CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

The Virginia Medicaid Program is dependent upon the participation and cooperation of Virginia physicians who provide health care.

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and 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 it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

SERVICE AUTHORIZATION

Refer to *Physician/Practitioner* provider manual, Appendix D for details regarding service authorization instructions, timely submittal, retroactive reviews, criteria, procedure codes and other pertinent information.

PHYSICIAN'S ROLE IN RENDERING SERVICES

Physician services are those services provided within the scope of professional license. These services must be rendered by or under the supervision of an individual licensed under State law and, including care delivered by physician assistants, are to be billed by the physician who renders the service. In those instances where coverage is provided by a physician other than the patient's regular physician, the actual provider of services must be a participating Medicaid provider in order to bill for services performed even though he or she may not be the patient's regular physician (e.g., "covering physicians" must bill for the services they personally render). Additionally, physicians are required to maintain records detailing the nature and scope of the health care provided to Medicaid members. Entries in patient records must be signed by the physician rendering the service (name and title) and dated (month, day, year) on the date of service delivery.

Dates may not be typed onto medical records in advance of the signature. Care rendered under the supervision of the participating provider must be countersigned by that provider.

Out-of-State Physicians

Out of state providers (non-participating, enrolled) are held to the same service authorization processing rules as in state (participating, enrolled) providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to DMAS Service Authorization contractor, KePRO. If the provider is not enrolled with Virginia Medicaid, the provider is encouraged to submit the request to KePRO. KePRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled. Providers will not be penalized if DMAS does not process the enrollment request within 12 business days.

If KePRO receives confirmation of the provider's enrollment with Virginia Medicaid within 12 business days, the request will then continue through the review process and a final determination will be made on the service request. If the request was pended for no provider enrollment and KePRO does not receive confirmation of the provider's enrollment within the 12 business days, KePRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request. Timeliness from the prior submission will not be considered with the re-submission.

Any provider not enrolled with Virginia Medicaid may do so by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on "*Provider Services"* and then "*Provider Enrollment"* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

(Note: If specific physician services required by the member are available in Virginia within a reasonable distance from the member's home, the member should not be referred to an out-of-state physician.)

Physician's Role in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

The EPSDT benefit provides preventive health care to individuals (from birth up to age 21) eligible for medical assistance. The purpose of the EPSDT benefit is prevention of health problems through early detection, diagnosis, and treatment. The goal of the EPSDT benefit is to promote a medical home so members can receive both sick and well-

child care from the same provider. EPSDT screenings are Medicaid's well child visits and should occur according to the DMAS periodicity schedule included as Appendix 1 under "Exhibits" of the EPSDT Supplement.

Any physician enrolled as a provider in the Medicaid Program to provide physician or clinic services can provide EPSDT screening services. See Supplement B to this manual for details on EPSDT coverage and billing.

The EPSDT screening is a comprehensive health screening/well-child examination. The comprehensive health screening/well child visit content should be in line with the most current recommendations of the **"American Academy of Pediatrics (AAP), Guidelines for Health Supervision".** Another resource for preventive health guidelines is the AAP compatible **"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"**. **All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.**

EPSDT Screening Services

Required EPSDT screening components include:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Vision screening by a standardized testing method according to the DMAS periodicity schedule;
- Hearing screening by a standardized testing method according to the DMAS periodicity schedule;
- Developmental screening with a standard screening tool according to the American Academy of Pediatrics guidelines;
- Age appropriate immunizations as needed according to the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Laboratory tests (including lead blood testing at 12 and 24 months or for a new patient with unknown history up to 72 months or as appropriate for age and risk factors);
- Health Education/Anticipatory Guidance/problem-focused guidance and counseling.
- The chart below indicates when a child should receive an EPSDT screening:

INFANCY	EARLY CHILDHOOD	LATE CHILDHOOD	ADOLESCENCE
1 month	15 months	5 years	12 years
2 months	18 months	6 years	14 years
4 months	2 years	8 years	16 years
6 months	3 years	10 years	18 years
9 months	4 years		20 years
12 months			

Billing for Hearing, Vision, and Developmental Screenings During the EPSDT Well Child or Problem Focused Visit

Objective hearing screening (CPT code 92551), vision screening (CPT code 99173), and developmental assessment (CPT code 96110) procedures performed using a standardized screening method on the same date of service as a Preventive Medicine E&M will be reimbursed separately when Modifier 25 is used along with the appropriate E&M code for that visit.

Other Necessary Health Care, Diagnostic Services and Treatment Services – Specialized Services

As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, the state must provide other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The non-state plan services are called Specialized Services. Please refer to the EPSDT Supplement and other EPSDT manuals to find more information about the EPSDT Specialized Services.

Physician's Role in Home Health Services

Home health services provide periodic nursing care and therapy under the direction of a physician. Such services are provided by participating home health agencies and can be used effectively by the physician for post-hospital care and periodic nursing care. The Medicaid Program will reimburse home health agencies for necessary services prescribed by the physician. The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician. For the home health services that exceed five (5) visits and require service authorization, home health providers will be asked, during the service authorization process, to "attest" that the face-to-face encounter requirement was met.
The face-to-face encounter may occur through telehealth, which is defined as the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment (DMAS Medicaid Memo dated May 20, 2014). Telehealth shall not include by telephone or email. See the Home Health Manual for additional information.

PHYSICIAN'S ROLE IN THE PRESCRIPTION DRUG PROGRAM

Prescription drugs are covered under the Virginia Medicaid Program. The physician's normal procedure for prescribing drugs should be followed. However, the prescriber's National Provider Identifier (NPI) number must be included on all prescriptions for Medicaid members including those serviced by Health Maintenance Organizations (HMOs).

The prescribing of drugs should be in accordance with community standards of medical and pharmacy practices and consistent with economy. Virginia Medicaid requires the use of generic drugs where possible. Physicians may specify a brand name only when it is medically necessary. In acute illnesses, prescribed drugs should be limited to the quantity needed for the course of treatment for the illness. Maintenance drugs for chronic illnesses should be prescribed in quantities according to treatment needs.

Coverage and Limitations

Prescription services are provided to Medicaid members. Please see the Pharmacy Manual under Chapter IV. Providers are referred to the Preferred Drug List (PDL) for verification of covered drugs, and Physician requirements.

PROGRAM COVERAGE

Introduction

The Medicaid Program is designed to assist eligible Medicaid members in obtaining medical care within the guidelines specified in this manual and the State Plan. Allowable Medicaid reimbursement is based upon medical necessity. Medicaid defines "medically necessary services" as those services that are covered under the State Plan and are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member. Coverage may be denied if the requested service is not medically necessary according to the preceding criteria or is generally regarded by the medical profession as experimental or unacceptable.

Scope

"Physician Services" are defined as services provided within the scope of a physician's professional license as defined by Virginia law. These services must be rendered by or under the supervision of an individual licensed under State law to practice as a doctor of medicine (M.D.), or doctor of osteopathy (D.O.), and are to be billed by the physician rendering the service.

In billing for covered services, the Department of Medical Assistance Services requires the use of codes and definitions published in the Physicians' Current Procedural Terminology, Fourth Edition (CPT), which has been incorporated into the federal Health Care Financing Administration Common Procedure Coding System, or HCPCS (for clarity, this combined coding system is identified as "CPT/HCPCS"). The physician is to select from the CPT/HCPCS book the procedure code which most appropriately describes the service rendered and documented. Definitions and descriptions of levels of service contained in the introduction to the CPT/HCPCS are to be used when determining the level of service to be billed. These same definitions and descriptions will be used to evaluate documentation during program audits of medical records. (See also the section on documentation). Copies of the Physicians' Current Procedural Terminology, Fourth Edition (CPT) may be obtained from:

Order Department: OP054192
American Medical Association
P.O. Box 10950
Chicago, Illinois 60610

Payments for physician services are made only when medically necessary for the diagnosis and treatment of an illness, injury, restoration of a body function, family planning, or maternity care. Patient records must document fully the extent of all services which are rendered and billed to the Program. These records must be made available for

inspection by an authorized Program representative and/or federal personnel when requested. Failure to do so may result in termination of the provider participation agreement.

Benefit and Coverage Limitations

The following services are covered under the Virginia Medicaid Program only when provided in accordance with the limitations and requirements specified.

Anesthesia

A qualified provider may submit charges for anesthesia administration only under the following conditions:

- The cost of the anesthesia services is not included as an expense item in the hospital reimbursable cost report and the hospital makes no charge for the service; and,

- The anesthesia is personally administered by a physician who remains in constant attendance during the surgery; or,

- The anesthesia is administered by a Certified Registered Nurse Anesthetist in accordance with the supervision and practice requirements as established by the Board of Nursing.

- In a hospital setting, the services are provided in accordance with the Department of Health's hospital licensure requirements.

Anesthesiology' services are paid for by units of time - one unit for each 15 minutes or fraction thereof for the surgical procedure performed. When billing for anesthesiology, use the CPT/HCPCS anesthesia code for the procedure performed and insert the time units in Locator 24G of the CMS1500 (08-05) (08-05) claim form. The base unit (preoperative consultation with the patient) is included in the reimbursement and should not be included in the units of time for the procedure. Example: An anesthesiological procedure required one hour and 45 minutes. Locator 24G would properly show seven (7) units. (NOTE: regarding the administration of epidural blocks, only those units of time during which the anesthesiology provider directly attended the patient will be paid.)

Chemotherapy

The combination of several procedure codes is required in order to bill for the administration of chemotherapy treatments:

- The appropriate CPT/HCPCS chemotherapy administration procedure codes, 9640196549
- The appropriate HCPCS codes for chemotherapy drugs, J9000-J9999
- The appropriate office visit (if applicable), procedure codes 99201-99215 (See the CPT/HCPCS book for additional listing.)

The chemotherapy injection or infusion procedure codes are independent of the office visit. These codes describe chemotherapy administration by a qualified assistant under the supervision of a physician or by the physician and include the necessary administration supplies and mixing agent. The chemotherapy drug procedure codes describe the drug administered and do not include the chemotherapy administration or the office visit, if applicable.

Physicians administering chemotherapy in their offices may bill for the appropriate chemotherapy administration (procedure codes 96401-96549), the appropriate procedure code for chemotherapy drugs (J9000-J9999), and the appropriate office visit (procedure codes 99201-99215), if applicable.

Concurrent Care

Payment for concurrent care will only be considered when more than one physician is actively engaged in the patient's treatment. Each physician must sufficiently explain the condition or conditions for which treatment was rendered through the use of an attachment to the Health Insurance Claim Form, the CMS-1500 (08-05) (08-05) billing invoice

Consultations

A service rendered by a physician whose opinion or advice is requested by another physician for the further evaluation or treatment or both of the patient is considered a consultation. If such a service is provided and Medicaid is billed for this type of service more than once within a six-month period, justification must be furnished as an attachment to the CMS-1500 (08-05) (08-05) claim form, and individual consideration requested. Enter "ATTACHMENT" in Locator 10D and enter procedure modifier "22" ("Unusual Service") in Locator 24D of the CMS-1500 (08-05) claim form. Consultation services should be billed using the appropriate CPT/HCPCS code. If the consulting physician assumes the care of the patient, any subsequent services rendered will cease to be a consultation and should be billed according to the appropriate CPT/HCPCS treatment/visit codes.

Referrals

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services for a referral patient are to be billed according to CPT/HCPCS treatment/visit codes.

Dental Services

Any eligible member under 21 years of age can receive medically necessary dental care, such as preventive care, fillings, extractions, crowns, and prosthetics from participating dentists. The member can be referred directly by the physician to any dental provider participating in the Doral Dental USA Program.

Smiles for Children, for Medicaid, FAMIS, and FAMIS Plus children covers all children under age 21 and over will receive the same limited oral surgery benefits that are currently provided under the Medicaid program. The ***Smiles for Children*** office Reference Manual outlines procedures that dental providers should follow for services rendered. This manual and other important information can be accessed on Doral's website at www.doralusa.com.

End-Stage Renal Disease

Medicaid has secondary coverage to Medicare for end-stage renal disease (ESRD) treatment. Kidney transplantation when preauthorized by Medicaid and supervision of chronic hemodialysis are covered by Medicaid only when the patient is not eligible for Medicare benefits. (Medicaid will withhold payment until a determination is made concerning the patient's Medicare eligibility.)

Professional staff in the Medicare-certified ESRD facility will have responsibility for management of the treatment program and will determine the appropriate type of services needed at any time, e.g., patient hospitalization.

Dialysis centers enrolled in the Virginia Medicaid Program are responsible for submitting charges for outpatient and home dialysis services. The provider must advise the Program as to whether or not the facility charges include the physician component.

Eye Care

Ophthalmologists and other physicians skilled in treatment of diseases of the eye and its appendages may provide eye care and treatment. Eyeglasses for members under age 21 are covered by Virginia Medicaid; however, no more than one pair will be allowed by Virginia Medicaid within a 24-month period without a statement of medical need submitted as an attachment to the CMS-1500 (08-05) form, and the word "attachment" written in block 10d. The refraction that is not covered by Medicare may be billed to Medicaid. To bill Medicaid for the refraction, use CPT/HCPCS procedure code 92015 (determination of refractive state) on the CMS-1500 (08-05) form. Locator 11D will need to be indicated as a 'Yes.'

Contact lenses are not covered by Virginia Medicaid except as may be service authorized by DMAS' Service Authorization contractor. Authorization will be based on medical necessity and that eyeglasses cannot accomplish the optometric treatment.

Family Planning Services (Plan First)

Plan First is the limited benefit Medicaid fee-for-service family planning services program. The purpose of this program is to improve birth outcomes and reduce unintended pregnancies. Men and women who meet the income level and meet citizenship and identity requirements may be eligible for Plan First. Individuals, who are eligible for full Medicaid benefits coverage, are not eligible to participate in the program. Refer to the Plan First Provider Manual available at http://dmasva.dmas.virginia.gov for specific information about the Plan First program.

Services to Promote Fertility

The Virginia Medicaid Program does not cover services to promote fertility. If there is a disease of the reproductive system that requires treatment to maintain overall health, it will be covered. Providers must submit sufficient documentation to substantiate the medical necessity of the procedure. To receive special consideration, providers must request individual consideration on the CMS-1500 (08-05) by attaching documentation to the claim form.

The following procedures are not covered by Virginia Medicaid for the purpose of promoting fertility:

54900	Epididymovasostomy, anastomosis of epididymis to vas deferens, unilateral
54901	Bilateral
55400	Vasovasostomy, vasovasorrhaphy
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method) with or without hysterosalpingography
58672	Laparoscopy, surgical with fimbrioplasty
58750	Tubotubal anastomosis
58752	Tubouterine implantation
58760	Fimbrioplasty
58770	Salpingostomy (salpingoneostomy)
58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo transfer, intra-uterine
58976	Gamele, zygole or embryo intra-fallopian transfer, any method
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria
89331	Sperm evaluation, for retrograde ejaculation, urine

Free Services

Services provided at no charge to the general public cannot be billed to Medicaid.

Gender Dysphoria

Covered services for treatment of Gender Dysphoria are outlined in the Gender Dysphoria Supplement.

Hospital Visits

Payment to physicians for inpatient hospital services is limited to the number of days covered by Medicaid for the medically necessary hospital stay.

Payment to physicians for inpatient hospital visits conducted in acute general hospitals will not be limited by DMAS. DMAS will be reimbursing hospitals based on AP-DRG's payment methodology for the total hospitalization rather than a daily per-diem rate. Physician services provided for psychiatric care, either to members hospitalized in a free-

standing psychiatric hospital or as part of a psychiatric unit of a general acute care hospital, the limitation of their services is related to the number of covered days authorized by Medicaid or the DMAS Service Authorization contractor.

Radical or Modified Radical Mastectomy

Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with a lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for radical, modified, total, or partial mastectomies may be covered if medically justified and authorized. Nothing in this manual shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

Unauthorized inpatient services will not be covered or reimbursed by Medicaid.

Regardless of service authorization, if the invoice reflects organ transplant, a sterilization, hysterectomy, or abortion procedure, the claim will pend for Medicaid manual review. If the required Medicaid form is not attached, the claim will be reduced or denied according to Medicaid policy.

Maternity Care

Antepartum care, delivery, and postpartum care should be billed as an all-inclusive, single unit ("global billing"), except when the antepartum care and the delivery are provided by different physicians or the member is enrolled as a non-resident alien (NRA). Antepartum care is not covered for these NRA clients. Additionally, if the member changes benefit plans [i.e., fee-for-service or DMAS contracted managed care organization (MCO)] during antepartum care, i.e., prior to delivery, the provider should bill services according to the most appropriate CPT code definition according to the member's benefit plan of coverage.

As defined by CPT, Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Per CPT guidelines, Delivery services include admission to the hospital, the admission H&P, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. Per CPT guidelines, postpartum care includes hospital and office visits following delivery.

If a physician provides all or part of the antepartum care, and/or postpartum care but does not perform the delivery, that physician would bill the antepartum and postpartum codes according to CPT guidelines.

Charges for total maternity care are to be submitted only after the final postpartum visit. The Program recognizes that this will result in billing after the suggested 30-day timely-filing period identified in Chapter V of this manual. When billing for total maternity care, the date of delivery is to be used as the billing date (both "from" and "through" dates), using a one (1) in Locator 24G, "Days or Units," of the CMS-1500 (08-05) claim form. In the event the member has changed benefit plans [i.e., fee-forservice or DMAS contracted managed care organization (MCO)] prior to the final postpartum visit, and the physician who did the delivery and provided the inpatient postpartum care is also providing the office postpartum visit, the coverage at the time of delivery will determine which plan (fee-forservice or MCO) is to be billed the global delivery/postpartum charge.

Long Acting Reversible Contraceptives (LARC)

Effective for dates of service on or after January 1, 2017, DMAS will reimburse for LARCs provided after delivery in inpatient hospitals. Prior Authorization is not required. Providers billing for the insertion of the device must bill on the CMS 1500 claim form using either 11981 (implant insertion or 58300 (IUD insertion) depending on the device used. The provider must use place of service Inpatient Hospital (21). Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery.

Inpatient Hospital and Early Discharge Follow-Up Visit Policy

The 1996 General Assembly passed two bills that discuss allowable insurance provisions for the length of inpatient hospital stays for maternity cases (House Bill 87 and Senate Bill 148). These bills require the Medicaid program to provide for inpatient lengths of stay in accordance with the Guidelines for Perinatal Care as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The language also requires payment for follow-up as recommended by the attending physician in accordance with the guidelines.

Medicaid covers maternity inpatient hospital charges as follows. Medicaid covers the day of delivery plus an additional two days for a normal, uncomplicated vaginal delivery without requiring documentation of medical necessity. Medicaid covers the day of delivery plus an additional four days without requiring documentation of medical necessity for cesarean births. Claims for any additional days must be medically justified.

If the mother and newborn are discharged earlier than 48 hours after the day of delivery, Medicaid will cover an early discharge follow-up visit as recommended by the physician, in accordance with the guidelines. The mother and newborn must both meet the criteria

for early discharge to be eligible for the early discharge follow-up visit. This early discharge visit does not affect or apply to any usual postpartum or sick/well baby care; it applies only to an early discharge. The criteria for an early discharge are in the most current edition of the Guidelines for Perinatal Care.

Psychiatric Services Under EPSDT

Medicaid provides an all-inclusive rate to freestanding inpatient psychiatric hospitals for all services rendered to Medicaid children (up to age 21) under EPSDT. The professional component for the psychiatric care may be billed separately by the professional who is enrolled in Medicaid. Medicaid provides a per diem rate for inpatient residential programs. The professional component for the psychiatric care and pharmacy and laboratory services are billed separately by the enrolled provider. Please refer to the Psychiatric Services Manual for additional criteria and documentation requirements.

Psychiatric Services

For information regarding inpatient psychiatric services (including inpatient psychiatric services and freestanding inpatient psychiatric services) and outpatient psychiatric services, refer to the Psychiatric Services provider manual.

Payment for psychiatric services is available within Program limitations as set forth within the Psychiatric Services provider manual.

Services of Interns and Residents-In-Training

The medical services provided by an intern or resident-in-training under an “approved teaching program” of a hospital are covered. An “approved teaching program” means a program approved by the Council on Medical Education of the American Medical Association.

The services performed by interns and residents are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are not reimbursable on a fee-for-service basis as physicians’ services.

House Calls

Payment for house calls is limited to patients who are bedridden and for whom a trip to a physician's office would be detrimental to both safety and health. CPT/HCPCS code 99056 is to be used for billing mileage

Injections

Reimbursement for the administration of a therapeutic injection is included in the office visit when a medical service is rendered. When a therapeutic injection is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211) may be listed in addition to the injection.

To bill for the administered drug either:

- Use the appropriate HCPCS "J" code in Locator 24D and the usual and customary charge for the injectable in Locator 24F of the CMS-1500 (08-05) (08-05) claim form; or
- Use the appropriate CPT/HCPCS code for a therapeutic injection (90772-90779) with an attachment to the CMS-1500 (08-05) (08-05) listing the substance, quantity, and actual invoice for the cost of the drug.

Laboratory and Radiology Procedures

Payment for laboratory and radiology services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The ordering physician may bill for the handling of specimens sent to the laboratory when billed as a single unit using CPT/HCPCS procedure code 99000. Only one specimen-handling fee is allowed per office visit.

Laboratory procedures performed by outside sources at no charge to the practitioner are not to be billed to Medicaid, and only a handling fee will be paid.

Providers MUST put the Clinical Laboratory Improvement Amendment (CLIA) number of the physician office laboratory (POL) performing the service in Block 19 (Reserved for Local Use) of the CMS -1500 (08-05) claim form, as mandated by the Health Care Financing Administration.

Should the situation arise when multiple physician office laboratories are used for services for the same member, file a separate claim form listing the services that each laboratory performed and their applicable CLIA certificate number.

For example, if Physician Office Laboratory A performs CPT code 88150, and Physician Office Laboratory B performs CPT code 81000, and medical services are also performed on the same member, submit a separate claim for CPT 88150 since the CLIA number will be different than for the physician office laboratory performing CPT 81000. The medical services can be billed on either claim since the CLIA number is not applicable for medical services.

A claim will be denied if one or all of the following conditions exist:

- There is no CLIA number on the claim, and the billing is for a laboratory service.
- The CLIA number that is on the claim is invalid.
- The CLIA number is valid, but the provider is billing Medicaid for a service that is outside of the scope of the laboratory's CLIA certificate (e.g., the lab holds a Certificate of Waiver, and the provider is billing for a Physician Performed Microscopy Procedure).
- The services that are being billed were rendered outside of the effective dates of the CLIA certificate.

Providers who currently submit claims electronically should contact their service centers to have their software updated. The CLIA number must be put in the FA0 Record, Claim Service Line Record, in field number 34.0 (CLIA ID NO).

- Medicaid requires that the services, as defined in the CPT Manual, be billed using the appropriate panel code and not the code for the individual components.

- For codes 80046-80076, if all of the components are completed, the provider must bill using the panel code that best defines the panel.

- Whenever four or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code must be used (85025-85027). The appropriate CPT/HCPCS codes are to be used when specimens are tested using automated or manual equipment.

- If fewer than four components of a hemogram are performed, bill for them using the appropriate individual CPT/HCPCS codes.

Telemedicine Services

Coverage of services delivered by telehealth are described in the manual supplement "Telehealth Services."

MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Tobacco cessation screening and counseling

- Tobacco screening: If tobacco screening is conducted when another medical service is rendered, tobacco screening is not separately reimbursable. When

tobacco screening is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211) may be used.

- Tobacco cessation: For those who use tobacco products, tobacco cessation counseling, as part of two tobacco cessation attempts per year, is covered. Five tobacco cessation counseling sessions of at least 10 minutes each are covered without prior authorization as part of each cessation attempt, using CPT codes 99406 or 99407 or HCPCS code S9446 under existing rates. Tobacco cessation counseling services are covered when billed with the ICD-10 diagnosis code F17.200 (Nicotine dependence, unspecified, uncomplicated) or Z87.891 (history of tobacco use). For information on coverage of tobacco cessation pharmacotherapy, see the DMAS Common Core Formulary for covered Smoking Cessation agents at https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list.

Non-Covered Services

The following laboratory and radiology services are specifically EXCLUDED from coverage and payment:

- Tests performed on a routine basis but not medically indicated by the patient's symptoms.
- Laboratory test professional component (CPT/HCPCS procedure modifier "26") for procedures performed in the physician's office, outpatient hospital, or in the independent laboratory. Payment for supervision and interpretation is included in the full procedure payment.
- Sensitivity studies when a culture shows no growth or urine cultures with contaminant growth (103 or less). Payment will only be made for the culture.
- Radiology procedure professional component (CPT/HCPCS procedure modifier “26”) is used only when billing for interpretation and reporting of x-ray. The technical component (HCPCS/CPT procedure modifier “TC”) is used when billing for the use of the radiology equipment.

COVERED SERVICES FOR MEDICAID EXPANSION

Individuals covered by Medicaid Expansion may receive the following additional covered services:

- Annual adult wellness exams

- Nutritional counseling for individuals with obesity or chronic medical diseases. These services are covered for pregnant women, members with Diabetes Type 1 or Type 2, and members with a disorder of lipoprotein metabolism and other lipodemias.
- Advisory Committee on Immunizations Practices recommended adult vaccines (members ≥ 21 years of age):
    - Coverage of the Shingles vaccine for members 50-65 years of age
    - Coverage of the HPV vaccine for members ≤ 26 years of age
    - Coverage of the Hemophilus influenza type B vaccine available for members with asplenia (either congenital or acquired), sickle cell disorders and stem cell transplants
    - Coverage of the Meningococcal vaccine available for members with asplenia (either congenital or acquired), HIV infection, Persistent complement component deficiency (predisposes to lupus) and Eculizumab use
    - Coverage of the Hepatitis A or Hepatitis B vaccine is available for members on Dialysis, with chronic liver disease, acute kidney failure or chronic kidney disease

PROCEDURES COVERED FOR A PATHOLOGIST OR LABORATORY OUTSIDE THE PHYSICIAN'S OFFICE

Payment for the following tests will be made only to a pathologist, a hospital laboratory, or a participating laboratory. Specimens for the tests listed below may also be sent to the State Laboratory:

86171	Complement fixation tests, each antigen
87116	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only
87118	Culture, mycobacteria; definitive identification of each organism
87250	Virus identification; inoculation of embryonated eggs or small animal, includes observation and dissection

<u>Pap Smears</u>

Screening Pap smears shall be covered annually for females consistent with the guidelines published by the American Cancer Society. Medicaid guidelines do not allow

preventive care visits for anyone age 21 or over. The use of any preventive evaluation and management (E&M) CPT code for this age group will be denied as a non-covered service.

Therefore, if you want to submit a claim for a visit and the reason for the visit was to receive a yearly pap smear you may use the following guidelines for billing Medicaid.

- Use the E&M code that will reflect the level of care given during the visit plus the administration of the pap smear.
- Documentation to support the level of care provided must appear in the patient's medical records.
- Use either a preventive ICD diagnosis code or a diagnosis code for any presenting problem found in the process of examination.
- Additional guidelines may be found in the current CPT manual "Evaluation and Management (E/M) Services Guidelines.

Screening Mammography

Screening mammograms for the female member population shall be covered consistent with the guidelines published by the American Cancer Society.

Claims for mammography services for women determined to be at high risk according to accepted medical practices that are performed at the screening frequency for high risk must be coded for unusual service (Code 22) and must include an attachment providing a brief explanation of the high-risk condition.

Screening PSA

Screening PSA (prostate specific antigen) and the related DRE (digital rectal examination) for males shall be covered, consistent with the guidelines published by the American Cancer Society.

Gynecological and Obstetric Services

Medicaid members are given the same freedom of choice for these services that is currently available to the general public under private insurance and health maintenance organizations (HMOs). The Department of Medical Assistance Services implemented this change as a result of the recommendations made by a study commissioned by the Virginia General Assembly in House Joint Resolution 598.

Audiology Services

Medicaid reimburses audiologists for medically necessary services provided for diagnostic purposes to adults as long as they are physician-referred.

Physicians and audiologists must indicate the NPI of the referring primary care physician in Block 17A (I.D. Number of Referring Physician) on the CMS-1500 (08-05) (08-05) claim form.

Intravenous Services

Effective for dates of service on and after July 1, 1998, Medicaid implemented the service day rate methodology for the reimbursement of home I.V. therapy services.

DMAS convened a Task Force to research the most efficient method of ordering and reimbursing for the equipment and supplies related to the delivery of intravenous (I.V.) therapy in the home. This I.V. Therapy Task Force was comprised of durable medical equipment (DME) providers actively involved in delivering home I.V. therapy, pharmacists who provide I.V. therapy services, and Medicaid staff. The Task Force developed the policy, which is effective for claims with dates of service on and after July 1, 1998.

See "Exhibits" at the end of the chapter for a sample of the DMAS-354, Therapy Implementation Form.

Home Infusion Therapy is the intravenous administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting. Medicaid will reimburse for the services, supplies, and drugs only when they are determined to be:

- Medically necessary to treat a member's medical condition;
- In accordance with accepted medical practice; and
- Not for the convenience of the member or the member's caregiver.

The member must:

- Reside in either a private home or a domiciliary care facility, such as an adult care residence. Members in hospitals, nursing facilities, rehabilitation centers, and other institutional settings are not eligible for this service;
- Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;
- Have body sites available for I.V. catheter or needle placement or have central venous access; and

- Be capable of self-administering or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently following the appropriate teaching and adequate monitoring. In those cases where the member is incapable of administering or monitoring the prescribed therapy, and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

Provider Eligibility

Providers must have a valid NPI to participate in the home I.V. therapy program. Providers eligible to participate in this program are:

- I.V. therapy providers;
- Home health agencies;
- Pharmacies; and
- DME providers.
- A provider must be enrolled as a Medicaid provider and must:
- Meet any state licensing and certification requirements;
- Render infusion therapy covered services;
- Use Medicaid-established billing guidelines; and
- Accept Medicaid reimbursement as payment in full.

Therapy Coverage

Medicaid has assigned a service day & reimbursement rate code for each of the following:

- Hydration therapy;
- Chemotherapy;
- Pain management;
- Drug therapy; and
- Total parenteral nutrition (TPN).

Service Day Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all I.V. therapy services, unless the member is enrolled in one of the waivered services outlined under Special Considerations. Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services. The

service day rate payment will be in two service categories: durable medical equipment (DME) and pharmacy. Items in the DME service day rate include all supplies required to administer I.V. therapy, including but not limited to, the:

- I.V. pump/pole rental/control devices;
- Tubings, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs; and
- I.V. start kits and central venous catheter dressing kits.

Items in the pharmacy service day rate include the:

- Diluent for the therapeutic agent;
- Mixing and compounding;
- Flush kits and solutions (heparin and saline); and
- Cassettes and bags/mini-bags.

Drugs used in addition to I.V. therapy, such as intramuscular and subcutaneous injections (Compazine, insulin, etc.) and subcutaneous therapies for hydration and/or pain management, are not covered under the I.V. service day rate policy. These medications and their associated DME supplies must be ordered and billed separately according to current Medicaid guidelines.

DME Service Authorization

The designated HCPCS codes for DME services do not require initial service authorization, but will have a limit of three months. If the service is needed beyond the three-month-limit, it must be service authorized by DMAS' Service Authorization contractor. Special Considerations: Providers of I.V. therapy services to those members enrolled in special or waivered Medicaid programs must abide by all the guidelines of the program in which the member is enrolled. For further information review Appendix D of this manual.

Certificate of Medical Necessity (CMN) (DMAS-352)

The CMN must be completed for I.V. therapy DME services. The provider may fill out the CMN, but the physician, nurse practitioner and/or physician's assistant must date and sign the CMN within 60 days of the begin date of service. Medicaid will not reimburse the DME provider for any DME and supplies provided prior to the date of the physician's,

nurse practitioner's and/or physician's assistant signature when the signature is not obtained within 60 days of the first date of service.

Under the item/service and HCPCS code on the CMN, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the physician within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must be attached to each CMN and I.V. Therapy Implementation form upon completion of the therapy. The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form may be completed by the provider, but must be signed and dated by the physician.

Post-Payment Review

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid members. For DME services, I.V. therapy providers must maintain records that contain the fully completed CMN, signed and dated by the physician; the I.V. Therapy Implementation Form (DMAS354), with the begin and end dates for each drug/therapy provided and signed and dated by the physician; and the order to discontinue the therapy (the official end date), signed and dated by the physician. These forms shall be furnished to Medicaid staff upon request. The absence of documentation to support I.V. therapy services may result in the retraction of moneys.

Code to Use for Incompatible Drug Therapy

In the event of incompatible drug administration, a separate HCPCS code has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing for each day of service. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapter I of this manual, the State may designate certain members to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid member's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.
- A written referral from the primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.
- For other services covered by Medicaid which are excluded from the Client Medical Management Program requirements.

See "Exhibits" in Chapter I for details.

EMERGENCY ROOM SERVICES UNDER CLIENT MEDICAL MANAGEMENT

Reimbursement for emergency room services for Client Medical Management (CMM) members will be automatically paid if the Admitting (presenting signs/symptoms) diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD CM Code (see "exhibits" at the end of this chapter for the list.)

Client Medical Management (CMM) members must have a written primary care provider (PCP) referral in order for non-emergency services provided in the emergency room to be reimbursed at the all-inclusive rate for facilities of $ 30. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

When billing for emergency room services, the attending physician bills evaluation and management codes with CPT codes and enters "Y" in Block 24C. When the PCP has referred the member to the emergency room, place the PCP's NPI in Block 17B on the CMS-1500 (08-05) and attach the Practitioner Referral Form, DMAS-70. PCP referral IS required for reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting.

The following requirements will be applied either individually or in combination to determine the payment for medical services provided in the outpatient hospital emergency room setting. Flexibility with individual patient status and conditions is taken into consideration in the use of these guidelines. The member's age and the time of admission to the emergency room do not determine the emergency status. The conditions relating to the emergency visit will determine the emergency status. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

The Department of Medical Assistance Services uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." The threat to life or health of the member necessitates the use of the most accessible hospital available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

The practice standards of Physician's Assistants in Hospitals and the Emergency Departments of Hospitals are specifically addressed in the Code of Virginia § 54.1-2952, as amended. These practice standards are unique to these settings. DMAS policy conforms to the standards stipulated in State law regarding the provision of care in a Hospital setting by Physician's Assistants. Additionally, DMAS requires that the patient's medical record must be documented sufficiently to clearly show that these unique practice standards have been met.

Telephone or standing orders, or both, do not support emergency treatment.

Emergency room claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements. Hospitals and physicians should insure that the documentation to support the medical necessity for the emergency visit is complete and legible.

Emergency Situations:

- Initial treatment following a recent injury. "Recent" is defined as having occurred less than 48 hours prior to the visit.
- An injury sustained over 48 hours prior to the visit and the symptoms have deteriorated to the point of requiring medical treatment for stabilization.
    - Note: Minor injuries requiring only simple first aid that can be done in the home such as cleansing and bandaging an abrasion, are not considered emergencies. A secondary diagnosis such as Diabetes Mellitus may support the emergent need if substantiated.
- Initial treatment for medical/surgical emergencies, including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of

consciousness, status epilepticus, or other conditions considered "life-threatening."

- Visit in which the member's condition requires observation status or immediate hospital admission or transfer to another facility for further treatment or visit.
- Motor Vehicle Accident (MVA) within 48 hours.
- Physical abuse (suspected or confirmed) within 48 hours.
- Epistasis requiring packing
- Allergic reaction with airway compromise
- Acute vital sign changes including, but not limited to, the following:

Adult:

- Temperature of 103° F or higher
- Pulse rate below 40/minute
- Pulse rate above 140/minute
- Respiratory rate below 10/minute
- Respiratory rate above 28/ minute
- Systolic blood pressure below 90mm Hg
- Systolic blood pressure above 200mm Hg
- Diastolic blood pressure below 40mm Hg
- Diastolic blood pressure above 120mm Hg
- Pulse Oximetry reading < 91%

- For adults: Use of IV fluids for hydration purposes - rate should be 100ml/hr or greater

Pediatric:

- Temperature of 102° F or higher
- Pulse rate above 180/minute for patients 1-18months of age
- Pulse rate above 170/minute in patients 18 months to 12 years
- Pulse rate below 80/minute in patients 1-18 months of age
- Pulse rate below 60/minute in patients over 3 months of age
- Respiratory rate above 50/minute in patients 1 to 10 months
- Respiratory rate above 40/minute in patients 18 months to 12 years
- Systolic blood pressure below 65mm Hg in patients 6 months and under

- Systolic blood pressure below 80mm Hg in patients 6-12 months of age
- Systolic blood pressure above 120 mm Hg in patients 1-18 months
- Systolic blood pressure above 140 mm Hg in patients 18 months - 12 years of age
- Systolic blood pressure above 180 mm Hg in patients 12 years and older
- Diastolic blood pressure above 80 mm Hg in all pediatric patients
- Diastolic blood pressure below 40mm Hg in all pediatric patients
- Pulse Oximetry reading < 93%

- For Pediatrics: Use of IV fluids for hydration purposes - rate should be 75ml/hour or greater

Non-Emergency Conditions (unless the criteria described below have been met):

Depression/Anxiety: Documentation must clearly indicate that the member is an immediate danger to self or others.

Otitis Media – not an emergency unless one or more of the following is noted:

- The tympanic membrane is ruptured.
- There is drainage from the ear(s).
- A fever is documented while in the emergency room:

Children: Temperature of 102°F or above rectally

Adult: Temperature of 103°F or above orally

- The member is age 2 or under and is crying inconsolably.
- The physician's examination documents the presence of acute otitis media, and there is no access to a physician's office due to being after office hours or on a holiday or a weekend.

Seizures – not an emergency unless:

- The condition was previously undiagnosed, and the visit is immediately following or during a seizure.
- A secondary disorder/diagnosis exists (i.e., hypoglycemia, infection)
- The member is 12 years of age or younger.

- Accompanied to the ER by a law enforcement officer and the condition was unknown.
- The member is in status epilepticus.
- The member is in an epileptic state aggravated by alcohol or drug ingestion

Non-Emergency Situations:

- Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures or treatments, such as drawing blood for lab work.
- The member had previously been in the same or different emergency room or in a physician's office for the same condition without worsening signs or symptoms of the condition.
- Scheduled visits to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion.
- Visits made to receive a "tetanus" injection in the absence of other emergency conditions.
- Visits made to obtain medications in the absence of other emergency conditions.
- The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition.

- Medical Clearance/Screenings for Psychological or Temporary Detention Order admissions.

EMERGENCY ROOM SERVICES EXCEPT FOR MEMBERS IN THE CLIENT MEDICAL MANAGEMENT PROGRAM)

Reimbursement for emergency room services for Medicaid members (not enrolled under the Client Medical Management Program) will be automatically paid if the principal diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD CM Code (see "Exhibits" at the end of this chapter for this list). Claims for emergency services with the principal diagnosis on Diagnoses to Pend for Review By ICD CM Code will pend for review of the necessary documentation supporting the need for emergency services. (See "Exhibits" at the end of this chapter for this list.) Effective with emergency room claims the Admitting (presenting signs/symptoms) diagnosis will be utilized to determine the pay or pend status of the claim. All claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements.

All emergency physician room claims will be paid for emergency CPT codes 99281, 99282, 99284, & 99285 under existing rates. DMAS will pend CPT code 99283 that is submitted with admitting diagnosis code or pend table to determine the emergency situation warranting care. DMAS will pay an all-inclusive fee of $22.06 to the physician for those claims found not in compliance for emergency room services. All-inclusive is defined as all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services. Laboratory services will continue to be reimbursed under the existing system of rates. Claims identified as emergencies will also be reimbursed under existing rates. The ordering and interpretation of appropriate diagnostic tests are considered part of the payment to the physician in the emergency department.

A professional component for these services may not be billed separately by a physician in the emergency department, and no separate payment will be made to the physician in the emergency department for a professional component. The professional component will be reimbursed only to those providers who interpret a test and sign and issue the final report.

Follow-Up Care Post ER Visit

Any follow-up outpatient or office consultations for CMM clients require a referral from the primary care physician. Place the PCP's NPI in Locator 17B on the CMS-1500 (08-05). Attach the written referral form and mark Locator 10D "attachment."

DURABLE MEDICAL EQUIPMENT

Coverage of Apnea Monitors

As a part of the Quality Care Assurance routine program evaluation of durable medical equipment (DME) and in response to concerns and questions that had been raised, the Department reconvened the Apnea Monitor Task Force to evaluate the appropriateness of the criteria for initial use, continuance of use, discontinuation, and other issues related to the coverage of apnea monitors. The Task Force consisted of physicians representing all regions of the state, respiratory therapists, durable medical equipment providers, and DMAS staff, including medical consultants and other health professionals.

In addition, an extensive literature search for standards of practice was initiated. The following policy is a result of the work of this Task Force and became effective for claims with dates of service on and after January 1, 1996.

Diagnoses Which Automatically Meet Criteria and Identified-High Risk Conditions

Apnea monitor usage for individuals with the following diagnoses or identified high-risk conditions will be approved for payment if the diagnosis/condition is supported with a completed Certificate of Medical Necessity (CMN) (DMAS-352) with appropriate supporting and verifiable documentation:

- Apparent life-threatening episode(s), i.e., Gastro Esophageal Reflux, severe; apnea; seizures; cardiac arrhythmias;
- Apnea of Prematurity;
- Bronchopulmonary Dysplasia/Chronic Lung Disease of Infancy with oxygen dependency;
- Respiratory Control Disorder such as: Congenital Hypoventilation, Obstructive Sleep Apnea, Central Apnea, Obstructive Airway Disease;
- Infant or child with Tracheostomy;
- Infant of drug-dependent mother, symptomatic for apnea;
- Sibling of SIDS (payment will be made for six months from birth or up to one month beyond age of sibling at time of death); and
- Congenital Anomalies, at risk of airway obstruction.

If the member does not meet the above criteria, the request will be reviewed in accordance with the following criteria.

Criteria for Home Monitoring

The instrument recommended for home use must monitor both cardiac and respiratory status. Apnea mattresses or displacement pads are not appropriate. The member may use either the recording or nonrecording monitor.

One or more of the following will be used for selection of patient home monitoring (initial and ongoing continued use), with appropriate supporting individual documentation:

- Observed or recorded episode of prolonged apnea with no identifiable and/or treatable cause or an inadequate response to treatment;
- Documented apnea associated with bradycardia, cyanosis, or pallor;
- History of apnea described by parent or caretaker and documented in the medical records; or

- Evidence of abnormal respiratory control.

Guidelines for Discontinuation of Monitor Reimbursement

Initial approval for payment will be for a period up to four (4) months (120 days). If continued use is indicated by medical necessity, supporting and verifiable medical documentation must be submitted to the Department of Medical Assistance Services Service Authorization contractor for review and service authorization. Reimbursement for apnea monitors will be discontinued when a clinical evaluation (including neurological, developmental and physical examinations) shows that the problems or the initial reasons behind the decision to monitor have been resolved or stabilized:

- The patient has been free of events requiring stimulation or resuscitation for 2-4 months; or
- The patient has experienced significant stressors such as respiratory illness or immunizations without apnea; or
- There is normalization of a previously abnormal respiratory pattern or no prolonged apnea episodes for 2-4 months.

Pneumograms/Downloads, Polysomnagrams, and Multi-Channel Sleep Studies

Definitions:

Pneumogram is a 2-channel study of breathing and heart rate, including EKG signal and chest wall movement. A download serves the same purpose as a pneumogram if the member is monitored on a recording apnea monitor.

Multi-channel sleep study contains three or more signal sources that may include: cardiac EKG signal, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2.

Polysomnagram includes cardiac EKG signal, respiratory chest wall movement, respiratory abdominal wall movement, respiratory airflow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2, EEGx2, EOG x2, and EMG, attended by a technologist.

It was determined that reimbursement for these studies should be made based on the number of channels in the study. Criteria for determining the number of appropriate channels to be studied would be determined by the attending or ordering physician.

The certificate of medical necessity documentation must specify the number of signals and what signals are to be done and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis. A summary report must be maintained at the provider's location.

If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. This information will be obtained from the download summary report. If a member with a recording monitor needs a pneumogram, the DME provider must submit a request for service authorization.

Billing Procedures

The DME provider is to use current CPT codes when billing for these studies. HCPCS code E1399 will be used for a two-channel pneumogram or download without interpretation. HCPCS code E1399 will be used for a two-channel pneumogram or download that includes interpretation. HCPCS code E1399 will be used for a multi-channel sleep study or polysomnagram with or without interpretation.

The technical component (scoring) must be included in these three codes.

HCPCS CODES	DESCRIPTION	BILLING UNIT	AUTHORIZATION	LIMITS	COMMENTS
E1399	2-Channel Pneumogram/ Download without interpretation	Each	No	1 per month	See Below.
E1399	2-Channel Pneumogram/Download with interpretation	Each	No	1 per month	See Below.
E1399	Multi-channel sleep study or polysomnagram with or without interpretation	Channel or Signal	Yes	I.C.	See Below.
If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. If a member with a recording monitor needs a pneumogram, the DME provider must submit a request for service authorization.					

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies

For the initial 120 days, which do not require service authorization, there must be a Certificate of Medical Necessity (CMN) stating the member's diagnosis that indicates the need for a monitor or a description of the member's condition. The following documentation is required for the continued use of an apnea monitor over 120 days:

1. A CMN and documentation outlining what the member has experienced related to apnea in the previous 120 days of monitoring, including:

a. The dates and number of occurrences of observed apnea;
b. An interpretation of any related diagnostic tests;
   For example: an upper GI series for GE reflux; pneumograms, or downloads for recording apnea monitors that are interpreted and indicated that the child had clinically significant apnea during the first 120 days and/or the condition is resolving;
c. Download reports with clinical interpretation from recording monitors, (the physician is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to get a clear picture of what the child is experiencing);
d. Adequate and verifiable documentation on the CMN of the oxygen flow rate for those members who continue on oxygen, if applicable; and
e. Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome if the child was placed on the monitor for this reason.

2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor or pneumogram studies).

The provider must submit a clinical description to DMAS staff of what happened during the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, need to reach significant age for a sibling of SIDS), and a physician's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the member's physician to interpret the data. It is the responsibility of the DME provider to obtain the interpretation from the physician and submit it to Medicaid.

Documentation for discontinuation of apnea monitor reimbursement will consist of a clinical evaluation (including neurological, developmental, and physical examinations) which shows that the problems or the initial reasons behind the decision to monitor have been resolved or stabilized.

Documentation for pneumograms, polysomnagrams, and multi-channel sleep studies must specify the number of signals and what signals are to be done and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

The DME provider must maintain all documentation (CMN, summary reports, delivery tickets, billing) on file at the location that is serving the member. Documentation must be maintained on file for five years.

Rental Versus Purchase of an Apnea Monitor Criteria

Medicaid does not require service authorization for the initial 120 days. If the physician determines that the member will need the apnea monitor longer than 120 days but less than eight months, the DME provider must obtain authorization for continued rental from DMAS Service Authorization contractor. To obtain authorization, the DME provider must submit supporting documentation for the additional time requested. If the physician determines that the member will need the apnea monitor eight months or longer, the DME provider must request purchase of the apnea monitor with supporting documentation at the initiation of service or time of determination of long-term usage. At the time of purchase, the DME vendor is required to provide a new monitor with a full manufacturer's warranty.

Non-Compliant Behavior

The provider shall document the non-compliant use of the apnea monitor in the member's file. Noncompliant use of the apnea monitor by the member or the member's caregiver is a refusal to provide care necessary for the child's health and creates a substantial risk of death for the child. The provider shall report non-compliant behavior to the attending physician or health care professional. There shall be compliance with Section 63.1-248.3 of the Code of Virginia.

The Department of Medical Assistance Services shall continue to reimburse for the monitor while reasonable efforts to insure compliant behavior are taken.

Information about Service Agreements for Purchased Apnea Monitors

HCPCS code E1399 has been developed to cover the service and maintenance of purchased apnea monitors. HCPCS code E1399 requires service authorization. The service maintenance agreement will allow for trouble-shooting and download visits (18 visits per six months). Downloading can be done during a trouble-shooting visit. The vendor can utilize these 18 visits for any combination of trouble-shooting or download visits.

Providers must agree to send the purchased monitor to the manufacturer for necessary servicing. The cost for servicing, shipping, and handling will be covered in HCPCS code E1399 and service authorization is required. A copy of the manufacturer's invoice for servicing must be attached to the invoice. These invoices will pend for manual review before reimbursement is made.

The service maintenance agreement does not include repairs. All repairs must be requested under the established HCPCS code for repairs.

Service Agreement for Purchased Apnea Monitors

The service maintenance agreement requires service authorization by DMAS Service Authorization contractor in order for the provider to be reimbursed. Once service maintenance is authorized, the provider may bill using the HCPCS codes in the DME listing. The following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with staff that will be available to make timely necessary home visits related to the use of the apnea monitor. The DME vendor must assure that the staff being sent into the home is qualified to render the necessary services.
- The provider agrees to perform routine maintenance of the apnea monitor in the home, replacing rib belts, lead wires, and electrodes (disposable or reusable) associated with this routine maintenance. Supplies that must be provided under this agreement are listed in the table below. If the member requires additional supplies that are medically justified, the provider should submit a service authorization request to DMAS Service Authorization contractor with attached medical justification that documents the need for these additional supplies.
- The cost for trouble-shooting and download visits will be included in the service maintenance agreement fee (18 visits per six months). Downloading can be done during a trouble-shooting visit. These 18 visits can be utilized by the vendor for any combination of trouble-shooting or download visits.
- The provider agrees to provide a back-up apnea monitor throughout the period of apnea monitor repairs or services.
- The DME vendor may bill Medicaid for a rental apnea monitor for up to one month during routine repairs/services using the established HCPCS code. The rental must only be for the actual time the monitor is out of the home being serviced by the manufacturer.
- The cost of parts which would constitute a repair may be billed separately as a repair using the established HCPCS codes for repairs.
- The provider agrees to send the apnea monitor for necessary servicing by the manufacturer. The cost for servicing, shipping, and handling will be covered in a separate HCPCS code. The provider must attach a copy of the CMN and manufacturer's invoice to the claim in order for the claim to be paid. Medicaid will pend claims for this HCPCS code for manual adjudication.

HCPCS CODE	DESCRIPTION	BILLING UNIT	AUTHORIZATION	LIMITS	COMMENTS
E1399	Service Maintenance Agreement for a Patient-Owned Apnea Monitor	Each	Yes	2/12 Months	
SUPPLIES REQUIRED TO BE PROVIDED WITHIN THE SERVICE MAINTENANCE AGREEMENT 12 ELECTRODES DISPOSABLE OR 2 REUSABLE ELECTRODES 2 LEAD WIRES 2 RIB BELTS					

Enteral Nutritional Supplements

Nutritional supplements may only be provided by enrolled durable medical equipment (DME) vendors and be reimbursed based on HCPCS codes that define categories of supplements. A fixed fee amount is established for the categories.

Coverage of enteral nutrition, which does not include a legend drug, is limited to when the supplement is the sole source form of nutrition, (except for individuals authorized through the Technology Assisted, or through EPSDT where the supplement must be the primary source of nutrition), is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does not include the provision of routine infant formulae.

Sole source means that the individual is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that nutritional supplements are medicallyindicated for the treatment of the member's condition if the member is unable to tolerate oral nutrients. The patient may either be unable to take any oral nutrition or

the oral intake that can be tolerated is inadequate to maintain life. The focus must be the maintenance of weight and strength commensurate with the patient's condition.

EPSDT Coverage of Medical Formula and Nutritional Supplements

The Early Periodic Screening Diagnosis and Treatment (EPSDT) program allows the Virginia
Department of Medical Assistance Services (DMAS) to provide medically necessary formula and medical foods to EPSDT eligible children under the age of 21 based on medical necessity. The current DMAS Durable Medical Equipment (DME) Provider Manual defines EPSDT formula approval criteria in Chapter 4 of that manual. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under physician direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Enrollees under the age of five (5) may receive medical formula and nutritional supplements through either DMAS enrolled DME providers or a local Women, Infants and Children (WIC) office. Provision of medically necessary formula and medical foods for children under the age of 21 is not required of DMAS contracted MCO's as this service is carved out from the DMAS Managed Care Contract and covered through DMAS fee-for-service, within DMAS coverage guidelines.

Medical formula and nutritional supplements must be physician recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. The physician must document medical necessity by using the Certificate of Medical Necessity (DMAS 352) and the Nutritional Status Evaluation when the family uses a DME provider to provide the medical formula. When a local WIC office provides the formula for children under the age of five (5) then the WIC program forms are used to document medical necessity.

Documentation Requirements for Enteral Nutritional Supplements

The physician's order (the Certificate of Medical Necessity [CMN]) must specify either a brand name of the supplement being ordered or the category of enteral nutrition which must be provided.

If a physician orders a specific brand of supplement, the DME provider must supply the brand prescribed. The physician's order must include the daily caloric intake ordered and the route of administration for the supplement. The physician's order (the CMN) is valid for a maximum of six months regardless of the member's age.

A face-to-face nutritional assessment completed by trained clinicians (i.e., physician, registered nurse, registered dietitian) must be completed as required documentation of enteral nutrition for both the initial order and every six months. The DME provider/ordering practitioner can use the CMN or a Letter of Medical Necessity that contains all of the required assessment elements and then provide this information to the DME provider who will be supplying enteral nutrition; however, providers may use any format, provided that all the elements are addressed. Home health visits for the sole purpose of performing a nutritional assessment for members whose conditions are stable and chronic in nature will not be covered under the home health program.

The nutritional assessment must include the following elements:

1. Height (or length for pediatric members);
2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the patient weight loss over time;
3. Formula tolerance (e.g., the patient is experiencing diarrhea, vomiting, constipation). This element is only required if the patient is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration; and
7. Section F must include the daily caloric order and the number of calories per package/can/etc.

The DME provider must assure that there is a physician's order and nutritional assessment, completed in accordance with Medicaid policy, on file for any Medicaid member for whom enteral nutrition is provided.

NOTE: The nutritional assessment/supporting documentation does not replace the requirement for a CMN.

Blood Glucose Monitors

DMAS will reimburse for blood glucose monitors and associated supplies for members eligible for the DME program or EPSDT when all of the following criteria are met:

- The member has a condition that requires adjustment of insulin dosage based on at least daily blood glucose findings, or the member has clinically demonstrated unstable glucose readings and must report frequent findings to a practitioner for adjustment of hypoglycemic medications; and
- There must be written verification that the member and/or caregiver have participated in diabetic training (diet, medication, monitoring, etc.) and that the member and/or caregiver have demonstrated the ability to appropriately use the prescribed blood glucose monitor.

(This requirement is applicable for initial blood glucose monitors and is not required for future monitors unless the practitioner feels additional education is necessary).

For Pregnant Women

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for which the practitioner determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome (effective for dates of service on and after July 1, 1993).

The Certificate of Medical Necessity (CMN) (DMAS-352) is required. As of July 1, 2010, the maternity risk screen is no longer required; however, 12VAC 30-50-510 requires that pregnant women who receive a blood glucose meter covered by DMAS must also be referred for nutritional counseling.

COUNSELING, HIV TESTING, AND TREATMENT FOR PREGNANT WOMEN

The Code of Virginia §54.1-2403.01 requires providers to counsel pregnant women on the importance of HIV testing during pregnancy and treatment if the testing results are positive.

As a routine component of prenatal care, every licensed practitioner who renders prenatal care, regardless of the site of such practice, must advise each patient of the value of testing for Human Immunodeficiency Virus (HIV) infection and request that she consent to such testing.

Practitioners must also counsel all pregnant women with HIV-positive test results about the dangers to the fetus and the advisability of receiving treatment in accordance with the current Centers for Disease Control recommendations for HIV-positive pregnant women. All pregnant women shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal must be maintained in the patient's medical record.

The HIV/AIDS epidemic is increasing in women of childbearing age and spreading beyond previously defined risk groups and geographic areas. This increase has been paralleled by a similar increase in children. The Health Care Financing Administration estimates that a minimum of 90% of children infected with HIV are Medicaid beneficiaries.

Clinical trials were conducted under the National Institutes of Health on the use of AZT (zidovudine) to prevent perinatal transmission of AIDS. The clinical trials [AIDS Clinical Trial Group 076 (ACTG 076)] demonstrated that participants who received AZT therapy had a 66% reduction in transmission of HIV from the mother to her newborn. The results of this clinical trial were significant because perinatal transmission accounts for most cases of HIV infection among children.

As the primary caretakers of this population, both the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) strongly believe that the answer lies in an aggressive HIV education and counseling initiative. They have issued a joint statement stating "clear medical benefits of knowing the HIV status of pregnant women and newborns have been documented. Treatments are currently available to significantly reduce the HIV transmission from mother to infant (zidovudine/AZT). This finding represents the most important medical breakthrough in this area in recent years. In addition, the lives of the infants, not protected by the AZT treatments in utero, may be prolonged by initiating medical care within the first months of life. For newborns whose mother's HIV status was not determined during pregnancy, the infant's health care provider should educate the parent(s) concerning HIV testing and recommend HIV testing for the newborn."

The combined strategy of HIV counseling for all pregnant women and voluntary HIV testing is already proving effective in several communities. Voluntary testing means that after a woman receives appropriate counseling from her health care provider, she is able to make an informed decision about having a test for HIV. Studies show that when her health care provider talks with a pregnant woman about the test and what it means for her and her baby, most women choose to be tested and then to be treated as their doctor recommends. For example, in one inner-city hospital, 96% of women chose to be tested after receiving HIV counseling.

Printed copies of the "U.S. Public Health Service Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women" and "Recommendations of the U.S. Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency
Virus" (MMWR 1994; 44[RR-11]) which have more information about AZT treatment during pregnancy are available from the CDC National AIDS Clearinghouse (CDC NAC). Printed copies may be ordered by calling the CDC National AIDS Hotline (1-

800-342-AIDS). The Hotline can also provide information about any AIDS-related issue.

The guidelines are also available electronically through CDC NAC on-line bulletin board as well as through other HIV/AIDS bulletin boards, including the Internet.

For specific information regarding the 076 Clinical Trial or any other HIV/AIDS clinical trial, call the AIDS Clinical Trial Information Service (ACTIS) at 1-800-TRIALS A. For information regarding treatment and care of HIV infection and AIDS, including the use of AZT in pregnant women, call the HIV/AIDS Treatment Service (ACTIS) at 1-800-448-0440.

BILLING PROCEDURES FOR NEWBORN SCREENING TEST KITS

Enrolled Medicaid providers would use CPT code 99070 for the newborn PKU test kit only, for testing done outside of the initial newborn hospitalization or for one done in an outpatient setting for necessary follow up. The enrolled Medicaid provider will use the CMS-1500 (08-05) claim form and would need to have an attachment that contains the member name and ID number, date of service and the actual charge for the PKU Kit from the state lab. The test kit and actual laboratory test would be part of the initial newborn hospital facility charges and reimbursed to the facility under the established facility reimbursement, if done with the hospitalization of the birth, the actual laboratory blood test would be billed by the performing laboratory using CPT code 84030- Phenylalanine.

BABYCARE SERVICES

The BabyCare program includes the following components:

- Behavioral health screenings by a physician, physician assistant or nurse practitioner as defined in the BabyCare Provider Manual, Chapter II;
- Case management for high risk pregnant women and infants up to two years of age, by registered nurse or social worker as defined in Chapter II of the BabyCare Provider Manual; and
- Expanded prenatal services for pregnant women including member education classes (including tobacco dependence education), nutrition services, homemaker services and substance abuse treatment services (SATS) by a DMAS approved provider as detailed in Chapter II of the BabyCare Provider Manual.

BabyCare services described in this chapter are covered under the Virginia Medical Assistance Program. Forms referenced in this chapter may be found under the Maternal

and Child Health / BabyCare section on the DMAS website at http://dmasva.dmas.virginia.gov.

The physician is an essential link in identifying high-risk members and referring for services. Behavioral health screenings and case management services are available for pregnant women and infants who are enrolled in Fee-for-Service (FFS) or Primary Care Case Management (PCCM) for Medicaid, Family Access to Medical Insurance Security (FAMIS), FAMIS Plus or FAMIS MOMS programs. Expanded prenatal services are available to pregnant members in FFS or PCCM Medicaid, FAMIS, FAMIS Plus or FAMIS MOMS programs. The covered services available to enrollees in a MCO are described below. Pregnant women are eligible for BabyCare services during pregnancy and up to the end of the month following their 60th day post-partum. Infants are eligible for BabyCare services up to their second birthday.

BEHAVIORAL HEALTH SCREENINGS

The physician is the critical link between the high-risk pregnant woman or infant and the services available through the BabyCare program. The physician is responsible for identifying potential or existing problems through the systematic review of the pregnant woman or infant's medical/obstetrical/developmental conditions, as well as lifestyle and environmental factors, and making referrals for care directed at preventing or ameliorating those problems.

DMAS reimburses for administration and interpretation of the *Behavioral Health Risks Screening Tool for Women of Child Bearing Age*. The purpose for the screening is to identify and assist pregnant women as well as new mothers who may be at risk for mental health, substance use or intimate partner violence as well as infants who may be at risk for developmental issues secondary to their family situation and mother's risks. Early identification and referral for intervention of these risks are paramount in helping improve the outcomes of pregnancy as well as health/well-being of the infant. BabyCare reimburses for administration of this instrument for pregnant/postpartum women who are enrolled in a fee-for-service or primary care case management program using Current Procedural Terminology (CPT) code 99420.

BabyCare will reimburse pediatricians for administering the *Behavioral Health Risks Screening Tool for Women of Childbearing Age* to mothers of infants up to age two, under the infant's medical benefit for FFS or PCCM Medicaid, FAMIS or FAMIS Plus. The purpose is to identify mothers of infants who may be experiencing depression, substance abuse or intimate personal violence and thus increasing the risk that the child will have developmental issues as a result. BabyCare reimburses for administration of this instrument for postpartum women and when billed under the infants up to two years of age who are enrolled in a fee-for-service or primary care case management program using CPT code 99420.

Managed Care Organization High Risk Maternity and Infant Programs

MCOs participating with the Virginia Medical Assistance Program have their own high risk maternity and infant programs including case management and expanded prenatal services (services comparable to those identified in 12VAC30-50-410 and 12VAC30-50-510). Each MCO has established authorization and approval requirements for these programs. In addition, in order to provide and be reimbursed for services to a managed care member, providers must have a contract with the MCO. Providers should contact the appropriate MCO about the requirements of their maternity and infant program. A list of the MCO High Risk Maternity and Infant Programs can be located on the DMAS website under Managed Care / Contact Information / High Risk Maternity and Infant Programs: (http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-guide_p2.pdf).

The major goals of BabyCare services are to:

1. Reduce infant mortality and morbidity by improving pregnancy outcomes;

2. Ensure access to comprehensive preventive and therapeutic services by pregnant women and their infants; and

3. Assist pregnant women and infants under age two in meeting other priority needs that affect their well-being and that of their families.

For more information about BabyCare and the referral process, please refer to the BabyCare Provider Manual available online at: http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.

Substance Abuse Therapy Services for Pregnant and Postpartum Women

DMAS provides coverage for the following substance abuse treatment services for pregnant and postpartum women. More information about the substance abuse treatment services may be found in the DMAS Community Mental Health Rehabilitation Provider Manual available online at: http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.

Substance abuse treatment services (SATS) for pregnant and postpartum women are described in the DMAS Community Mental Health Rehabilitative Services Manual and are not included in MCO contracts. Members who are pregnant may access substance abuse treatment through any approved DMAS-enrolled SATS provider. Also, the MCO may refer a member to these services. It is the responsibility of the provider of these services to coordinate service delivery and the member's needs with the MCO.

MEDICAL EQUIPMENT AND SUPPLIES

Expendable medical supplies normally used in the physician's office, such as gauze, dressings, syringes, and culture plates, are included in the Medicaid Program's reimbursement for the office visit or test performed. Only the actual cost of special expendable medical supplies, such as an ace bandage or a surgical tray, can be billed to Medicaid. DME and supplies are a covered service available to the entire Medicaid population. In addition, Medicaid may cover DME services when any of the following are met:

- The member is under age 21 and the item or supply could be covered under the Virginia State Plan for Medical Assistance (the State Plan) through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); or
- The member is enrolled in the CCC Plus Waiver Program.

All medically necessary medical equipment and supplies under the State Plan may be covered only if they are necessary to carry out a treatment prescribed by a physician. Unusual amounts, types, and duration of usage must be authorized by Medicaid in accordance with published policies and procedures. When determined to be cost-effective by Medicaid, payment may be made for rental of the equipment in lieu of purchase. (Virginia State Plan for Medical Assistance, Supplement 1 to Attachment 3.1-A&B, 7-D, 1.a.) Durable medical equipment (DME) and supplies that are on a Certificate of Medical Necessity (DMAS-352) and are physician ordered for the home environment are reimbursable for the general Medicaid populations. The non-covered DME and supplies are outlined in the State Plan for Medical Assistance and the Durable Medical Equipment and Supplies Manual. DME and supplies for home use do not require that the member meet the home health criteria by being classified as homebound; therefore, DME and supplies may be obtained through an enrolled DME provider who must request service authorization when required.

Procedure Codes for Medical Supplies and Equipment Used in the Practitioner's Office

In the course of treatment in a practitioner's office, it may be necessary to use supplies and/or equipment beyond those routinely included in the office visit. The applicable CPT/HCPCS code may be used when billing for a specific supply item. The following procedure code may be used:

Item Procedure Code * Unlisted Supplies 99070

* Note: When using procedure code 99070, Unlisted Supplies, an explanation provided as an attachment to the CMS-1500 (08-05) claim form must describe the item and its actual invoice cost. The manufacturer’s invoice should also be attached.

MATERNITY AND NEWBORN INPATIENT CARE

Refer to the Appendix D of the Physician/Practitioner Provider Manual.

NURSING FACILITY VISITS

Nursing facility visits are covered as medical conditions require. However, subsequent nursing facility services are limited to one per month unless the medical necessity for more frequent visits is explained as an attachment to the CMS-1500 (08-05) claim form and is indicated through the use of the procedure modifier "22" ("Unusual Services") in Locator 24D.

PHYSICAL THERAPY

Medically necessary physical therapy treatments are covered. The physician may only charge for physical therapy provided in his or her office by the physician or by a licensed physical therapist under his or her supervision. When only physical therapy is provided, an office visit charge may not be submitted to the Program.

PROSTHETIC DEVICES

Refer to the *Prosthetic Device* provider manual.

All hospital admissions at the acute care level, associated with or determined to have developed as a result of substance abuse are covered services. Examples of these are acute gastritis, hematemesis, seizures, and coma as a result of the abuse of alcohol.

Also covered is the treatment of chronic problems attributable to substance abuse. Examples of these are peptic ulcer, pancreatitis, cirrhosis, polyneuropathy, cardiomyopathy, and delirium tremens caused by abuse of alcohol.

Please refer to the Community Mental Health Rehabilitative Services Manual and the Psychiatric Services Manual for covered substance abuse services. Medicaid provides coverage for substance abuse services for pregnant and postpartum women. Refer to the Community Mental Health Rehabilitative Services Provider Manual available online at: http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx for information regarding these services. For persons under the age of 21 EPSDT may provide medically necessary treatment to correct or ameliorate health or mental health conditions as diagnosed during an EPSDT screening.

SURGERY

Covered surgical procedures which are medically necessary are compensable.

Abortion (Elective)

As of July 1, 2010, induced (elective) abortions will be paid for by the Department of Medical Assistance Services **only** upon the physician's certification that in his or her professional medical judgment the life of the mother would be substantially endangered if the fetus were carried to term.

Note: The policy statement does not pertain to the treatment of incomplete, missed, or septic abortions. Reimbursement for these types of abortions are covered as before.

If, in the physician's professional judgment, the woman's life would be endangered by carrying the fetus to term, an abortion certification form, MAP-3006 (See "Exhibits" at the end of the chapter for a sample of the form), must accompany each claim for an induced (elective) abortion. Note that, if a woman's life would be endangered by carrying the fetus to term, the attending physician must so certify.

The originating physician is required to supply a copy of the proper certification to other billing providers. Any claim submitted using the following procedure codes without the appropriate physician certification or required documentation will be pended. If the appropriate information is not attached, the claim will be denied.

- Abortions Performed During a Period of Retroactive Eligibility - Reimbursement is available for those abortions performed during periods of retroactive eligibility if the physician certifies in writing on the MAP-3006 form that, in his or her professional judgment, the life of the mother would have been endangered if the fetus had been carried to term. The certification must also contain the name and address of the patient.

- Abortion Procedure Codes - CPT/HCPCS procedure codes, 01966, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, or 59866 must be used as appropriate in submitting all physician and hospital claims for induced (elective) abortions.

Regardless of the service authorization for the hospitalization, if the invoice reflects an abortion procedure, the claim will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy.

Assistant Surgeon

Assistant surgeon fees are covered when services of an assistant surgeon are considered medically necessary due to the complexity of the procedure. The assistant surgeon must be an enrolled provider and is to bill the procedure using the appropriate procedure code and procedure modifier "80", "81", or "82" in Locator 24D of the CMS-1500 (08-05) claim form. Note: Assistant at Surgery is not covered by Virginia Medicaid.

Breast Reconstruction/Prosthesis following Mastectomy and Breast Reduction

Refer to Appendix D (Service Authorization Information) of the Physician Provider Manual.

Biopsy

Biopsy procedures performed concurrently with major surgical procedures are included in the payment for the major procedure.

Cosmetic Surgery

Refer to Appendix D (Service Authorization Information) of the *Physician/Practitioner* Provider Manual.

Elective Surgery

Refer to Appendix D (Service Authorization Information) of the *Physician/Practitioner* Provider Manual.

Transplant Surgery

Refer to Appendix D (Service Authorization Information) of the *Physician/Practitioner* Provider Manual.

Gender Dysphoria Surgery

Refer to the Gender Dysphoria Supplement of the *Physician/Practitioner* Provider Manual.

Endoscopy

Payment for diagnostic endoscopy procedures performed concurrently with a related major surgical procedure is included in the payment for the major procedure.

Experimental Surgery

Surgery considered experimental in nature is not covered.

Hysterectomies

According to federal regulations, hysterectomy is not a sterilization procedure. Medicaid does not cover hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing. Payment may be made for hysterectomies as follows:

- Medically Necessary - A medically necessary hysterectomy may be covered only when the person securing the authorization to perform the hysterectomy has informed the individual or her representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the individual permanently incapable of reproducing, and the individual or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form, DMAS-3005. (See "Exhibits" at the end if the chapter for a sample of the form).
- The Physician Statement must be completed and signed by the physician, and in this situation, Block A must be marked. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form (DMAS-3005) is also required. Therefore, it is advisable to inform the patient or her representative prior to the exploratory surgery or biopsy. Again, Block A of the Physician Statement must be completed.

- Emergency - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances, Block B of the Physician Statement must be marked and a description of the nature of the emergency must be included. The completed Physician Statement must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign this form. An example of this situation would be when the patient is admitted to the hospital through the emergency room for immediate medical care and the patient is unable to understand and respond to information pertaining to the acknowledgment of receipt of hysterectomy information due to the emergency nature of the admission.

- Sterility - If the patient is sterile prior to the hysterectomy, Block C of the Physician Statement must be marked and a statement regarding the cause of the sterility must

be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign the form. (For example, this form would be used when the sterility was post-menopausal or the result of a previous surgical procedure.)

- Gender Dysphoria - Hysterectomy in conjunction with treatment for Gender Dysphoria is covered as outlined in the Gender Dysphoria Supplement.

- A copy of the form DMAS-3005 must be attached to each provider's invoice for a hysterectomy procedure if Medicaid is to consider the claim for payment. Failure to provide the appropriate acknowledgment or certification will result in the denial of the claim.

  Regardless of the service authorization for the hospitalization, if the invoice reflects a hysterectomy, the claims will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy. The originating physician is required to supply other billing providers with a copy of the DMAS-3005.

- CPT/HCPCS Hysterectomy Procedure Codes

  00846 Anesthesia for intra peritoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
  00944 Vaginal hysterectomy
  01962 Anesthesia for urgent hysterectomy following delivery
  01963 Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
  01969 Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia
  51597 Pelvic exenteration, complete, for vesical, prostatic, or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof;
  51925 Closure of vesicouterine fistula with hysterectomy;
  58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
  58152 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz, Burch);
  58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s);

58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s);
58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s);
58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof;
58260 Vaginal hysterectomy; for uterus 250g or less;
58262 with removal of tube(s), and/or ovary(s);
58263 with removal of tube(s), and/or ovary(s), with repair of enterocele;
58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control);
58270 with repair of enterocele;
58275 Vaginal hysterectomy, with total or partial colpectomy; Vaginectomy;
58280 with repair of enterocele;
58285 Vaginal hysterectomy, radical; (Schauta type operation);
58290 Vaginal hysterectomy, for uterus greater than 250 grams;
58291 with removal of tube(s) and/or ovary(s)

58292 with removal of tube(s) and/or ovary(s), with repair of enterocele
58293 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294 with repair of enterocele
58541 Laparoscopy, surgical; supracervical hysterectomy, for uterus 250g or less
58542 with removal of tube(s) and/or ovary(ies)
58543 Laparoscopy, surgical; supracervical hysterectomy, for uterus greater than 250g
58544 with removal of tube(s) and/or ovary(ies)
58548
58550 Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;
58552 with removal of tube(s) and/or ovary(s), for uterus
58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;

58554 with removal of tube(s) and/or ovary(s), for uterus greater than 250 grams 58570 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;

58571 with removal of tube(s) and/or ovary(s)

58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;

58573 with removal of tube(s) and/or ovary(s)

58575 Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed

58951 Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy;

58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;

58954 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

58956 Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy

59135 Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy;

59525 Subtotal or total hysterectomy after cesarean delivery;

- Hysterectomies Performed During a Period of Retroactive Eligibility - Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician will certify on the DMAS-3005 that one of the following conditions was met:

  1) He or she informed the member before the operation that the procedure would make her sterile. In this case, the patient and the physician must sign the DMAS-3005; or
  2) The member met one of the exceptions provided in the Physician Statement Section of the DMAS-3005. In this case, no member signature is required.

Multiple Procedures

Multiple surgical procedures may require manual review during the payment process. The major procedure is given maximum payment of 100% DMAS fee file and all other related procedures reimbursed at 50 percent of the DMAS fee file. Surgical procedures incidental to the primary procedure are not covered. For example: an appendectomy incidental to gall bladder surgery is not covered.

Preoperative and Postoperative Care

Routine, uncomplicated preoperative and postoperative medical care that is related to the primary surgery considered included as part of the surgical reimbursement allowance and therefore may not be billed separately.

Mandatory Outpatient Surgical and Diagnostic Procedures

The Department of Medical Assistance Services will not reimburse the hospital and/or practitioner for the outpatient surgical or diagnostic procedures listed in Appendix B when performed on an inpatient basis unless the procedure meets one of the exceptions to this policy. This policy applies to all Medicaid-eligible patients regardless of any other medical coverage, except for those members in the retroactive eligibility period. The exceptions as defined below must be well-documented and support the medical necessity for these procedures when performed on an inpatient basis.

- An existing medical condition which requires prolonged post-operative observation by skilled medical personnel (e.g., heart disease or severe diabetes).

- The member had been admitted to a hospital for another procedure or condition and the surgeon decides that one of the listed procedures is also necessary or is done in conjunction with the procedure requiring hospitalization.

- Another procedure, which requires the inpatient setting, may follow the initial procedure (e.g., gynecological laparoscopy followed by oophorectomy). Adequate outpatient facilities are not available within a reasonable distance (i.e., 50 miles), requiring the procedure to be rendered on an inpatient basis; in this case, a one-day inpatient hospital stay would be allowed unless a longer stay is medically necessary.

All physician claims will pend for review when the site of the service is inpatient and a listed outpatient surgical or diagnostic procedure code is used. Complete case documentation must support the medical necessity for these procedures when performed

on an inpatient basis. Payment will only be approved when appropriate justification for the inpatient necessity is provided on (or accompanies) the invoice.

STERILIZATION

Human Reproductive Sterilization

Human reproductive sterilization is defined by the Department of Medical Assistance Services as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Sterilizations that are performed because pregnancy would be life-threatening to the mother ("therapeutic" sterilizations) are included in this definition. The term sterilization means only human reproductive sterilization, as defined above.

Note: Treatment which is not for the purpose of, but a result in, sterility (formerly referred to as secondary sterilization) does not require completion of the Sterilization Consent Form. This applies for the purposes of payment only. Informed consent and billing requirements associated with the performance of a hysterectomy are referred to earlier in this section.

Conditions of Coverage

The conditions under which sterilization procedures for both inpatient and outpatient services are payable by the Program conform to federal regulations.

The Virginia Medicaid Program does not cover sterilization procedures for mentally incompetent or institutionalized individuals or an individual under age 21.

A sterilization will be covered under the Program only if the following conditions are met:

- The individual is at least 21 years old at the time consent for sterilization is obtained.

Note: A patient must be 21 years old to give consent to sterilization. This is a federal requirement for sterilizations only and is not affected by any other State law regarding the ability to give consent to medical treatment generally. The age limit is an absolute requirement.

There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

- The individual is not a mentally incompetent individual. For Virginia Medical Assistance Program purposes, a mentally incompetent individual is a person who has been declared mentally incompetent by the federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. The competency requirement is an absolute requirement. There are no exceptions.

- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure.

- The individual is not institutionalized. For the purposes of Medicaid reimbursement for sterilization, an institutionalized individual is a person who is:

- Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or

- Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

- The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section.

- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the following instances:

- Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.

- Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at

least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.

- Regardless of the service authorization for the hospitalization, if the invoice reflects a sterilization, the claim will pend for Medicaid manual review.

- If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy.

- A completed DMAS-3004, Sterilization Consent Form must accompany all claims for sterilization services. This requirement extends to all providers:

attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

Informed Consent Process for Sterilization

The informed consent process may be conducted either by a physician or by the physician's designee.

An individual has given informed consent only if:

- The person who obtained consent for the sterilization procedure:

- Offered to answer any questions the individual may have had concerning the sterilization procedure;

- Provided the individual with a copy of the consent form;

- Provided orally all of the following information to the individual to be sterilized;

- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal

of any federally-funded program benefits to which the individual might be otherwise entitled;

- A description of available alternative methods of family planning and birth control;
- Advice that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the benefits or advantages that may be expected as a result of the sterilization; and
- Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery, in which case 72 hours must have passed between the informed consent and surgery; also, in the case of premature delivery, consent must have been given at least 30 days prior to the expected date of delivery.
- Suitable arrangements were made to ensure that the information specified above was effectively communicated to a blind, deaf, or otherwise impaired individual to be sterilized.
- An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.
- The individual to be sterilized was permitted to have a witness of the individual's choice present when consent was obtained.
- The sterilization operation was requested without fraud, duress, or undue influence.
- All other State and local requirements were followed.

- The appropriate consent form was properly filled out and signed (see below).

- Informed consent may not be obtained while the individual to be sterilized is:

- In labor or within 24 hours postpartum or post-abortion;

- Seeking to obtain or obtaining an abortion; or

- "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made.
- "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

The Virginia Medical Assistance Program prohibits the giving of consent to sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.

- Under the influence of alcohol or other substances that affect the individual's state of awareness.

Sterilization Consent Document

The only acceptable sterilization consent form is the Virginia Department of Medical Assistance Services Sterilization Consent Form (DMAS-3004). An informed consent does not exist unless this form is completed voluntarily by a person 21 years of age or over and in accordance with the following instructions. (See the section titled “Exhibits” at the end of the chapter for a sample of the form.) No payment will be made without the submission of this form completed, signed, and dated by the patient giving the consent, the person obtaining the consent, and the physician who performed the surgery. The date of the signature of the person obtaining an informed consent must be the same as the date of signature of the person giving consent.

Instructions for completing the form are shown on the next page:

Instructions for Completing the Sterilization Consent Form (DMAS-3004)

Ref. No.	Blank	Instructions
1	Doctor or Clinic	This line may be pre-stamped. If the provider is a physician group, all names may appear (e.g., Drs. Miller and Smith); the professional group name may be listed (e.g., Westside Medical Group); or the phrase "and/or his/her associates" may be used
2	Name of Operation	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
3	Month, Day, Year	Enter the patient's birth date. This information is required.
4	Patient name	Must be completed. The name used should be identical to the patient name appearing on the claim form.
5	Doctor	May be pre-stamped. If a group, all names may be listed, or the phrase "and/or his/her associates."
6	Name of Operation	Enter the name of the operation. If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
7	Signature	The patient must sign here. If the patient is illiterate, the form of signature permitted is an "X," which must be countersigned by a witness.
8	Month, Day, Year	Patient's signature must be dated. The waiting period is calculated from this date.
9	Ethnic Designation	This information is voluntary and should be completed only by the patient.
10	Language	Indicate the language in which the patient was counseled, if other than English.
11	Interpreter's Signature	Must be signed if an interpreter was used.
12	Month, Day, Year	Interpreter's signature must be dated.

Ref. No.	Blank	Instructions
13	Name of Individual	Enter the patient's name here.
14	Name of Operation	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
15	Person Obtaining Consent	The person providing sterilization counseling may be a physician or the physician's designee (e.g., an office nurse). Once this section is completed, the patient should be given a copy of the form.

Ref. No.	Blank	Instructions
16	Month, Day, Year	Signature of the person obtaining consent must be dated.
17	Facility	May be pre-stamped.
18	Address	May be pre-stamped.
19	Name of Patient	Enter the patient's name.
20	Date of Operation	Enter the date of the operation.
21	Type of Operation	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form. Consent is not invalidated if the operation actually performed differs from the method of sterilization originally planned.

22-23	Final Paragraphs	Cross-out the paragraph not used. The minimum waiting period is 30 days from the date consent was given, except in cases of premature delivery or emergency abdominal surgery.
24	Premature Delivery	If this box is checked, a date of expected delivery must be present in Item 25.
25	Individual's Expected Date of Delivery	The date estimated by physician based on the patient's history and physical condition.
26	Emergency Abdominal Surgery	Indicate the operation performed.
27	Physician Signature	Must be completed after the sterilization operation, by the physician who has verified consent and who actually performs the operation. The purpose of obtaining consent "shortly before" the operation is to reaffirm consent. This may be done while the patient is in labor or after delivery. In this context, "shortly before" means up to 72 hours prior to the operation.
28	Month, Day, Year	The physician's signature must be dated.

Use of the Sterilization Consent Form

The consent form must be signed and dated by the following:

- The individual to be sterilized;
- The interpreter, if one is provided;
- The individual who obtains the consent; and
- The physician who will perform the sterilization procedure.

The person securing the consent shall certify by signing the consent form that he or she:

- Advised the individual to be sterilized, before the individual to be sterilized signed the consent form, that no federal benefits may be withdrawn because of the decision not to be sterilized;
- Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the consent form and in regulations; and
- Determined to the best of his/her knowledge and belief that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The physician performing the sterilization shall certify by signing the consent form that:

- The physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (For Program purposes, the phrase "shortly before" means a period within 72 hours prior to the time the patient receives any preoperative medication.)
- The physician explained orally the requirements for informed consent as set forth on the consent form.
- To the best of the physician's knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

- At least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed, except in the following instances:
- Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least 30 days before he or she intended to be sterilized; that at least 72 hours have passed after written informed consent to be sterilized was given; and the physician describes the emergency on the consent form.

- Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the expected date of the delivery. The physician shall state the expected date of the delivery on the consent form. At least 72 hours have passed after written informed consent to be sterilized was given.

The interpreter, if one is provided, shall certify that he or she:

- Transmitted the information and advice concerning the sterilization procedure and possible complications orally to the individual to be sterilized;

- Read the consent form and explained its contents to the individual to be sterilized; and

- Determined to the best of his or her knowledge and belief that the individual to be sterilized understood what the interpreter told the individual.

A copy of the signed consent form must be:

- Provided to the patient;

- Retained by the physician and the hospital in the patient's medical records; and

- Attached to all claims for sterilization services. In addition, no sterilization procedure will be covered by Virginia Medicaid unless a copy of the Department of Medical Assistance Services Form (DMAS-3004) is attached to the invoice submitted by each provider, including the surgeon, assistant surgeon, anesthesiologist, hospital, or outpatient clinic in order that each claim might be evaluated. The DMAS-3004 is the only consent form that will be accepted by Medicaid, and no payment will be made without submission of this form by each provider involved in the sterilization procedure. Only claims directly related to the sterilization surgery, however, require consent

documentation. Claims for pre-surgical visits and tests or services related to post-surgical complications do not require consent documentation.

Claims for Service

Any claim submitted without a properly-executed consent form or documentation showing medical necessity will be pended. If appropriate information is not received within 30 days of the request for the information, the claim will be denied. The originating physician is required to supply a copy of the DMAS-3004 to other billing providers.

CPT/HCPCS Sterilization Procedure Codes

00851 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy, tubal ligation/ transection
00921 Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
54690 Laparoscopy, surgical; orchiectomy
55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

58565 Hysteroscopy Sterilization
58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) List separately in addition to code for primary procedure.
58615 Occlusion of fallopian tube(s) by device (e.g., band, clip, or Falope ring), vaginal or suprapubic approach
58661 Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670 Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671 Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700 Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)

58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Retroactive Coverage

Providers are reminded that sterilization is covered only if all applicable requirements are met at the time the operation is performed:

- The requirements related to the time period required between the date of informed consent and the date of sterilization;
- The informed consent requirements for the individual to be sterilized; and
- The certification requirements for signatures of the individual to be sterilized, the interpreter (if applicable), the person obtaining consent, and the physician who performed the sterilization procedure that must be present on the DMAS-3004.

If a patient obtains retroactive program coverage, previously provided sterilization services cannot be billed unless the applicable requirements have been met. There are no exceptions made for retroactive eligibility in regard to the requirements for sterilization.

Surgery for Morbid Obesity

Refer to Appendix D of the Physician/Practitioner Manual.

VACCINES

Routine immunizations including annual influenza vaccinations are covered for members under the age of 21 as part of the EPSDT program (see Section on Vaccines for Children for further information). Vaccine counseling is covered for EPSDT-eligible members (see EPSDT Supplement B). Immunizations for individuals 21 years of age and older who are not covered by Medicaid Expansion are limited except for instances when:

- It is necessary for the direct treatment of an injury, such as tetanus vaccinations or
- The immunization is a pneumococcal or influenza vaccination given as part of a plan of treatment.

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VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, childhood immunizations and annual influenza vaccinations are covered according to the most current Advisory Committee for Immunization Practices (ACIP) schedule.

To be eligible for free vaccines from the VFC Program, children must be under the age of 19. VFC-eligible individuals must also meet one of the following criteria:

- Medicaid/FAMIS PLUS, enrolled, including Medicaid MCOs,
- Uninsured (no health third party insurance),
- Native American or Native Alaskans (no proof required) and
- Underinsured (those whose insurance does not cover immunizations).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC.

Upon enrollment, the Department of Medical Assistance Services will not reimburse the provider for the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which CMS requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check “YES” in Block 11-D (Is there another health benefit plan?) on the CMS-1500 claim form.

Reimbursement for Children Ages 19 and 20

Since Medicaid policy provides coverage for vaccines for children under the age of 21, and VFC provides coverage only under the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code and Medicaid will reimburse the acquisition cost for these vaccines. Medicaid will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

VFC Coverage of Other Vaccines

The VFC program covers all vaccines in the ACIP immunization schedule, including indications for when a single-antigen vaccine that is normally part of a combination vaccine may be medically appropriate. Claims for single-antigen vaccines normally part of a combination vaccine will automatically pend for review by DMAS staff.

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Situations Where Vaccines Are Not Covered Under VFC

There may be some situations where a child is attempting to "catch-up" on vaccines that have been missed. In some cases, the VFC program will not provide coverage for these "catch-up" vaccines, and the provider will have to purchase them from his or her normal vaccine distributor. If this occurs, Medicaid will continue to reimburse the provider for the acquisition cost of these vaccines as long as there is information attached to the claim indicating the reason for billing Medicaid for the acquisition cost. In addition to the attachment to the claim, use modifier 22 in Block 24-D of the CMS-1500 claim form.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. See Supplement B - EPSDT for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid

cannot reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

Questions

For questions relating specifically to the VFC program, call the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday through Friday from 7:00 a.m. to 5:00 p.m. For other questions, call the Medicaid HELPLINE.

Orthotics

Please refer to Appendix D in the *Physician/Practitioner* provider manual.

Rehabilitation Program

Items made for the member by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the Medicaid-approved rehabilitation visit. These ancillary charges are not reimbursed separately for Rehabilitation Agencies.

Intensive Rehabilitation

Please refer to Appendix D, in the *Rehabilitation* Provider Manual.

EPSDT (Children Under 21 Years of Age)

Children do not have to be enrolled in Children's Specialty Services to receive orthotics. All medically necessary orthotics are covered for children under the age of 21 years. The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician using the correct HCPCS "L" procedure codes. Service authorization is required and may be submitted to DMAS' Service Authorization contractor. Refer to the Physician/Practitioner Manual, Appendix D. Documentation of provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under HCPCS "L" codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the member with instructions for the proper use.

Service Authorization

Refer to Appendix D of the *Physician/Practitioner* Provider Manual.

REIMBURSEMENT

Payments for covered services submitted by physicians are based on the individual physician's usual and customary fees, within Program limitations.

Reimbursement for the administration of vaccines/immunizations is included in the office visit when a medical service is rendered. When an immunization is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211), may be listed in addition to the injection. When billing for immunizations, only the actual acquisition cost of the injectable is to be billed separately using the appropriate CPT/HCPCS code. Special supplies beyond those routinely included in the office visit are to be billed reflecting the provider's acquisition cost and using the appropriate HCPCS/CPT codes are listed in this chapter.

When there are extenuating circumstances, individual consideration, if requested, is given to additional allowances in compensation. However, payment by Medicaid cannot exceed the Medicare allowance for the same or similar service. It should be noted that the payment allowance for covered professional services includes the necessary administrative services as required for the care of a member, i.e., the preparation of records, plan of treatment, and certification for services, etc. Therefore, separate payment, in addition to the professional visit, will not be made for these services.

To request individual consideration, enter "ATTACHMENT" in Locator 10D and procedure modifier "22" ("Unusual Service") in Locator 24D of the CMS-1500 (08-05) claim form, and attach sufficient documentation to support the claim that is being billed.

Payment Basis

Payment for physician services is the lowest of the Program's fee schedule, actual charge, or Medicare allowances.

Payment in Full

In accepting payment from the Program, a physician must agree to accept Program payment as payment in full for all covered services rendered to the patient and billed to the Program. The physician may not bill Medicaid or the member for the difference (if any) between the allowed charge and the actual billed charge. The provider may not bill the member for missed or broken appointments. The physician must bill any other possibly liable third-party payer prior to billing the Program. The Program will pay the difference between the Program's allowable fee and the amount paid by another third party, except for Medicare. When Medicare (Title XVIII) makes a payment for physician's covered services, the physician may claim payment of any deductible and coinsurance amounts due from the Program. However, he or she may not claim payment of the difference (if any) between the Medicare-allowed fee and his or her actual fee for services. Also, Medicaid payments for Medicare Part B

coinsurance are limited to the difference between Medicaid's maximum fee for a given procedure and 80 per cent of Medicare's allowance. The combined payments by Medicare and Medicaid will not exceed Medicaid's allowed charge for that procedure.

Implementation of a New Physician Fee Schedule

The fee schedule effective July 1, 1995 was based in many respects on the Medicare Resource Based Relative Value Scale (RBRVS) fee schedule. The calculation of RBRVS fees for Virginia Medicaid uses Medicare's Relative Value Units (RVUs) and Conversion Factors (CFs), with an additional "budget neutrality" adjustment to ensure that total Medicaid expenditures do not increase solely due to the updates to the Medicare fee schedule. Multiple budget neutrality factors by service category are now used. Starting in 1996, the Medicaid fee schedule was updated each January to reflect modifications to the Medicare Relative Value Units (RVUs). Effective July 1, 2005, the Medicaid fee schedule is updated each July to reflect modifications to Medicare RVUs. Effective July 1, 2008, the Medicaid fee schedule reflects different rates for services depending on the site of service, facility or non-facility, based on the relative value units for procedure codes published by the Medicare.

Adjusting fees for Geographic Practice Cost Indices (GPCIs) is not part of the Medicaid fee schedule.
Medicaid fees will continue to be applied on a statewide basis. All of the payment rules adopted by Medicare at the time RBRVS was first implemented and over time have not been adopted by Medicaid.

COPAYMENT REQUIREMENTS

As required by the Appropriations Act of 1992, the copays are the same for categorically needy members, Qualified Medicare Beneficiaries (QMBs), and medically needy members. The services and copay amounts are:

SERVICE	COPAY AMOUNT
Inpatient hospital	$100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit

SERVICE	COPAY AMOUNT
Physician office visit	1.00 per visit
Other physician visit	3.00 per visit
Eye examination	1.00 per examination

Prescription	1.00 for multi-source generic; 3.00 for brand per prescription or refill for dates of service on or after September 1, 2002
Home health visit	3.00 per day
Rehabilitation service	3.00 per day

For purposes of copays, a visit is defined as a patient encounter in the place of treatment, by the same provider on the same day regardless of the number of procedures performed. The encounter may be indirect. For example, if on July 15, 2009, the physician in a hospital performs an interpretation and report for an electrocardiogram (CPT/HCPCS code 93010) and an interpretation and report for an electrocardiogram (CPT/HCPCS code 93018); this would be considered one visit and would be subject to a $3.00 copay for a member who was not exempt. If the physician performed one procedure on July 15, 2006, and the other on July 16, 2009, the procedures would be considered two visits and would be subject to two $3.00 copays.

The copays apply to all members except the following:

- Children under 21 years of age (identified by a Special Indicator code “A” on their Medicaid identification cards);
- Individuals receiving long-term care service or hospice care (identified by a Special Indicator code “B” on their Medicaid identification cards); and
- Individuals participating in health maintenance organizations under the Managed Care program.

The following services are never subject to copays:

- Emergency services;
- Members in waivered programs (hospice, LTC, E&D waiver);
- Family planning services including office visits, drugs and supplies; and
- Pregnancy-related services (services delivered to pregnant women if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy, e.g., prenatal, delivery, postpartum care).

A provider may not deny services to a member solely because of his or her inability to pay any applicable copayment charge. This does not relieve the member of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the member.

MCO/HMO Copayments

DMAS allows the submission of claims and the reimbursement of the co-payment for Medicaid enrollees who have a Managed Care/Health Maintenance Organization (MCO/HMO) as their primary carrier. These claims are submitted on the CMS-1500 (08-05) (08-05) claim form. The following locators would need to be completed, in addition to the other required locators as indicated in Chapter V of this manual.

- Locator 10d – Write "Attachment"
- Locator 11c – Enter "HMO Copay"
- Locator 24D – Enter the CPT/HCPCS code that was billed as the primary procedure to the MCO/HMO
- Locator 24F. - Enter the actual enrollee's co-payment amount as the charged amount.

The Explanation of Benefits (EOB) must be attached to the claim if the billed charge is greater than $25.00.

The billing and reimbursement of the MCO/HMO co-payment does not apply for enrollees in a Medicaid MCO/HMO, e.g. Medallion 3.0. DMAS will apply the Medicaid co-payment amounts for enrollees age 21 or up. Therefore, a Medicaid co-payment will be deducted from the MCO/HMO charged co-payment. Example: Medicaid enrollee with MCO/HMO primary insurance may have a $20.00 co-payment for an office visit. Medicaid's co-payment for the office visit is $1.00. The Medicaid allowance will be $19.00 for this office visit. The remaining $1.00 should be collected from the enrollee at the time of service. For electronic data interchange (EDI) claims filers; please refer to the EDI companion guide. Companion guides can be found at:
(https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides).

MEDICAL COVERAGE FOR NONRESIDENT ALIENS

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended, requires Medicaid to cover emergency services for nonresident aliens when these services are provided in a hospital emergency room, inpatient hospital setting, or dialysis center.

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks;
- Traumatic injuries;
- Deliveries;
- Acute coronary difficulties;
- Emergency surgeries (e.g., appendectomies);

- Episodes of acute pain (etiology unknown);
- Acute infectious processes requiring intravenous antibiotics;
- Fractures; and
- End-stage renal disease.

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care;
- Physician services provided in a covered location;
- Inpatient hospitalization not to exceed limits established for other Medicaid members;
- Services provided at a dialysis center for renal dialysis;
- Ambulance service to the emergency room or hospital; and
- Inpatient and outpatient pharmacy services related to the emergency treatment.

Hospital outpatient or inpatient planned procedures, outatient diagnostic testing, follow-up visits or physician office visits related to the emergency care are not included in the covered services. Emergency treatment of a medical condition does not include care and services related to either an organ transplant procedure or routine prenatal or postpartum care. Sterilization is not a covered service. Note: With the implementation of DRG payment methodology, the facility can remove both the associated charges for the sterilization procedure and ICD- Sterilization Procedure Codes. Do not include the specific sterilization procedure code on the claim. This will allow payment for the labor and delivery.

LABOR AND DELIVERY SERVICES

Departments of Social Services can certify and enroll clients for non-resident alien services for labor and delivery only. These cases do not have to be sent to DMAS for certification.

Criteria that would have to be met for the local DSS office to certify:

The inpatient admission date and delivery date are the same and the discharge date is within the allowed three days for a vaginal delivery and five days for a Cesarean section delivery.

The inpatient admission date is one day prior to the delivery date (client is admitted in labor and delivers the next day) and the discharge date is within the allowed time frame.

Note: The length of stay calculation does not consider the discharge date and DMAS does not pay for the discharge day,

Verification of the labor and delivery services must be from the facility or the attending physician and contain the following information:

- Patient name, address and date of birth
- Facility name and address where the delivery occurred
- Type of delivery (vaginal or cesarean) indicated
- Inpatient hospital admission date
- Dates of service for inpatient hospitalization

DSS REQUEST FOR CERTIFICATION

Local departments of social services determine the eligibility of the nonresident alien to receive emergency Medicaid coverage based on normal eligibility criteria. Referrals to the local social services agency may come from the provider or from the nonresident alien.

The Emergency Medical Certification form can be found in the Exhibits section at the end of Chapter III. All emergency medical certification requests must be submitted with this form. No modifications to this form are permitted.

DMAS will review the documentation submitted by the local department of social services and determine if the medical condition is an emergency. Required documentation includes

- Emergency room records
- History and Physical
- Discharge Summary

DMAS will complete the certification section of the form and indicate dates of coverage. If all necessary documentation is not received, the entire request will be sent back to the social services agency with a cover form noting the information needed. Each hospital admission or medical encounter must be submitted with its own certification form. Do not send multiple requests with one form.

The applicant must have a current, or pending application in the Virginia Case Management System (VaCMS) before the emergency medical certification is sent to DMAS for review.

If the member is found eligible and the emergency service coverage is approved by DMAS, each provider rendering the emergency care will be notified via the Emergency Medical Certification Form of the member's temporary eligibility number, the conditions for which treatment or services will be covered, and the dates for which the eligibility number is valid. Coverage for nonresident aliens is valid only for the conditions and time stated on this form. This form will also be used to notify providers that a nonresident alien is not eligible for emergency certification

SUBMISSION OF CLAIMS FOR NONRESIDENT ALIENS

To submit a claim for these approved emergency services for a nonresident alien:

- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.
- Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and therefore, does not need to be duplicated with this claim.
- Submit the claim to Medicaid to the appropriate post office box, listed below:

Department of Medical Assistance Services
PO Box 27443
Richmond, Virginia 23261-7443

Note: The same procedures apply for adjusted or voided claims.

All claims for nonresident aliens will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeal process for those services which are not approved.

OUTPATIENT DIALYSIS SERVICES FOR NONRESIDENT ALIENS

Outpatient dialysis services for nonresident aliens is a covered service for treatment of a medical condition so long as absence of immediate treatment for that condition could reasonably be expected to result in one of the three consequences: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or to serious dysfunction of any bodily organ or part. The absence of outpatient renal dialysis can reasonably be expected to result on one of these three consequences.

DMAS can authorize a maximum of 12 months of out-patient dialysis services based on a physician's treatment plan stating the number of visits needed per week. This treatment plan must also contain the begin date of the dialysis and the patient's diagnosis. **This treatment plan must be signed by a physician.** The local social services agency will submit this documentation to Medicaid for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

At the end of the 12 months it will be necessary to recertify the client with DMAS by sending an updated physician's plan of treatment with the Emergency Medical Certification Form.

Eligibility for non-resident alien members receiving dialysis is limited to routine outpatient dialysis services. Members who have additional services that are not directly related to

dialysis services (emergency room visits, planned outpatient hospital services, inpatient admission) must have these additional services authorized by DMAS in order to be reimbursed by DMAS.

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

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

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

EXHIBITS

Please use this link to search for DMAS Forms:
https://vamedicaid.dmas.virginia.gov/provider/forms

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