West Virginia Medicaid

Personal Planning for the Future

Medicaid is a state run program that provides medical services for individuals who may not be able to afford medical care. The federal government writes the general guidelines for Medicaid that all states must follow. As long as the state follows these general guidelines, it can run the program however best suits the state. That is why Medicaid eligibility, services provided, and benefits differ from state to state.

Services covered by West Virginia Medicaid are:

- Physician services
- Personal care services
- Private duty nursing
- Home health therapies
- Case management
- Hospice care
- Prescribed drugs
- Prosthetic devices
- Diagnostic services
- Screening and preventative services
- Dental
- Physical, occupational, speech, hearing and learning disorder therapies
- Chiropractic services
- Podiatry
- Optometry and eyeglasses
- Psychological services
- Rehabilitation services
- Intermediate care facility services for people with mental retardation
- Inpatient psychiatric services for people under 21

There are many medical services that Medicaid usually does not pay for. However, Medicaid may cover treatment costs if you meet certain conditions and receive prior approval (permission from Medicaid to receive medical treatment before you receive it).

Below is a list of medical services that require prior approval:

- General and acute inpatient hospital services
- Organ transplant services
- Psychiatric inpatient and residential treatment facilities
- Inpatient medical rehabilitation services
- Intensive medical case management
- Home health services
- Medical supplies, orthotic and prosthetic services
- Physical, occupational and speech therapies
- Private and home nursing visits
- Outpatient partial hospitalization services
- Chiropractic services
- Nursing facility services
- Aged and Disabled Waiver services
- Home based community services
- Vision care services
- Services for children with special healthcare needs
- I/DD Waiver services
- Intermediate care facility/Mentally Retarded services

There are several Medicaid programs that are specifically for children and families. Check with your local Department of Health and Human Resources (DHHR) office for more information or call **800-642-8589** to find your closest DHHR office. General programs include:

- **American Families with Dependent Children (AFDC) Medicaid-** This program is for families with children who do not have economic support because parents are not present; not able to provide support for their family; or are unemployed.
- **AFDC –Related Medicaid-** This program is for families with children who have a family member suffering from an illness or disease that has caused the family to spend most of their money and assets on medical bills.
- **Children with Disabilities Community Services-** This program is for children with disabilities whose families make more than Medicaid eligibility requirements and have been denied Supplemental Security Income (SSI). Children can be in this program if getting care at home costs less than the cost of getting care at a healthcare facility.
- **WV CHIP-** This is not a Medicaid program but DHHR takes applications and decides eligibility. This program is only for children under 19 years old and from a family whose income is at or below 200% of the federal poverty line (this equals $21,660 for 1 person, $44,100 for a family of four, or $59,060 for a family of six). If your family income is greater than 200% of the federal poverty line, your child may still be eligible for this program but you may have to pay a monthly premium for services.

There are several Medicaid programs that are specifically for adults. Check with your local DHHR office for more information. General programs include:

- **Supplemental Security Income (SSI)-Related Medicaid-** This program is for older adults or people with disabilities who would not qualify for SSI but have spent their money down to SSI eligibility levels because of the cost for medical care.
- **Qualified Medicare Beneficiaries (QMB)-** The QMB program covers the cost of Medicare premiums, deductibles and coinsurance that Medicare beneficiaries usually pay. This is for people with extremely low income who cannot afford co-payments, premiums or other fees associated with Medicare.
- **Medicaid Work Incentive (M-WIN)-** This program is for individuals with disabilities who are between 16 and 65 and are employed. This program helps people continue to work without losing their public benefits.

Who is eligible for Medicaid?

You must meet certain medical and financial requirements to be eligible for Medicaid. To be financially eligible, you must have less than $2,000 in assets (like a savings account or property) as an individual, or less than $3,000 in assets as a couple.

Also, you must have proof that you are a U.S. citizen. To find out if you are eligible for any of West Virginia Medicaid's programs and services, visit **www.wvdhhr.org** or call **800-642-8589** or **304-558-2400**.

Medicaid programs have three eligibility groups:

- Categorically needy- This group's eligibility covers people with low incomes (assets below $2,000.00 for an individual and $3,000.00 for a couple) and Supplemental Security Income (SSI) recipients.
- Medically needy- This program covers people whose incomes are above eligibility levels for the categorically needy but who cannot afford private insurance because of the cost to cover their medical needs.
- Special Groups- Medicaid also covers populations that tend to be financially vulnerable, specifically older adults and adults with disabilities. Medicaid covers Medicare premiums, deductibles and coinsurance for those who qualify. Check with your local DHHR office for details and other eligibility requirements.

How do I apply for Medicaid?

If you receive Supplemental Security Income (SSI), you are automatically eligible for and enrolled in Medicaid. You should receive a medical card from DHHR in the mail.

If you do not receive SSI, you will have to apply for Medicaid. Applications are taken weekdays at your local DHHR office.

Many local hospitals and primary care clinics have staff available who can help you complete your application. You can also go to your local DHHR office to fill out a Medicaid application.

If you are not able to visit your DHHR office, you can ask for someone from the DHHR staff to come to you to assist you with completing your application. To find your closest DHHR office, call **800-642-8589**.

What happens if I need medical treatment outside of West Virginia?

Most of the time, West Virginia Medicaid will only cover medical costs for services inside of the state. If you receive emergency medical treatment while traveling or visiting another state, then the services may be covered by Medicaid. However, check with your local DHHR office to make sure.

If you live close to West Virginia's state lines, you may be able to receive medical services at healthcare facilities in bordering states. These healthcare facilities must be within thirty miles of West Virginia's state lines and accept West Virginia Medicaid reimbursement. These healthcare facilities are called 'border providers'. You can receive medical treatment there because Medicaid considers them the same as in-state providers. If you want to get medical services from a healthcare provider who is close to state lines, make sure to call or ask ahead if the provider takes West Virginia Medicaid before you receive services. If the provider does not accept West Virginia Medicaid and you receive services, WV Medicaid will not cover the cost of the services.

What if I need transportation to my medical appointments?

If you need transportation to medical appointments, you may be eligible for the Non-Emergency Medical Transportation Program. This program provides cash payments and mileage reimbursement for bus or taxi fares.

To be eligible you must:

- Be a Medicaid recipient
- Have an appointment
- Get approval from DHHR before you make the trip.

Usually, reimbursement is not given for trips less than 15 miles. However, reimbursement may be paid if you make multiple short trips within sixty days of each other that total 15 miles or more. Call you local DHHR office for more information and reimbursement forms.

Does Medicaid cover Durable Medical Equipment?

Durable Medical Equipment (DME) is reusable medical equipment, like wheelchairs and home hospital beds, that helps people lead more independent lives. DME assists people with mobility, staying in their homes, and keeping a quality of life that they want. DME can range from adaptive stroller to breathing machines.

The following lists what durable medical equipment West Virginia Medicaid usually pays for:

- Adaptive strollers
- Aerosol delivery devices (delivers medication to the lungs through inhalation to treat asthma, Chronic Obstructive Pulmonary Disease, and other respiratory disease)
- Augmented and alternative communication devices
- Bone growth stimulator
- Continuous passive motion device (constantly moves joints through a controlled range of motion as part of rehab after certain types of surgeries)
- Home oxygen therapy
- Hospital beds
- Ambulatory insulin pump
- Lymphedema compression devices
- Manual and powered wheelchairs
- Recliner/tilt manual wheelchairs
- Negative pressure wound therapy (used to promote healing of wounds and fight infection)
- Non-invasive airway assistance devices
- Pediatric mobility equipment
- Power operated vehicles (such as a scooter)
- Secretion clearance devices
- Support surfaces (materials such as mattresses that support people who must stay in bed)
- Transcutaneous electrical nerve stimulation
- Wheelchair cushions/seating system

Home Services

Medicaid offers more than just medical services. It also provides in-home services for adults with disabilities so they can continue to live independently in their own homes and communities of their choice.

Medicaid Aged and Disabled Waiver

This waiver offers in-home and community-based services for people with acquired disabilities over the age of 18.

Services include:

- Case management
- Consumer-directed case management (program recipient is in charge of directing his/her own case management)
- Homemaker services (personal hygiene, nutritional support, transportation and medical assessment)
- Personal options (monthly stipends for program recipient to recruit, hire and supervise his/her own support staff).

The financial amount of services covered is based on what level of care the person needs.

To apply, a “Medical Necessity Evaluation Request Form” must be completed by you and your doctor. It must state the medical diagnosis; other important medical conditions; identification of whether the applicant has Alzheimer’s, dementia, or a related condition; and whether the applicant has a terminal diagnosis. The form is submitted to the Bureau of Senior Services (BOSS). Once your request has been received, a registered nurse (RN) from the waiver program will call you and schedule a home visit. If the RN cannot reach you on the first try, two more attempts will be made. If you do not respond to the RN’s phone calls, a letter will be sent to you and your doctor. The letter will explain that your request is no longer being considered because you cannot be reached.

If you do respond to the RN’s calls, a home visit can be scheduled. The RN will then visit you at your home and make notes about how you get around and how you are able to do things within your home. After the home visit you will either be accepted as a waiver recipient or be temporarily denied. If you are accepted into the program, services will not start until funds become available to pay for your services. Getting in-home services may take some time depending on how long the waiting list is. In the meantime, you will receive information on choosing a case management agency. The agencies available vary by county. You can also indicate you have “no choice” and an agency will be assigned to you.

If you are denied, you will also receive a letter. The denial letter will tell you why you will not receive services. You will then have two weeks to submit further medical documentation from your doctor. BOSS will review this and send you another letter either granting or denying you services. All waiver recipients are reevaluated each year to make sure everyone is still eligible.

To be eligible, you must:

- Not have assets (savings account, property) valued over $2,000.
- Not have a monthly income of more than $2,022.
- Meet medical eligibility as set by your county DHHR office.

Call the West Virginia Bureau of Senior Services at **877- 987-3646** or **304-558-3317** for more information.

Medicaid Personal Care

This program offers outpatient medical services for adults with disabilities. The purpose of this program is to allow people with disabilities to stay in their homes when receiving medical care, instead of having to stay in a hospital.

In-home medical services must be ordered by your doctor in a plan called the Nursing Plan of Care. A registered nurse (RN) with the Medicaid Personal Care program oversees and follows this plan. The RN will come to your home to give you medical care. You may not always get your medical treatments from a registered nurse. A person who is trained specific to this program may give you your medical treatments. However, a registered nurse must oversee your treatments and your Nursing Plan of Care.

Medicaid Personal Care also covers personal care services. These include help with personal hygiene, dressing, feeding, nutrition, environmental support functions (housecleaning, laundry, bed changing, dishwashing, grocery/ pharmacy shopping), and health related tasks (giving medication and taking vital signs as ordered by your doctor). Services under this program can be provided ongoing or at specific times when needed.

To be eligible, you must:

- Have a disability. The Social Security Administration defines an adult with a disability as a person who is 18 or older and is not able to do things for him/herself (like work a full-time job) because of a physical or mental impairment. This impairment must last or be expected to last at least 12 months, or can be expected to end with death.
- Need assistance to do daily living activities at work or at home. Daily living activities are things you typically do everyday whether or not you have a disability, such as dressing, cleaning and eating.
- Have a Personal Care Medical Eligibility Assessment (PCMEA). This assessment is done by your doctor to decide if treatment for your medical needs will be covered by the Medicaid Personal Care Program.
- Not have assets (savings account, property) over $2,000.
- Not have monthly income over $674.
- Have medical needs that affect your health over the long term.

For more information, call the Bureau of Senior Services' Medicaid helpline at **866-767-1575**.

West Virginia Transition Initiative

This program works to move people with disabilities from nursing home facilities back into their home communities. Up to $2500.00 is given to help people with disabilities pay for moving expenses and start-up costs that are part of moving. Examples are:

- Security deposits for housing
- Deposits and set-up fees for utilities
- Basic home furnishings
- Home accessibility adaptations (lowered sinks, grab bars).

For more information, contact the Olmstead Office at **304-558-3287** or the Bureau of Senior Services at **304-558-3317.**

Medicaid Appeals Process

Many people in West Virginia rely on Medicaid to pay medical bills and provide health care services. That is why it can be a shock when you get a notice saying Medicaid payment is being denied for services. Sometimes denials happen because clerical mistakes are made or forms were not filled out correctly. There are also other reasons, such as a procedure being too new or not pre-approved when prior approval was required. The good news is that there is an appeals process to make sure that everyone gets the medical services they deserve. If Medicaid denies your claim, you will receive an appeals form and denial letter that tells you how to appeal your claim.

Most denials are for one of six reasons:

- Your doctor may not have asked for prior approval from DHHR before providing you with services.
- You received services that are not covered by West Virginia Medicaid.
- You may have gone beyond the limits of your coverage.
- You may not have been approved to receive covered services on the date you received them.
- Your doctor may not have filled out the forms correctly.
- Your doctor may not have been a Medicaid provider when the service was provided.

The appeal itself is free. However, if you hire a lawyer to assist you, you will need to pay their fees. If you believe that services have wrongly been denied, you can appeal and be given a fair hearing. At the hearing you may represent yourself, or you can have a friend, relative, spokesperson or lawyer represent you.

Will I be able to continue receiving services while I wait for my appeal?

If you appeal before the date that the covered service will end, you may continue to receive services until your appeal is final. The drawback is you may have to pay back the cost of the services you received during the appeals process if your appeal is denied.

Resources

A DHHR office is located in every county. To find your county's office, call **800-642-8589** or visit **www.wvdhhr.org**.

Legal Aid of West Virginia assists some qualified individuals with Medicaid cases, such as Medicaid spend down, coverage of nursing home care, Aged and Disabled waivers, and I/DD waiver services. They are available to do client intake by phone from 9AM-3PM. Call **866-255-4370** or visit their website at **www.lawv.net**.

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