered for coverage. The CSHCN Program does not cover procedures, treatments or medications which are classified as experimental in nature. Program participants with Medicaid, CHIP or private insurance should review their benefit plan to determine if experimental procedures, treatments or medications are covered.

**C. Physician Services**

1. Although the CSHCN Program does not pay for routine and/or acute medical care, all families receiving services from CSHCN are encouraged to have a primary care physician/medical home. Program participants with Medicaid, CHIP or private insurance should review their benefit plan to determine if routine or acute medical care is covered. To assure continuity of care, the client's primary care physician (PCP) will be provided copies of the CSHCN clinic reports when there is a current signed release of medical information from the parent/guardian.

2. Medical treatment for CSHCN clients is provided by specialty care physicians who are board-certified or board-eligible in their field of practice. **All physicians must be enrolled as a provider through the WV Medicaid system.** The CSHCN Program reserves the right to request credentials of any physician participating in or treating patients under the auspices of the program. CSHCN reserves the right to limit physician participation, scope of practice, and/or number of clients.
3. Medical treatment in CSHCN Program sponsored clinics must be provided by specialty care physicians. All physicians participating in the CSHCN clinic system sign a Physician Agreement which describes the responsibilities of the clinician and the rate of reimbursement for the clinician's services.

Payment for clinic services cannot be issued to a physician who has not been approved to participate with the program by the CSHCN Program Director.

**D. Out-of-State Care**

It is the policy of the CSHCN Program and the West Virginia Medicaid Program, Bureau for Medical Services (BMS), to authorize coverage of medical care within the state of West Virginia whenever that care is available.

Out-of-state medical facilities/practitioners within 30 miles from the West Virginia border and certain other facilities/practitioners have been granted "border facility" status by BMS and participate as WV Medicaid providers in the same manner as in-state facilities/practitioners. (A list of hospitals granted "border facility" status is included in Appendix D)

CSHCN Program participants whose care is paid for solely with Title V funds will adhere to similar standards and guidelines for out-of-state care as those participants who have WV Medicaid.

**E. Consultation/Second Opinion**

The CSHCN Program covers requests for consultations or second opinions from other specialists when the request is made by the CSHCN treating physician assigned to the case or by the family/client. The physician completing the requested consultation or second opinion must be an approved Medicaid Provider. Requests for out-of-state consultations will follow the procedure for out-of-state care. When clients are seen by other physicians, either in consultation or for second opinions, these visits and examinations do not constitute a transfer of care.

**F. Ambulance Services**

Ambulance services, including air ambulance, can be provided only for the condition or a complication of the condition for which the client is enrolled with the CSHCN

Program. Ambulance services for emergency services may be considered for coverage after the service has been rendered.

Non-emergency ground ambulance transportation must be prior approved by the care coordinator. Air ambulance services must be prior approved by the Director of Nursing, Social Service Director, or Program Director.

## G. Durable Medical Equipment/Medical Supply

The Durable Medical Equipment and Medical Supply (DME/Medical Supply) policy and procedures for clients served by the CSHCN Program are based upon the same medical necessity criteria and prior authorization requirements followed by the WV Medicaid Program. The Department of Health and Human Resources (DHHR) contracts for the services of a DME expert (currently West Virginia Medical Institute, WVMI) which is responsible for review and prior authorization of DME/Medical Supply purchases (including replacements) and repairs for all CSHCN clients, regardless of payer. Program payers include Medicaid, West Virginia Children's Health Insurance Program (CHIP), and Title V (Maternal and Child Block Grant funds) and private insurance.

Most CSHCN clients have other government-funded primary coverage sources under Medicaid and CHIP. After determination of medical necessity is made, the policies of these funding sources are used to approve or deny DME/Medical Supplies.

Some CSHCN clients have all eligible services paid from Title V funds. In addition, CSHCN offers certain services to clients covered by another primary source, using Title V to pay for these services. **For both these categories of participation, all services described in CSHCN policies, including DME/Medical Supplies, are subject to availability of funds and thus do not constitute an entitlement to participants.**

Only DME/Medical Supplies that are directly related to the medical diagnosis for which the client is enrolled in CSHCN (covered condition) will be considered for payment from Title V funds. For example, a CSHCN client may have two conditions, one covered by CSHCN and one that is not. In such a case, DME/Medical Supplies for the non-covered condition will not be considered for payment from Title V funds.

### 1. Requests

- a. The following guidelines are utilized when DME is considered for coverage for CSHCN clients:
  - Most CSHCN clients have primary coverage from another source. That coverage source must deem the requested DME/Medical Supplies medically necessary for consideration by CSHCN.

- The CSHCN Program will not cover insurance co-pays, deductibles, or co-insurance. This means that if another coverage source has paid for any part of the billed service(s), CSHCN will not authorize any additional payment.
  - **Consideration does not guarantee approval and/or payment of any item/service.**
  - The most economical items/services that meet the member's basic health care needs will be provided.
  - DME and/or accessory repairs paid for by CSHCN are limited to medically necessary items. Items must have at least a one year manufacturer's warranty.
  - Intermediate care facilities cover the total cost of care, including DME/Medical Supplies and other related services/items.
  - Following the established cap-rental timeframe, DME items are determined purchased. The provider that received the last cap-rental reimbursement maintains responsibility for the item and must provide repairs and/or modification as needed.
  - Repair of DME items purchased by CSHCN will be considered if the repair is more economical than replacement. DME items damaged due to the client's abuse or misuse will not be repaired/replaced.
  - A policy or insurance report is required with all requests for replacement of stolen equipment. A report of insurance liability is required with requests for replacement of equipment lost or destroyed. A fire report is required with requests for replacement due to loss in a fire.
  - For all requested DME items, a Certificate of Medical Necessity (CMN) must be completed by the CSHCN assigned specialist treating the client.
  - Services requiring prior authorization must be reviewed and approved by the CSHCN Program before any service is rendered.
  - DME providers must anticipate growth rate of the child and plan accordingly when providing DME to CSHCN clients. The client must have a current height, weight, abdominal circumference (at the widest point), and hip circumference submitted with the request for DME before consideration for coverage by the program.
- b. When DME is recommended, the treating physician assigned by CSHCN gives the family a prescription for the recommended equipment. The family has the right to choose the DME provider **as long as the provider is registered as a West Virginia Medicaid provider**. The family must take the prescription to the DME provider to have the equipment ordered.

- c. Families should choose a DME provider who is conveniently located. **All** adjustments and repairs to the equipment **must** be made by the original vendor.
- d. CSHCN uses the CMN for documentation of requested DME. The CMN must be signed by the treating physician assigned by CSHCN. The CMN signed by the treating physician with the provider's quote/cost and the appropriate code for the service delivery must be submitted to WVMI by the dealer for requested DME. However, to give a clearer picture of the appropriateness and quality of services being requested, the CMN must list all the codes that are pertinent to equipment/supplies being delivered. Provider's quote/cost invoice must be submitted for unlisted procedure codes. The provider must use all approved, appropriate codes for equipment. If there is an active code for an item, a miscellaneous code cannot be used.
- e. The DME provider completes the demographic portion of the CMN, attaches necessary quotes and itemizations, and secures the CSHCN physician's signature, diagnostic coding and justification.
- f. **If a request for services or equipment is deemed Not Medically Necessary by WVMI, it will not be forwarded to CSHCN and it will not be considered for approval if submitted to CSHCN by another source. CSHCN will not review requests for items that have been determined not medically necessary by the primary payer source (Medicaid, CHIP, private insurance, etc.).**
- g. The CSHCN Nursing Director will review requests for **medically necessary** items that are not covered by the primary payer source, (Medicaid, CHIP, private insurance, etc.).
- h. The provider must submit the CMN, the denial letter from WVMI (Notice of Initial Denial), and cost invoice for any unlisted/un-priced codes to CSHCN.

Items **that will be considered** for coverage by the CSHCN Program include the following:

- Vitamins and enzymes ordered by a CSHCN physician for treatment of cystic fibrosis;
- Diapers for clients receiving services through Title V funds only will be considered according to Medicaid guidelines. Medicaid guidelines state that a child must be over three years of age with the total limit set at 250/month (which includes both diapers and under pads);

- Nutritional supplements ordered by a physician and recommended by a registered dietician after a nutritional evaluation;
  - Adaptive feeding tools, i.e., spoons, forks, bowls, sippy cups;
  - Augmentative communication building devices and accessories, if not provided by the educational system;
  - CSHCN will cover one hearing aid as often as every three years (unilateral/bilateral) for participants. The program will authorize repairs to hearing aids once during the three- year period, if the aid is repairable and the warranty has expired. The hearing aid must have a three year warranty;
  - Amplification devices other than hearing aids, such as FM systems;
  - Corrective lenses and glasses that exceed allowable service limits of the primary payer when prescribed for treatment of a CSHCN covered diagnosis;
  - Safety glasses for clients who have seizures;
  - Specialized non-standard car seats as ordered by the CSHCN treating physician for clients above three years of age with a service limit of one (1) every three years;
  - Apnea Monitor rentals and supplies for clients more than one year old, (first year is covered by Medicaid) and from birth for clients using Title V funds only to pay for medical care;
  - One rolling mobility item, such as strollers or wheelchairs. Clients may receive one rolling device every five years, regardless of payer source. CSHCN staff will assist families in determining the most appropriate device; Additional non-rolling mobility devices may be considered for coverage, such as canes or walkers, etc. All requests for mobility devices must be submitted to and denied by the primary coverage source before payment using Title V funds can be considered;
  - Shower chairs. If a shower chair is not appropriate, then a bathtub lift may be considered for coverage with appropriate documentation;
  - Gait trainer - one every five years;
  - Prone stander - one every five years;
  - Toileting systems for clients above five years of age;
  - Haberman feeders for clients with a diagnosis of cleft lip/palate;
  - EZ-On safety vests;
  - Blood pressure cuffs for clients with a cardiac diagnosis;
  - Protime micro-coagulation machines for clients, post cardiac surgery;
- i. The CSHCN Program **will not** approve requests for supplies and equipment that are primarily for caregiver/client convenience, or educational/recreational purposes.

The following supplies and/or equipment items **will not** be approved by the CSHCN Program:

- Activity chairs
- Adaptive clothing/hospital gowns
- Additional hardware that should be included as part of the DME item
- Bed Accessories
- Bed wetting monitors
- Bowel training kits
- Ceiling Track Lift Systems
- Craftmatic or power lift beds
- Diapers beyond the Medicaid service limits (250/month – including diapers and underpads)
- Enemas (any type)
- Exercise equipment, i.e. therapy balls, exercise mats, therapy benches, trampolines
- Environmental control equipment and supplies, i.e. air conditioners, air purifiers/filters, humidifiers, dehumidifiers, heaters
- Feeding seats
- Gloves, any type
- Glycerin swabs
- Hand-held showers
- Heat lamps
- Heating pads (any type)
- Home access lifts/ramps
- Hot water bottles
- Ice caps or collars
- Kitchen appliances, i.e. blenders, food processors, mixers
- Lacrilube
- Massaging pillows
- Medical necessity bags/backpacks for wheelchairs or walkers
- Motor vehicle lifts/ramps
- Pools/hot tubs
- Portable items, i.e. nebulizers, feeding pumps, etc.
- Portable room heaters
- Positioning chairs, Tomato seats, Grasshopper positioning system
- Scales
- Seat elevators for wheelchairs
- Fully electric or specialty beds (vail, canopy, etc.)
- Stairway elevators/lifts
- Standard car seats (from Toys-R-Us, Wal-Mart, etc.)

- Swings
- Toothettes
- Tricycles/bicycles
- Van wheelchair lifts
- Vibrators
- Vinyl/terry bibs
- Walker accessories, i.e. baskets
- Weighted vests
- Wet wipes
- Wheelchair accessories, i.e. armrest pouches, back packs, headlights, rain capes, etc. for wheelchairs
- Whirlpools (any type)

2. **Providers**

- a. All clients in the CSHCN Program have the right to select a DME vendor of their choice as long as the vendor is licensed to do business in the State of West Virginia and is enrolled as a participating West Virginia Medicaid provider. Professional practitioners who render services to CSHCN clients and develop care plans defining the need for medical equipment and supplies, orthotics, or prosthetics must not direct clients to a particular provider, but must make them aware of all available, qualified providers of those items.
- b. All DME providers must be enrolled as participating Medicaid providers and licensed to do business in the State of West Virginia. As with other medical services, out-of-state providers may only be used if the equipment is not available through a provider within the State of West Virginia. DME providers located within a 30 mile radius of the West Virginia border are considered in-state providers. Individuals providing respiratory therapy, orthotics and prosthetics services must be properly credentialed, i.e. West Virginia Board of Respiratory Care, American Board of Certification in Orthotics and Prosthetics, or the Board of Certification for Orthotics and Prosthetics.
- c. The DME provider is responsible for assuring that the equipment/service provided is appropriate to the client's needs, that the service/equipment is what was ordered by the physician, and that it can be used by the client. If the client is unable to use the equipment, the provider of such equipment will furnish the appropriate replacement at no extra cost.

**The DME provider is also responsible for assuring that equipment has the maximum ability to grow with the patient.**

- d. Selective participation is prohibited. Vendors must accept reimbursement amounts as payment in full for CSHCN participants with government-sponsored care (Title V, Medicaid and CHIP). No charge may be billed to a CSHCN client for a covered service unless a co-payment is applicable by regulation (example: private insurance coverage).
  - e. It is the responsibility of the DME provider to secure prior approval before rendering the service. In addition, Title V does not guarantee reimbursement based solely on the issuance of a prior authorization number. If items and/or services are provided at the request of the family or representative before prior approval is obtained, the provider must inform the CSHCN client that he/she will be responsible for the bill.
3. Responsibilities of Durable Medical Equipment (DME)/Orthotic/Prosthetic Consultants
- a. The WVMI consultants are responsible for reviewing requests for DME and Orthotics/Prosthetics that require prior authorization.
  - b. The consultants will review for code appropriateness and recommend the most economical item/service which meets the member's basic health care need be provided.
4. Contact Information
- a. Provider inquiries related to recipient eligibility or claims status should be directed by mail to Unisys, Provider Services Unit, PO Box 3767, Charleston, WV 25337, by phone at Phone:888-483-0793 ( toll free) or (304)348-3360, or by E-mail at [edihelpdesk@unisys.com](mailto:edihelpdesk@unisys.com).
  - b. Client/family inquiries related to the status of service and/or authorization requests for clients served through the CSHCN should be directed to the area care coordinator.

## **H. Emergency Room Visits**

Emergency room visits may be considered for payment only when the emergency is associated with the covered condition for which the client is receiving services through the CSHCN Program.

## **I. Inpatient Hospital Services**

The Children with Special Health Care Needs Program can provide coverage of medically necessary inpatient hospital admissions for evaluation and/or treatment of CSHCN covered diagnoses. West Virginia Medical Institute (WVMI) is responsible for review for medical necessity and prior authorization of **all** in-patient hospitalization services in both in-state and out-of-state facilities, including out-of-state border facilities. Inpatient **rehabilitation** hospitalizations are not covered by the CSHCN Program.

The CSHCN Care Coordinator will assist families/clients, counselors and hospital staff with finding other coverage sources, reducing or consolidating medical bills and discharge planning whenever necessary.

## **J. Nutrition Services**

Nutrition evaluations are provided to assess the client's nutritional status, and the impact of the nutritional status on the progress of medical treatment. Services include nutrition counseling, dietary assessment and/or the recommendation of feeding supplements or special formulas.

If a client has a primary coverage source (i.e. Medicaid, CHIP, WIC or private insurance), that source is billed for the nutritional evaluation/services. The CSHCN Program may consider paying for the evaluation/services if denied by the primary payer for being a non-covered service, or if the client has no other source of payment.

**The CSHCN Program will not pay additional charges if a primary payer source has paid for any part of the evaluation/service.**

A dietary/nutritional evaluation by a registered dietician/nutritionist, who is also a WV Medicaid provider, must be completed before the CSHCN Program will consider paying for feeding supplements and special formulas. An evaluation must take place annually thereafter before additional supplements/formulas will be authorized. Evaluations by WIC registered dietitians, out-of-state registered dietitians, or registered dietitians that are not Medicaid providers (if another payer source is paying for it) can be accepted. However, evaluations done by other specialties are not accepted. Recommendations made by the registered dietician must match what has been ordered by the treating physician.

The CSHCN Program does not cover any brand or type of Instant Breakfast.

The CSHCN Program does not cover nutritional services while a client is in a hospital or rehabilitation facility.

Requests for IV hyper alimentation, with the physician's order and supporting documentation, must be submitted by WVMI for pre-service review and authorization.

**K. In-Home Services**

All in-home services, including physical therapy, speech therapy, occupational therapy and skilled nursing visits have a combined service limit of 124 units per calendar year. Medicaid service limits on in-home services must be followed.

One unit of intermittent skilled nursing service is less than four hours per day. Intermittent services offered by speech therapists or physical/occupational therapist should not exceed one hour per visit. These visits are considered one unit by Medicaid guidelines.

**L. Physical and Occupational Therapy**

The CSHCN Program provides limited coverage of physical therapy (PT) and occupational therapy (OT) services prescribed by the treating physician for treatment of the client's CSHCN covered condition or the effects of that condition.

1. The purpose of physical therapy coverage is to teach and supervise the client and family members in techniques of stretching exercises, range of motion exercises, and use of adaptive equipment to implement a treatment plan in the home. Physical therapy services include evaluation and treatment of muscle strength, range-of-motion, functional abilities and the use of adaptive/therapeutic equipment. Activities include, but are not limited to, rehabilitation through exercise and the use of equipment and rehabilitation through therapeutic activities.
2. Occupational therapy services address the developmental or functional requirements of an individual related to the performance of self-help skills, adaptive behavior, and sensory, motor and postural development. Occupational therapy services include, but are not limited to, perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.
3. Up to a total of 20 sessions of PT/OT can be provided without prior authorization per calendar year. Requests for PT/OT beyond the 20 session Medicaid service limit must be submitted to WVM I for review for medical necessity and prior authorization
4. The CSHCN Program provides PT/OT services to meet the immediate medical needs of the client. Requests for PT/OT services in the school setting must be referred to the Special Education Director at the local county Board of Education.

**M. Speech and Language Therapy**

Speech and language therapy may be covered for clients who have severe hearing loss, cleft lip and palate, or have a cochlear implant, if recommended by the assigned physician and not provided through other sources (i.e., school system, Birth to Three Program). The CSHCN Program does not supplement or approve additional sessions beyond what is covered by the primary source. The request for speech therapy is reviewed by WVMI for determination of medical necessity. Speech/language therapy done on an out-patient basis does not have a maximum limit and is approved according to the plan submitted by the therapist. If a patient is not eligible for services through educational resources during the summer when school is not in session, medically necessary supplemental therapy for school age patients will be considered for coverage.

Augmentative communication devices will be considered for coverage when determined medically necessary, or necessary for the client to participate in his/her own medical care.

#### **N. Private Duty Nursing**

Private duty nursing is defined as individualized face-to-face **nursing care of four hours or more per day** by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) by order of a physician. The nursing care the client is to receive is detailed in a written Plan of Care initiated by the Private Duty Nurse with input from the prescribing physician.

Private Duty Nursing (PDN) is a service available to CSHCN enrolled clients on a limited basis to assist families in caring for clients who meet the medical screening criteria as outlined in the *Medicaid Program Instruction MA-00-38*. **The primary responsibility of ongoing care of the patient lies with the family and/or caretaker.** This service is provided to educate the family in the appropriate care of the client. Once the training and education are complete, it is necessary for the family/caregiver to assume complete care of the client.

#### **O. Intermittent Skilled Nursing Services**

Intermittent skilled nursing services are defined as in-home individualized face-to-face nursing visits of less than four hours per day at least once every 60 days by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when there is an order from a physician.

1. Intermittent skilled nursing service is a service covered by the CSHCN Program using the same service limits as WV Medicaid. Intermittent skilled nursing services include:
  - Teaching the client/family techniques necessary to provide care as prescribed by the attending physician;
  - Assessing and monitoring the family's capabilities in carrying out skills previously taught; and

- Assisting a family member/caregiver in providing skilled services until the nurse is satisfied appropriate skills have been demonstrated.

**P. Medications**

Medications for treatment of program covered conditions are provided when prescribed by treating physicians, and are not covered under any other health plan such as Medicaid, CHIP or private insurance. The CSHCN Program does not cover **any** over-the-counter medications, with the exception of enzymes for the clients with the diagnosis of Cystic Fibrosis.

**Q. Non-Emergency Medical Transportation (NEMT)**

Non-emergency medical transportation (NEMT) is a reimbursement program for recipients of Medicaid and CSHCN services for the cost of transportation and other expenses associated with receiving medical care. Since the program is intended for reimbursement only, **payment in advance of a scheduled appointment can not be made.**

**All CSHCN clients** can be reimbursed for the cost of transportation and certain other expenses related to non-emergency medical care through the NEMT process when that medical care is related to the diagnosis for which the client was approved for program coverage. This may include reimbursement for mileage, meals, lodging, turnpike tolls, parking fees or a common carrier. The criteria, rate of reimbursement, non-covered services, and instructions for completion of the NEMT form are outlined in Chapter 19 of the *WV Income Maintenance Manual*.

Participants that have their medical care paid for by Title V funds, WVCHIP or private insurance will have the cost of transportation and certain other expenses reimbursed at rates similar to those used for participants receiving Medicaid services. There is a yearly cap of \$2500 for reimbursement of transportation and other expenses for these participants.

Travel expenses will be reimbursed for a single trip to and from the appointment regardless of how many clients are being transported. Trips to pick up medicine, eye glasses, medical supplies, or repairs to medical equipment are not eligible for reimbursement.

When reimbursement is available through other sources (i.e. Shriner's Hospitals, civic organizations, etc.), the CSHCN Program will not approve NEMT requests.

**R. Hospice Services**

The CSHCN Program does not pay for any type of Hospice services. The client's care coordinator will assist the family in making arrangements for Hospice services when a referral has been made by the physician.

