Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

# MEDICAID MEMO

TO: All Home Health and Home-and-Community-Based Waiver Providers participating in the Virginia Medical Assistance Program and all Managed Care Organizations providing services to Virginia Medicaid recipients

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services (DMAS)

MEMO Special

DATE 11/5/2004

SUBJECT: Waiver Billing and Maintenance Issues

The purpose of this memorandum is to update you on the Northern Virginia rate for home health and home-and-community-based waiver services and clarify how other maintenance issues are handled for home health services. We apologize for the billing problems that providers have experienced. As providers, you play an invaluable role in the lives of many Medicaid recipients. The Department of Medical Assistance Services (DMAS) truly appreciates your patience as we resolve these issues.

DMAS will be releasing a Medicaid Memo in the near future regarding home health services. This memo will address the requirements for physician signatures on the certifications and re-certifications related to the Outcome and Assessment Information Set (OASIS) requirements. DMAS is currently working on the changes to the Virginia Administrative Code regarding these changes.

## WAIVER SERVICES

Northern Virginia Rate: One of the issues that DMAS thought was fixed was the Northern Virginia rate differential. DMAS has determined that there are underlying issues with the way provider numbers were set up within the Virginia Medicaid Management Information System (VaMMIS) that caused this not to work for some providers. DMAS has verified that all of the codes (both local and national) for the waivers have the appropriate flag indicator present in order for the system to know to pay the claim based on the recipient location for services provided in the home. First Health has fixed the system so that any claims submitted now will be paid appropriately. There are certain claims that have the 46-specialty code present for the Mental Retardation Waiver that continue to have payment problems. First Health will recycle these claims as they are identified. If providers have provided services to recipients who live in

Northern Virginia and you have been paid at the "rest-of-state rate," please notify DMAS. You may fax information about the recipient(s) for whom you need claims recycled. Please include the provider identification number, the recipient's name and identification number, and the date of service ranges for each recipient. Please fax them to 804-371-4986.

For home health services, the current home health regulations require that payment be made to the provider's location on file with DMAS. Therefore, the system will continue to pay based on the provider's location.

## HOME HEALTH MAINTENANCE SERVICES

Home health services are services provided by a certified home health agency on a part-time or intermittent basis to a recipient in his/her place of residence. For Medicaid, the recipient does not have to be home bound, but the services must be provided in the recipient's home. Home health services are intended to provide skilled intervention with an emphasis on recipient or caregiver teaching. For all maintenance services, the emphasis will be on keeping the recipient at home rather than requiring the recipient to go to the physician's office, unless physician visits are scheduled and would coincide with the needed home health visits. Below are some common maintenance issues and related procedures that West Virginia Medical Institute (WVMI), DMAS' pre-authorization contractor, will follow when prior authorization is required.

The general questions that will be asked by WVMI for these procedures are:

- Can the recipient perform the procedure?
- If the recipient cannot perform the procedure, is there a caregiver who is willing and able to perform the procedure? The "willing and able" reason cannot be based solely on the provider's policy.
- If the provider states that there is no one willing or able to perform the service, this will be further explored. If the caregiver is able to learn, but is not willing, WVMI will ask for the reason(s). For example, if the caregiver has a fear of administering injections, WVMI will authorize extra teaching visits and request documentation of the teaching efforts.

In addition to the questions above, the following specific procedures require additional information:

- **B-12 injections and insulin injections:** If the physician certifies that there is a need for this procedure to be performed as a home health visit AND no one else is willing and able to perform this procedure AND if appropriate documentation is provided supporting the medical necessity of these home health visits, it will be approved.

- **Central venous access devices (dressing changes, etc.):** WVMI will ask the provider if the recipient is currently getting medication through the line, how frequently is it being accessed, and whether it is a PICC, Groshog, Hickman, Porta Cath, etc. If the physician certifies that there is a need for this procedure to be performed as a home health visit

AND no one else is willing and able to perform this procedure AND if appropriate documentation is provided supporting the medical necessity of these home health visits, it will be approved.

## OTHER MAINTENANCE SERVICES

- **Changing of indwelling catheters:** WVMI authorization will be based on the merits of each individual case. If the service is needed no more than once a month, no discharge plan is required. If the service is needed more than once a month, WVMI will request the provider to supply documentation supporting the medical necessity of these home health visits. Approval will be based on the documentation of medical necessity provided.

- **Blood draws:** WVMI authorization will be based on the merits of each individual case. WVMI will ask if the home health visits are medically necessary to address a specific medical condition (i.e. recipient is medically unstable or is morbidly obese and requires transportation by an ambulance). WVMI will ask if the medical condition is chronic and requires routine visits. If appropriate documentation is provided supporting the visits as medically necessary, WVMI will approve the visits.

## PROVIDER RECONSIDERATION AND APPEALS PROCESSES

If reimbursement for services rendered is denied by the WVMI pre-authorization analyst and the provider wants to request reconsideration of the denial, the provider may either request telephonic (804-648-3159 in Richmond; 1-800-299-9864 in all other areas) or written reconsideration from the WVMI Outpatient Review Services Supervisor within 30 days of the denial notice's receipt. The WVMI Outpatient Review Services Supervisor has the option of requiring written reconsideration of a telephonic pre-authorization request. If the provider submits a written reconsideration, the provider must submit a letter to the WVMI Outpatient Review Services Supervisor requesting reconsideration within 30 days of the denial notice's receipt. Written reconsideration requests should be faxed or sent to the following address:

WVMI
Outpatient Review Services Supervisor
6802 Paragon Place
Suite 410
Richmond, Virginia 23230

FAX: 804-648-6880 (Richmond area)
1-888-243-2770 (all other areas)

If the WVMI Supervisor upholds the decision to deny reimbursement of services rendered, the provider may appeal this decision in writing within 30 days of receiving the written notification of the reconsideration's denial. The request to appeal must be sent to the DMAS Appeals Division at the following address:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The provider may not bill the recipient for Medicaid services that have been provided and subsequently denied authorization by DMAS or WVMI.

## RECIPIENT APPEALS

If WVMI denies services not yet rendered, the recipient has the right to appeal this decision. The request to appeal must be submitted in writing to the DMAS Appeals Division within 30 days of receiving the written notification of the denial of services. This request must be addressed to the DMAS Appeals Division at the above address.

## ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

## COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov (***please note the new DMAS website address***). Refer to the Provider Column to find Medicaid and SLH Provider Manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

## "HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays, to answer questions. The "HELPLINE" numbers are:

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| 1-804-786-6273 | Richmond area and out-of-state long distance |
| 1-800-552-8627 | All other areas (in-state, toll-free long distance) |

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.