



KEPRO Overview of Assessments

1

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Purpose & Objectives

- 1. Identify the Role of KEPRO
- 2. Discuss Medical Necessity Criteria
- 3. Overview & Purpose of Assessments
(H0031, 90971, 90792)
- 4. Identify Staff Qualifications
- 5. Identify Assessment Components
- 6. Discuss Documentation Requirements with Examples
- 7. Review KEPRO Consultation Scoring Tools for Assessments

KEPRO

3

- KEPRO is an Administrative Service Organization contracted with three Bureaus within West Virginia Department of Health and Human Resources (DHHR):
 - **Bureau for Medical Services (BMS)**
 - **Bureau for Children and Families (BCF)**
 - **Bureau for Behavioral Health (BBH)**
- KEPRO, in conjunction with the Bureau for Medical Services, is conducting this webinar training for fee-for-service providers.



4

Medical Necessity

MEDICAL NECESSITY CRITERIA

- Medical Necessity is services that are:
 - ① Appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
 - ② Provided for the diagnosis or direct care of an illness;
 - ③ Within the standards of good practice;
 - ④ Not primarily for the convenience of the member or provider; and
 - ⑤ The most appropriate level of care that can safely be provided.

Demonstrating Medical Necessity for Assessments

6

Documentation should demonstrate medical necessity of the service by :

- ✓ Having an explicit, medically necessary purpose for the Assessment.
- ✓ Documenting the frequency, intensity, and duration of member's presenting symptoms.
- ✓ Documenting symptoms' impact on member's level of functioning is severe enough to warrant services.
- ✓ Suspected issues of function related to the behavioral health condition.
- ✓ Connect the behavioral health condition to the appropriate recommendations of treatment.



7

Overview & Purpose of Assessments

Purpose of Assessment Services

8

- ▶ Assessment services are designed to make determinations concerning the mental, physical, and functional status of the member.
 - ▶ Those identified as being in the Foster Care system should receive assessment as quickly as possible.
- Helps provide direction of care for the member and to have a more consistent thread of treatment.
- The providers are able to identify at the start of treatment the most imperative issues therefore linking them with the appropriate level of care.

Mental Health Assessment by Non-Physician

9

- **Procedure Code:** H0031
- **Service Unit:** Event
- **Telehealth:** Available with GT Modifier
- **LBHC Service Limits:** Maximum of four per year for members with complex behavioral healthcare needs (H0031*CC: Coordinated Care) and two per year per member with relatively simple behavioral healthcare needs (H0031*FC: Focused Care). The provider may request more units if a critical treatment juncture arises, however not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global assessment (H0031*GA) per year to reaffirm medical necessity and the need for continued care/services.
- **Private Practice Service Limits: H0031 AJ** Maximum of two per year per member.
- Change of payer source does not justify the need for a H0031(AJ) reassessment.

Approved Causes for Utilization

10

- 1. Intake/Initial evaluation (with known or suspected behavioral health condition);
- 2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral health condition to a lesser level of care.
 - Should not be billed after exit from CSU as it is included in the bundle.
- 3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or Designated Legal Representative and may cause a revision of the service plan;
- 4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services;

Service Exclusions

- No one under the age of three will receive prior authorization for a H0031. A Medicaid member under the age of three should be referred to the Birth to Three Program. If the child is aging out of the Birth to Three Program, an assessment allowing a smooth transition into other medically necessary behavioral health services may be conducted.
- The H0031 service must not be conducted if it is not intended to provide behavioral health services, i.e., 1915 C Waivers or E&M codes only.
- H0031, T1023HE and 90791 or 90792 are not to be billed at the same initial intake or re-assessment unless the H0031 is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify the need for further evaluation using the 90791 or 90792.

Psychiatric Diagnostic Evaluation (No Medical Services)

12

- **Procedure Code:** 90791
- **Service Unit:** Event (completed evaluation)
- **Telehealth:** Available with GT modifier
- **Service Limits:** Two events per year
- **Prior Authorization:** Required. Refer to Utilization Management Guidelines.
- **Definition:** An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.
 - **Must be completed and placed in the member's record within 15 calendar days.**

Psychiatric Diagnostic Evaluation With Medical Services (Includes Prescribing of Medications)

- **Procedure Code:** 90792
- **Service Unit:** Event (completed evaluation)
- **Telehealth:** Available with GT Modifier
- **Service Limits:** Two events per year
- **Prior Authorization:** Required. Refer to Utilization Management Guidelines
- **Definition:** An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.
 - **Must be completed and placed in the member's record within 15 calendar days.**

Staff Qualifications

Staff Qualifications Per Code

15

H0031	Mental Health Assessment by Non-Physician	<ul style="list-style-type: none">➤ LBHC: Minimum BA level staff that is internally credentialed by the agency<ul style="list-style-type: none">▪ When the assessment is conducted by a clinician without diagnostic privileges, it must be co-signed by a Master's Level clinician with diagnostic privileges (Physician, Lic./Sup. Psychologist, LPC, LICSW & LCSW)➤ PP: H0031*AJ - Minimum of a Master's Degree with a LGSW & LCSW
90791	Psychiatric Diagnostic Evaluation (No Medical Services)	<ul style="list-style-type: none">➤ Physician➤ Physician Extender (PA, APRN)➤ Licensed Psychologist➤ Supervised Psychologist (must have M.A. & current "Gold Card" from WV Board of Examiners of Psychologists)➤ LICSW➤ LPC
90792	Psychiatric Diagnostic Interview Evaluation (with Medical Services)	<ul style="list-style-type: none">➤ MD➤ DO➤ PA (Physician's Assistant)➤ APRN (Advanced Practice Registered Nurse)



16

Documentation Requirements

H0031 Documentation Requirements

17

- Demographic data (Name, age, date of birth, etc.)
- Medically Necessary Purpose Statement (i.e, indicates a known or suspected behavioral health condition requiring assessment to determine diagnosis(es) and treatment recommendations).
- Presenting problem(s), (must establish medical necessity for evaluation), including a description of frequency, duration & intensity of presenting symptomology that warrants admission
- Impact of presenting symptoms on current level of functioning, which may include as appropriate, description of activities of daily living, social skills, role functioning, concentration, persistence & pace
- History of behavioral health treatment (recent & remote, including efficacy & compliance)
- History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.
- Medical problems and medications currently prescribed (including efficacy & compliance)
- Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence, substance abuse, military history
- Analysis of available social support system

Documentation Requirements Continued

18

- Mental status examination;
 - Appearance, Behavior, Attitude, Level of Consciousness, Orientation, Speech, Mood & Affect, Thought Process/Form and Thought Content, Suicidality and Homicidality, Insight & Judgment
- Recommended treatment consistent with the findings of the assessment
- Diagnostic Impression, with rationale, per DSM or ICD methodology (approved/signed with credentials by licensed clinical professional with diagnostic privileges)
- Place of evaluation, date of evaluation, start and stop times, signature and credentials of evaluator
- Efficacy of and compliance with past treatment.
- Past treatment history and medication compliance
- SBIRT Assessment for ages 10 and older (initial assessment only).
- Demonstrate member was present for the evaluation

H0031 Reassessment

19

- A. Date of last comprehensive assessment;
- B. Current demographic data;
- C. Reason for re-assessment, including description of current presenting problems. Must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such;
- D. Changes in situation, behavior, and functioning since prior evaluation;
- E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
- F. Mental status examination;
- G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
- H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional within seven days of service date; and
- I. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.

Additional Requirements for 90791 & 90792

20

- 90791 Documentation Requirements:
 - All H0031 Requirements Plus:
 - Prognosis for treatment, including rationale

- 90792 Documentation Requirements:
 - All H0031 Requirements Plus:
 - Prognosis for treatment, including rationale
 - Demonstration of a medical evaluation
 - Brief Review of Systems (i.e., blood pressure, pulse, height, weight, etc.)
 - Prescription of medications and/or ordering of laboratory tests



21

Examples of Documentation

Tips for Developing a Medically Necessary Purpose Statement

22

- Indicate the known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations
- Include symptoms of the suspected or known behavioral health condition
- State the reason for the assessment rather than the referral source
- Individualize the statement
- Tie the purpose to the need for differential diagnosis and treatment recommendations

Appropriate Example of a Medically Necessary Purpose Statement

Member Name: John Smith **Date:** 4/30/19

Start/Stop Times: 10:03am-11:36am

Face to Face: Hilltop Mental Health Services

Purpose: Conducted Assessment due to reports of delusional symptoms to determine diagnosis and treatment needs.

Inappropriate Use of Purpose Statement

Member Name: John Smith **Date:** 4/30/19

Start/Stop Times: 10:03am-11:36am

Face to Face: Hilltop Mental Health Services
Needs Assessment and Reassessment

Purpose: John was referred by family physician to be assessed for mental illness.

OR

Purpose: John was assessed after completing CSU to enroll in outpatient services.

Tips for Documenting the Presenting Problem(s)

25

- ❑ Document Presenting Problem(s) to demonstrate Medical Necessity By Including:
 - **Frequency** of symptoms (how often do they occur?)
 - **Duration** of symptoms (how long have they occurred?)
 - **Intensity** of symptoms (how severe are they?)
- ❑ Include detailed description of the symptomology to assist in determining the appropriate diagnosis & treatment recommendation
- ❑ Document the **IMPACT** the member's symptoms have on current level of functioning
 - **MAY** include appropriate description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning.

Appropriate Example of Presenting Problem Section Meeting Documentation Standards

26

Member Name: John Smith **Date:** 4/30/19

Start/Stop Times: 10:03am-11:36am

Face to Face: Hilltop Mental Health Services

Presenting Problems: John states he has been hearing voices for the last six months on a daily basis (on some days, several times throughout the day), states he did not want to tell anyone because he was afraid the CIA would kill his loved ones. He has stopped going out in public unless it is very important because the voices are louder when riding in cars or on buses. He states sometimes when he is on the bus he can feel people touching him and this makes him feel uncomfortable. He has started to carry a knife every time he goes in public (for the past two weeks), he states he has it in his pocket as we speak. He denied any alcohol or illicit drug use for the past year. He says he has “smoked a joint or two” in his lifetime but not in the past five years. He does report difficulty falling asleep and staying asleep several times a week and that this has been going on most of his adult life. He reports a fair appetite, no changes in weight in the past six months; however, he does report not eating at Wendy’s because that is “where the CIA hangs out.”

Inappropriate Use of Presenting Problem

Member Name: John Smith **Date:** 4/30/19

Start/Stop Times: 10:03am-11:36am

Face to Face: Hilltop Mental Health Services

Needs Assessment and Reassessment

Purpose: John was referred by family physician to be assessed for mental illness.

Presenting Problems: John states he hears voices and thinks the CIA might be after him. No medical problems reported.

History of Substance Use: Unknown

Pertinent Historical Information

28

- Assess for past history of both psychiatric and medical treatment-
 - Indicate where the service occurred
 - Document types of services provided, including efficacy & compliance
 - Did they attend appointments?
 - Were the services beneficial? If no, then why not?
 - Was the consumer compliant with services?
 - Were they prescribed either psychiatric or medical medications?
 - If they were prescribed medication - name of medication, what it was intended to treat, did they take it as prescribed and did they find it beneficial?
- Assess any current or prior suicide/homicide attempts, high risk behaviors and/or self-injurious behaviors.

Appropriate Historical Information Example

29

Behavioral health and health treatment- John states he was hospitalized when he was twenty eight years old at the BHU due to depression and suicidal ideation. He said he found the treatment helpful and had no issues while there. He states he liked the doctor there and took medication she prescribed for five years. His mother reported that he went to his local mental health facility where he was prescribed the Zyprexa injection for depression. He states he stopped this medication (about a year and a half ago per mom) because it was a hassle although he felt it helped with his symptoms. He then tried Geodon but the weight gain was horrible and took Invega injection for a while but felt better so just stopped it because he did not need it. States he has never tried therapy because they work for the government. He states all family physicians just want to take his blood so he has not been to one since he was in his twenties. His mother reports that he has no serious medical history, no current medications for medical issues, no history of head trauma and no overnight hospitalizations.

High Risk behaviors- He states he has never attempted to harm himself because it is against his religion. He states he does not currently think about harming himself but does carry a knife to protect himself, states this is his right.

Inappropriate Documentation of Historical Information

30

Past Treatment History: Hilltop Mental Health

Compliant? Yes

Efficacy? Unsure

Medications? Yes

Effectiveness of Meds?

Suicidal? No

Homicidal? Yes

High Risk behaviors? None

Social History and Social Supports

- ❑ Could include personal or family history as relevant including but not limited to:
 - ❑ Description of significant childhood events,
 - ❑ Arrests,
 - ❑ Educational background,
 - ❑ Current family structure,
 - ❑ Vocational history,
 - ❑ Financial status,
 - ❑ Marital history,
 - ❑ Domestic violence (familial and/or personal),
 - ❑ Substance abuse (familial and/or personal),
 - ❑ Military history if any
- ❑ Review available social support system available

Appropriate Example of Social History

32

- ▶ **Social history:** He states he had a pretty good childhood, made decent grades, graduated from high school, no child abuse reported and related he didn't experience currently reported symptoms at that time. Never married and not in a current relationship, relating trust issues with having such close relationships. He states he drinks a little here and there, which he described 4 times a week and at least a 18pk of beer. He has not worked for 6 months because his last boss at Wendy's works for the CIA.
- ▶ **Social supports:** John states he used to have a lot of friends when he was younger, "but they all joined a cult." He reported that he doesn't currently have any friends due to concerns they are plants from the CIA. He said, his family will not have anything to do with him (except his mother) unless he has money which he says is never.

Inappropriate Documentation of Social History

33

Social history - Graduated high school; never married

Social supports - limited contact with anyone

Mental Status Examination

34

- The Mental Status Exam Requirements
 - Appearance
 - Behavior
 - Attitude
 - Level of Consciousness
 - Orientation
 - Speech
 - Mood and Affect
 - Thought Process/Form and Thought Content
 - Suicidality and Homicidality
 - Insight and Judgment

Appropriate Mental Status Example

35

- ❑ **Mental Status Exam-** John is of average build, blue eyes, blonde hair, average stature, dressed appropriate, he is guarded and has difficulty making eye contact, he is in a pleasant mood yet affect is blunted and he is uncooperative at times, speech is rapid, thought blocking is noticeable, he paced during the interview, evidence of tangential thinking, he is oriented x 4, normal level of consciousness, states he is not suicidal or homicidal but does carry a knife and is willing to defend himself. He does have some paranoid thoughts, auditory hallucinations, he has limited insight and judgement.

Inappropriate Documentation of a Mental Status Exam

36

Mental Status Exam - John is guarded, auditory hallucinations, paranoid thoughts, oriented x 4

SBIRT Requirements

37

- ❑ Completed Screening, Brief Intervention, and Referral to Treatment (SBIRT) Assessment
 - ❑ Must be performed on all individuals for ages 10 and older for all initial assessments.
 - ❑ **Screening**
 - ❑ Demonstrate screening/assessment of substance use
 - ❑ Any screening tool or assessment of substance use is sufficient
 - ❑ **Brief Intervention**
 - ❑ Documentation should include the brief intervention provided if substance use issues were indicated
 - ❑ **Referral to Treatment**
 - ❑ Demonstrate that a referral to treatment was provided

SBIRT Examples

38

➤ **Example of an Appropriately Documented SBIRT:**

- Conducted a substance abuse assessment, including the MAST. John reported drinking 4 times a week and drinking at least 18 beers each time. He began drinking at the age of 16. He said when he first started drinking he would get tipsy off of 5-6 beers and now it takes 16-18. He said he avoids doing activities with his mom so that she doesn't smell alcohol on him. He denies any alcohol related arrests. Discussed the impact his drinking has on the effectiveness of his psychotropic medications. Referred him to Hilltop Addiction Services. Recommend that he attend an Substance Use Education Group and NA.

➤ **Example of an Inappropriately Documented SBIRT:**

- John says he drinks alcohol 4 times per week

Remaining Documentation Requirements

39

- ❑ Recommended treatment related to the findings of the evaluation
 - ❑ Should be tied to a specific service and be medically necessary.
- ❑ Diagnostic Impression with rationale:
 - ❑ Must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice.
 - ❑ Must have descriptor and DSM/ICD10 code
 - ❑ Documentation must substantiate the diagnosis
- ❑ Place of evaluation, date of evaluation, start and stop times, signature and credentials of evaluator;
 - ❑ **MUST** have appropriate signatures with credentials and co-signature with credentials when needed.

Appropriate Example of Remaining Documentation Requirements

40

❑ Recommended treatment- This clinician recommends John to be scheduled to see the psychiatrist to have more in depth evaluation to be assessed for pharmacologic management. It is also recommended that he receive therapy to address his substance use issues.

❑ Diagnostic Impression:

Psychotic Disorder NOS F29

Alcohol Use Disorder, Moderate F10.10

Melissa Bell BA, 5/28/19 10:30-11:36 Hilltop Mental Health Service

Name, Credentials, Date, Start and Stop times, Place of service

Heather Smith MS, LPC 5/28/19, 10:40-10:50 Hilltop Mental Health Services

Supervisor Signature, Credentials, Date, Start and Stop times, Place of service

Inappropriate H0031 Example

41

Member Name: John Smith **Date:** 4/30/19

Start/Stop Times: 10:03am-11:36am

Face to Face: Hilltop Mental Health Services

Needs Assessment and Reassessment

Purpose: John was referred by family physician to be assessed for mental illness.

Presenting Problems: John states he hears voices and thinks the CIA might be after him.

Behavioral health and health treatment- unknown

Medications-Yes

High Risk behaviors- possibly homicidal

Social history- Graduated high school

Social supports- limited contact with anyone

The Mental Status Exam- John is guarded, auditory hallucinations, paranoid thoughts,

- SBIRT Assessment- Unknown
- Recommended treatment- medication management
- Diagnostic Impression:

Psychotic Disorder

Melissa Bell

Name, Credentials, Date , Start and Stop times, Place of service

Supervisor signature, Credentials, Date, Start and Stop times, Place of service

Additional 90791 & 90792 Requirement Examples

42

➤ **90791 & 90792 Prognosis for treatment with rationale**

➤ **Appropriate Example:**

- Prognosis is guarded due history of medication non-compliance and lack of familial support

➤ **Inappropriate Example:**

- Prognosis is fair

➤ **90792: Medical Evaluation**

➤ **Appropriate Example:**

- Height: 5'11" Weight: 210 Blood Pressure: 138/92 Pulse: 88
- Begin Geodon and complete labwork every 180 days

➤ **Inappropriate Example:**

- No medical issues reported, sleep and appetite are fair



43

QUESTIONS AND ANSWERS



H0031 Retrospective Review Tool

H0031 Retrospective Review Tool

1.	Does the purpose of the evaluation or reassessment meet medical necessity criteria? (NOTE: If Question #1 is scored 1.5, then the purpose did not meet medical necessity but the documentation demonstrated medical necessity. If Question #1 scores 0, then all remaining questions will be scored 0.)	3	1.5	0	
2.	Does the documentation reflect that the member was present for the evaluation? (NOTE: If Question #2 is scored 0, then all remaining questions will be scored 0.)	1	0		
3.	Does the report demonstrate a rationale for the diagnosis? (NOTE: If question #3 scores 0, then all remaining questions score 0.)	3	1.5	0	

Continued on next slide

H0031 Retrospective Review Tool (cont.)

4.	<p>Does the report contain the following:</p> <ul style="list-style-type: none">▪ Date of the service▪ Location of the service▪ Clinician's signature with appropriate credentials▪ Signature, appropriate credential & date of licensed clinical professional when required▪ Service code and/or descriptor? <p>(Note: if there is no signature with appropriate credentials, all questions on this tool score 0.)</p>	3	1.5	0	
5.	<p>Does the report include demographic data on the member including:</p> <ul style="list-style-type: none">•Name•Age/date of birth•Sex•Education level•Marital Status•Occupation	3	1.5	0	

Continued on next slide

H0031 Retrospective Review Tool (cont.)

6.	Does the report include documentation of the presenting problem that includes: <ul style="list-style-type: none">▪ A description of the frequency, duration, and intensity of all symptoms?▪ (If a Re-Assessment: changes in situation and behavior are documented)	3	2	1	0
7.	Does the report detail how the symptoms impact the member's current level of functioning? This may include: <ul style="list-style-type: none">▪ How symptoms impact activities of daily living▪ How symptoms impact social skills including establishing and maintaining relationships▪ Role functioning▪ Concentration▪ Persistence and pace▪ For children, current behavioral and academic functioning▪ If a Re-Assessment – Changes [or lack of changes] in functioning since prior evaluation are documented.	3	1.5	0	

Continued on next slide

H0031 Retrospective Review Tool (cont.)

8.	Does the report include a history of both current and prior behavioral health treatment that includes the efficacy and compliance with those treatments? <ul style="list-style-type: none">▪ If Re-Assessment a summary of treatment since prior evaluation including a description of treatment provided over the interval and the responsiveness of the member is documented.	3	1.5	0	
9.	Does the report include a discussion of high risk or self-injurious behaviors, including suicidal or homicidal ideation or attempts?	3	1.5	0	
10.	Does the report include a Screening, Brief Intervention, and Referral to Treatment (SBIRT) for members age 10 or above? [if initial Assessment]?	3	1.5	0	

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H0031 Retrospective Review Tool (cont.)

11.	Does the report include a medical history including: <ul style="list-style-type: none">▪ Any pertinent medical conditions/problems and treatments in the member's history (current or remote)▪ Psychotropic or pertinent medications prescribed (current or remote) including efficacy and compliance?	3	2	1	0
12.	Does the report include a relevant social history?	3	1.5	0	
13.	Does the report include an analysis of available social support systems (including familial if available)?	3	0		

Continued on next slide

H0031 Retrospective Review Tool (cont.)

14.	Does the report include a mental status examination? <ul style="list-style-type: none">▪ Appearance▪ Behavior▪ Attitude▪ Level of Consciousness▪ Orientation▪ Speech▪ Mood & Affect▪ Thought Process/Form & Thought Content▪ Suicidality & Homicidality▪ Insight & Judgment	3	1.5	0	
15.	Does the report include a diagnostic impression as per DSM or ICD methodology?	3	2	1	0

H0031 Retrospective Review Tool (cont.)

16.	Does the report contain appropriate recommendations consistent with the findings of the evaluation? Or, if a Re-Assessment, amendments in treatment/intervention and/or recommendations for continued treatment or discharge are documented?	3	1.5	0	
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Total Score Possible is 46

* The scoring for these questions are as follows:

3 – 100% of the documentation meets this standard

2 – 99% to 75% of the documentation meets this standard

1 – 74% to 50% of the documentation meets this standard

0 – Under 50% of the documentation meets this standard

52

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