6. d.2 Gerontological Nurse Practitioner Services
Adult Nurse Practitioner Services
Women's Health Nurse Practitioner Services
Psychiatric Nurse Practitioner Services

Coverage of Nurse Practitioner Services is limited to the scope of practice as defined in state law or the state licensure or regulatory authority with any limitations that apply to all providers qualified to provide service. Services to be covered will be defined by the State agency in accordance with scope of practice considerations and site of service – outpatient only.

d.3. Other Licensed Practitioners

Influenza and pneumonia vaccines may be administered by currently licensed pharmacists in the pharmacy setting. Pharmacies must assure that pharmacists possess and keep current licenses and registration to administer immunizations and work only within their scope of license and registration. The pharmacy must have a prescription signed by a practitioner acting within the scope of his/her license.

Medicaid covers selected active pharmaceutical ingredients (API) and excipients used in extemporaneously compounded prescriptions and selected over-the-counter vitamin and mineral supplements when dispensed by a participating pharmacy provider pursuant to a prescription issued by a licensed prescriber following all state and federal laws.

7. **Home Health Services**

a. / b. Prior authorization is required after sixty (60) units of all home health services per individual in a calendar year. One visit equals one unit. A unit includes a skilled nursing visit, or a home health aide visit, or a physical therapy services visit, or an occupational therapy services visit or a speech-language pathology services visit.

c. Medical equipment (ME) is equipment that generally:
1. Withstands repeated use;
2. Is primarily used to serve a medical purpose;
3. Is not useful in the absence of illness or injury;
4. Is appropriate for use in the beneficiary's home.

The medical supplies that are covered are listed in the Durable Medical Equipment (DME) Manual. Coverage of medical supplies does not generally include beneficiaries residing in long term care facilities or Intermediate Care Facilities for the Mentally Retarded (ICF/MRs).

Orthotic devices are covered when medically necessary, prescribed in accordance with program guidelines, and are utilized to support or correct a weak or deformed body part, and/or to restrict or eliminate motion in a diseased or injured body part.

Prosthetic devices are covered when medically necessary, prescribed in accordance with program guidelines, and are utilized as an artificial appliance or device to replace all or part of a permanently inoperative or missing body part.

The fee schedule and any published annual/periodic adjustments to the schedule are the same for both public and private providers of those 1905(a) services to which they apply. The fee schedule and any annual/periodic adjustments to the fee schedule are to be published.

4.19 Payments for Medical and Remedial Care and Services

usual and customary charge information supplied by the provider community which was analyzed using accepted mathematical principles to establish the mean dollar value for the service, or the provider's customary charge, whichever is less.

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public. The agency's fees were updated January 1, 2010 and are effective for services on or after that date.

6. d.2 Gerontological Nurse Practitioner Services
Adult Nurse Practitioner Services
Women's Health Nurse Practitioner Services
Psychiatric Nurse Practitioner Services

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. The conversion factors are published annually in the "Resource Based Relative Value (RBRVS) Policy and Procedure Manual".

Payment may not exceed the amount paid to physicians for the service the provider is authorized by State Law to perform or the provider's customary charge, whichever is less. All private and governmental providers are reimbursed according to the same published fee schedule that may be accessed at: ww.wvdhhr.org then medical services, then manuals.

d.3 Other Licensed Practitioners

Pharmacy reimbursement for vaccines will be based on the appropriate NDC code at the current pharmacy reimbursement rate for covered drugs and may include an administration fee. If the vaccine is free, only an administration fee will be reimbursed. Reimbursement will be through the MMIS point-of-sale system.

Pharmacy reimbursement for selected active pharmaceutical ingredients (API) and excipients used in extemporaneously compounded prescriptions and selected over-the-counter vitamin and mineral supplements will be based on the appropriate NDC code at the current pharmacy reimbursement rate for covered drugs. Reimbursement will be through the MMIS point-of-sale system.

7. **Home Health Services**

a. & b. Medicaid reimbursement of Medicare certified home health services shall be based on ninety percent (90%) of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge whichever is less. The calculated LUPA rates will include an applicable Core-Based Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to beneficiaries outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full. All private and governmental providers are reimbursed according to the same published fee schedule that may be accessed at www.wvdhhr.org.org.

c. Medical Equipment

Reimbursement for medical equipment (ME), medical supplies, esthetics and prosthetics is the lesser of 80% of the Medicare fee schedule or the provider's charge to the public. Reimbursement for unlisted/unpriced codes is based on cost invoice and reimbursed per WV Medicaid's established fee schedule. The Agency's fees were updated January 1, 2010 and are effective for services on or after that date. All private and governmental providers are reimbursed according to the same published fee schedule that may be accessed at www.wvdhhr.org or the Agency's Provider Manuals

Diabetic supplies are reimbursed at 90% of the Medicare fee schedule.

Certain medical equipment may be subject to a leasing arrangement with repairs the responsibility of the ME Provider.