

**KEPRO Utilization Management Guidelines for
West Virginia Medicaid Health Homes**

CHANGE LOG

Medicaid Chapter	Policy #	Effective Date
Chapter 535 Health Homes	535.1 Bipolar and Hepatitis in Health Homes	April 1, 2015
Chapter 535 Health Homes	Change to Company Logo/Name	June 7, 2016
Chapter 535 Health Homes	Pre-Diabetes, Diabetes, Obesity, BMI over 25 and at risk of anxiety or depression	April 1, 2017



Utilization Management Guidelines For West Virginia Medicaid Health Homes

Version 1.1

WV Medicaid Health Homes Program

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West Virginia Medicaid Health Homes for Enrolled Providers

KEPRO West Virginia Medicaid ASO

The purpose of the Utilization Management Guidelines is to provide an overview of Medicaid Chapter 535 of the WV Medicaid Health Homes Program and establish the basis for Utilization Reviews. Prior authorization for services requires completion of the KEPRO C3 Request and Assessment screens. To request an authorization, the provider registers with KEPRO to access the submission website. Health Home providers must be approved by the Bureau for Medical Services in order to register with KEPRO. The service provider may then submit the appropriate required information. The provider will be notified if the request is approved, if additional information is needed to make the decision (pend), or if the request for services has been closed for administrative reasons electronically via C3.

Duplication of services by providers is not allowed. It is the responsibility of the provider(s) to coordinate care and to authorize service appropriately. For the members served by multiple behavioral and medical health providers, the Health Home provider will be the lead provider in service planning and is considered the primary provider by KEPRO.

Health Home Definition

Definition: A Health Home is a comprehensive system of care coordination for Medicaid members with chronic conditions. Health Home providers will coordinate all primary, acute, behavioral health and long-term services and supports to treat the “whole-person” across his/her lifespan. Since the focus is on the whole-person, all of the member’s health care providers are part of his/her treatment team. The goal of the WV Health Homes Initiative is to improve the member’s health while reducing medical costs. Patient-centered Health Homes are intended to create a patient-centered system of care that will achieve three main goals established by Centers for Medicare and Medicaid Services (CMS):

- Improve the experience of care,
- Improve the health of the target population, and
- Reduce per capita health care costs

The Health Home service delivery concept is a longitudinal “home” that provides members access to an actively coordinated interdisciplinary array of care: medical, behavioral health, community-based social services, and support for children and adults with chronic conditions. Service will be provided through a whole-person concept that integrates continuous quality improvement in a person-centered planning process. Through this care integration, the West Virginia Health Homes Initiative is designed to:

- Reduce unnecessary emergency department visits,
- Reduce unnecessary hospital admissions and re-admissions,
- Reduce overall health care costs,
- Reduce reliance on long-term care facilities, and
- Improve the health care experience, care quality, and outcomes for members receiving services.

Health Home Core Services

Comprehensive Care Management includes the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each Health Home member. The care plan’s development basis is the information obtained from a comprehensive risk assessment that identifies the member’s needs in areas including: medical, mental health, substance abuse/misuse, and social services. The individualized care plan will include integrated services to meet the member’s physical health, behavioral health, rehabilitative, long-term care, and social service needs, as indicated.

The care plan will identify the required core Health Home team members as well as other health and health related providers and resources. These include but are not limited to: health, behavioral health, rehabilitation, long-term care and social services depending on an individual member’s need. The care plan will also identify community networks and supports needed for comprehensive quality health care. Goals and timeframes for improving the member’s health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update.

Comprehensive care management will assure that the member (or legal health representative) is an active team member in the care plan’s development, implementation, and assessment, and is informed about and in agreement with plan components. Member’s family and other recognized supports will be involved in the member’s care as requested by the member. The member will receive a copy of the care plan initially and any time a change is made.

Care Coordination is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data. Care coordination includes managing resource linkages, referrals, coordination, and follow-up to plan-identified resources. Activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes, and communicating with other providers and members/family members.

Health Promotion includes the provision of health education specific to a member's health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; understanding and management of prescribed medications; supporting improvement of social networks; and providing healthy lifestyle interventions. Areas of focus include, but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.

Comprehensive Transitional Care and Follow-up is care coordination - designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility. For each member transferred from one caregiver or site of care to another, the Health Home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. Through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services, this coordination is accomplished.

Patient and Family Support Services include service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members' and caregivers' knowledge about the member's diseases, promote member engagement and self-management capabilities, while assisting the member to adhere to his/her care plan.

The primary focus of individual and family supports will be strengthened through increased health literacy. This effort will include communicated information that is language, literacy, and culturally appropriate, and designed to improve the member's ability to self-manage their health and participate in the ongoing care planning.

Referral to Community and Social Support Services includes the identification of available community resources, active management of referrals, access to care, engagement with other community and social supports, coordination of services and follow-up. The member's care plan will include community-based and other social support services that address and respond to the member's needs and preferences, and contribute to achieving the care plan goals. Areas of focus include, but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

Bipolar at Risk of Hepatitis

S0281 – Level I Health Homes Service

Health Home	HH 01 and HH 02
Service Code	S0281- (Level I)
HCPCS Definition	Medical home program, comprehensive care coordination and planning, maintenance of plan
Unit Information	Per Member Per Month (PMPM) 1 Unit= 1 Month
Initial Authorization	4 units
Re-Authorization	4 units
Admission Criteria	<p>Health Home focuses on:</p> <ol style="list-style-type: none"> 1. Medicaid eligible individuals 2. Bipolar Disorder diagnosis <p>The qualifying diagnoses are :</p> <p style="margin-left: 40px;"> F06.33 F06.34 F30.10 F30.11 F30.12 F30.13 F30.2 F30.3 F30.4 F30.9 F31.10 F31.11 F31.12 F31.13 F31.2 F31.30 F31.31 F31.32 F31.4 F31.5 F31.60 F31.61 F31.62 F31.63 F31.64 F31.73 F31.74 F31.75 F31.76 F31.77 F31.78 F31.81 F31.89 F31.9 </p> <ol style="list-style-type: none"> 3. Infected with or at risk of Hepatitis B and/or Hepatitis C
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Medicaid eligible 2. Member would like to remain in the Health Home Program

Discharge Criteria	<ol style="list-style-type: none"> 1. Loss of Medicaid eligibility 2. Member does not want service
Service Exclusions	<ol style="list-style-type: none"> 1. Member remains Medicaid eligible 2. May not be receiving TCM services
Clinical Exclusion	<p>Once a member is enrolled, if the diagnosis changes, the member may remain in the Health Home.</p>
Documentation	<p>Each of the Health Home Services must be documented within the Enrollees Health Home Record. Each service provided must have a service note, which includes</p> <ul style="list-style-type: none"> • Enrollee/Member's name • Name of Health Home Service Provided • Summary of Service Provision • Team Member's Signature (legible) • Team Member's Credentials (legible) • Date of Service <p>An individualized care plan is required and includes:</p> <ul style="list-style-type: none"> • Integrated services that meet the enrollee's behavioral and medical health, as well as rehabilitative, long-term care, and social service needs, as indicated • Goals and timeframes for improving the enrollee's overall health status with identified interventions and responsible parties • Schedule of planned assessments and updates • Primary care physicians, other health and behavioral health care providers, care managers, and other health team providers involved in the enrollee's health care • Community networks and other social supports needs for comprehensive quality health <p>An initial and periodic assessment and information review of each enrollee will include, as appropriate, but is not limited to the following:</p> <ul style="list-style-type: none"> • KEPRO Comprehensive CareConnection(C-3) for WV Health Homes • CDC Hepatitis Risk Assessment

	<ul style="list-style-type: none"> • S-BIRT Assessment • Patient Health Questionnaire • Assist Questionnaire • Medication Reconciliation • Specific Laboratory Results as appropriate for each individual enrollee • Relevant Biometrics • Treatment History • Written crisis plan for each enrollee <p>The required monthly documentation will include one of the following:</p> <ul style="list-style-type: none"> • Comprehensive Care Management - Individualized care plan • Care Coordination- Delivery of comprehensive, multi-disciplinary care • Health Promotion - Assist member in the development and implementation of care plan • Comprehensive Transitional Care and follow-up - Prevent avoidable ER, admission/re-admission and follow-up • Patient and Family Support Services - Assist members to attain high level of health and functioning • Referral to Community and Social Support Services - Address and respond to needs and preferences to achieve Care Plan goals
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Additional Service Criteria: Quality Measures

Bipolar at Risk of Hepatitis

S0281*TF – Level II Health Homes Service

Health Home	HH 01 and HH 02
Service Code	S0281*TF (Level II)
HCPCS Definition	Medical home program, comprehensive care coordination and planning, maintenance of plan
Unit Information	Per Member Per Month (PMPM) 1 Unit= 12 Month
Initial Authorization	1 Unit
Re-Authorization	Limit 1 per year
Admission Criteria	<ol style="list-style-type: none"> 1. This intensive level of service is available for those members determined to require a greater amount of service than that covered under the standard service one time per calendar year, January to December (one unit). 2. It will be necessary for the provider to submit information reflecting each member's current condition and situation when requesting this Intensive level of service.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Medicaid eligible 2. Member would like to remain in the Health Home Program 3. Level II is only available once per calendar year
Discharge Criteria	<ol style="list-style-type: none"> 1. Loss of Medicaid eligibility 2. Member does not want service
Service Exclusions	<ol style="list-style-type: none"> 1. Member remains Medicaid eligible 2. May not be receiving TCM services 3. Level II is only available once per calendar year
Clinical Exclusion	<ol style="list-style-type: none"> 1. Level II is only available once per calendar year 2. Members that are not determined to require a greater amount of service than that covered under the standard service will be denied 3. Another Level II request maybe submitted at another time when the criterion has been met
Documentation	<p>This clinical information, may include but not be limited to:</p> <ul style="list-style-type: none"> • Hospitalizations • ER utilization • Assessment scores: PHQ-9, SBQ-R and Audit C • Clinical judgment documenting a deterioration of the member's condition and crisis situation requiring stabilization

Diabetes, Pre-diabetes or BMI over 25 at Risk of Depression and/or Anxiety

Eligible Diagnostic List:

Type 1 Diabetes ICD-10 Codes									
E10.10	E10.11	E10.21	E10.22	E10.29	E10.311	E10.319	E10.321	E10.329	E10.331
E10.339	E10.341	E10.349	E10.351	E10.359	E10.36	E10.39	E10.40	E10.41	E10.42
E10.43	E10.44	E10.49	E10.51	E10.52	E10.59	E10.610	E10.618	E10.620	E10.621
E10.622	E10.628	E10.630	E10.638	E10.641	E10.649	E10.65	E10.69	E10.8	E10.9
Type 2 Diabetes ICD-10 Codes									
E11.00	E11.01	E11.21	E11.22	E11.29	E11.311	E11.319	E11.321	E11.329	E11.331
E11.339	E11.341	E11.349	E11.351	E11.359	E11.36	E11.39	E11.40	E11.41	E11.42
E11.43	E11.44	E11.49	E11.51	E11.52	E11.59	E11.61	E11.610	E11.618	E11.620
E11.621	E11.622	E11.628	E11.630	E11.638	E11.641	E11.649	E11.69	E11.8	E11.9
Pre-Diabetes ICD-10 Codes									
R73.01	R73.02	R73.03	R73.09	R73.9					
Obesity ICD-10 Codes									
E66.01	E66.09	E66.1	E66.2	E66.3	E66.8	E66.9			
BMI ICD-10 Codes (BMI 25 or greater)									
Z68.25	Z68.26	Z68.26	Z68.27	Z68.28	Z68.29	Z68.30	Z68.31	Z68.32	Z68.33
Z68.34	Z68.35	Z68.36	Z68.37	Z68.38	Z68.39	Z68.41	Z68.42	Z68.43	Z68.44
Z68.45	Z68.53	Z68.54							

Diabetes, Pre-diabetes or BMI over 25 at Risk of Depression and/or Anxiety

S0281 – Level I Health Homes Service

Health Home	HH 03
Service Code	S0281 (Level I)
HCPCS Definition	Medical home program, comprehensive care coordination and planning, maintenance of plan
Unit Information	Per Member Per Month (PMPM) 1 Unit= 1 Month
Initial Authorization	4 units
Re-Authorization	4 units
Admission Criteria	<ul style="list-style-type: none"> • Medicaid eligible individuals • Have an eligible diagnosis from the list above
Continuing Stay Criteria	<ul style="list-style-type: none"> • Medicaid eligible • Member would like to remain in the Health Home Program
Discharge Criteria	<ul style="list-style-type: none"> • Loss of Medicaid eligibility • Member does not want service
Service Exclusions	<ul style="list-style-type: none"> • Member remains Medicaid eligible • May not be receiving TCM services
Clinical Exclusion	Once a member is enrolled, if the diagnosis changes, the member may remain in the Health Home.

Documentation	<p>Each of the Health Home Services must be documented within the Enrollees Health Home Record. Each service provided must have a service note, which includes</p> <ul style="list-style-type: none"> • Enrollee/Member's name • Name of Health Home Service Provided • Summary of Service Provision • Team Member's Signature (legible) • Team Member's Credentials (legible) • Date of Service <p>An individualized care plan is required and includes:</p> <ul style="list-style-type: none"> • Integrated services that meet the enrollee's behavioral and medical health, as well as rehabilitative, long-term care, and social service needs, as indicated • Goals and timeframes for improving the enrollee's overall health status with identified interventions and responsible parties • Schedule of planned assessments and updates • Primary care physicians, other health and behavioral health care providers, care managers, and other health team providers involved in the enrollee's health care • Community networks and other social supports needs for comprehensive quality health <p>An initial and periodic assessment and information review of each enrollee will include, as appropriate, but is not limited to the following:</p> <ul style="list-style-type: none"> • KEPRO Comprehensive CareConnection(C-3) for WV Health Homes • S-BIRT Assessment • Patient Health Questionnaire • GAD • Medication Reconciliation • Specific Laboratory Results as appropriate for each individual enrollee • Relevant Biometrics • Treatment History • Written crisis plan for each enrollee <p>The required monthly documentation will include one of the following:</p> <ul style="list-style-type: none"> • Comprehensive Care Management - Individualized care plan • Care Coordination- Delivery of comprehensive, multi-disciplinary care • Health Promotion - Assist member in the development and implementation of care plan
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	<ul style="list-style-type: none">• Comprehensive Transitional Care and follow-up - Prevent avoidable ER, admission/re-admission and follow-up• Patient and Family Support Services - Assist members to attain high level of health and functioning• Referral to Community and Social Support Services - Address and respond to needs and preferences to achieve Care Plan goals
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