CHAPTER IV
COVERED SERVICES AND LIMITATIONS

INTRODUCTION

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

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

The procedure fee file and CPT search page located at https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/ provides detailed information about all of the procedures to include rates, service authorization requirements, covered/non-covered designation, etc. Please refer to the Frequently Asked Questions located at this link for explanation the characters in each field of the procedure fee file. This document is updated three times per week.

SERVICE AUTHORIZATION

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

PRACTITIONER'S ROLE IN RENDERING SERVICES

Practitioner services shall be provided within the scope of their respective professional license. The provider of services must be a participating Medicaid provider in order to bill for services performed.

For EPSDT Specialized Services, please refer to the EPSDT Supplement and other EPSDT manuals to find more information about the EPSDT Specialized Services.

PRESCRIPTION DRUGS

Prescription drugs are covered under the Virginia Medicaid Program. Please see the Pharmacy Manual for additional information regarding the Medicaid FFS formulary as well as details regarding the DMAS Preferred Drug List (PDL).

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.

Audiology Services

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

Dental Services

Please refer to the Dental Manual at https://dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children-April-22,-2022.pdf/?lang=en-US. For dental services for individuals age 21 and older, please see Exhibit B.

End-Stage Renal Disease

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 practitioner component.

Virginia Medicaid does not cover intradialytic parenteral nutrition (IDPN) in the form of amino acids, vitamins, minerals, and other nutrients as an adjunct administered during the dialysis session.

Eye Care

Routine comprehensive eye examinations are covered as defined under Comprehensive Ophthalmological services in the American Medical Association CPT Code Book, at a frequency outlined as appropriate by the American Association of Ophthalmology. Ophthalmologists and other practitioners 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. For more information about EPSDT vision services, please see the EPSDT Supplement B.

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 is only permitted if eyeglasses cannot accomplish the optometric treatment.

Eye exercises (orthoptics) are not covered for members who are 21 years of age or older.

Family Planning Services (Plan First)

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.

Gender Dysphoria

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

Long Acting Reversible Contraceptives (LARC)

DMAS will provide reimbursement for LARCs provided after delivery in inpatient hospitals. Prior Authorization is not required.

Podiatry Services

Covered podiatry services are defined as reasonable and necessary diagnostic, medical, surgical (mechanical, physical, and adjunctive) treatment of disease, injury, or defects of the lower extremity. The diagnosis and treatment of disorders to facilitate ambulation and promote progress to a lower level of care, including self-care, will be covered by DMAS.

Routine' foot care (e.g., trimming toenails for the prevention of ingrown toenails, onychomycosis); other hygienic and preventive maintenance care, such as cleaning and soaking the feet; and any other services performed in the absence of localized illness, injury, or symptoms involving the foot are not covered. An exception to this rule is corrective toenail trimming that is performed to prevent further injury, such as in instances of lower extremity neuropathy, vascular compromise, or diabetes mellitus. In these instances, trimming is limited to once every 60 days.

Trimming of corns, warts, or calluses (including plantar warts) is only covered when necessitated by the presence of an associated pathological condition (i.e.

cellulitis, lower extremity neuropathy, vascular compromise, any limb-threatening pathology).

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.

Services of Interns and Residents-In-Training

For information regarding conditions under which medical services provided by an intern or resident physician are covered, see Chapter 2 of the Practitioner Manual.

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 may be listed in addition to the injection.

Laboratory and Radiology Procedures

Virginia Medicaid covers laboratory testing and radiology procedures. Service authorization may be required. Please refer to the fee file for more information.

A practitioner's order is required for the coverage of independent laboratory services.

All laboratory tests billed to the Program must have documented results.

DMAS requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS) codes, as well as codes and definitions published in the most recent Practitioners' Current Procedural Terminology (CPT) in billing for covered services.

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of beneficiary test results regardless of where the test was performed.

The laboratory provider shall comply with 42 Code of Federal Regulations (CFR) §493.5 Categories of tests by complexity. Payment for laboratory and radiology services will be made directly to the provider actually performing the service (i.e., practitioner, independent laboratory, or other participating facility). The ordering practitioner 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.

Should the situation arise when multiple practitioner 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.

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.

Non-Covered Services

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

- Tests performed but not based on the patient's symptoms.
- The use of modifiers to indicate billing for the professional or technical component of laboratory tests must be consistent with CPT guidelines.

PREVENTIVE SERVICES

Adults covered by Medicaid may receive the following additional covered services:

- All services assigned a grade A or B recommendation by the United States Preventive Services Task Force (USPSTF).
- Advisory Committee on Immunizations Practices (ACIP) recommended adult vaccines
- Women’s preventive health care per current Health Resources and Services Administration (HRSA) guidelines.

INFECTIOUS DISEASE TEST RESULTS

Select infectious disease test results warrant reporting to providers' local health departments. Additionally, specimens of select infectious disease tests results must be sent to the State Laboratory. Detailed information outlining applicable

tests, timelines and procedures are available from the Virginia Department of Health at: https://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastate-board-of-health/.

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.

Please refer to the BabyCare Manual.

Prosthetic Devices

The replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part shall be covered in accordance with 12 VAC 30-50-210. Please see Chapter 6 for service authorization information.

Abortion (Elective)

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. 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 *Practitioner* Provider Manual.

Cosmetic Surgery

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

Elective Surgery

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

Transplant Surgery

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

Gender Dysphoria Surgery

Refer to the Gender Dysphoria Supplement of the *Practitioner* Manual.

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 hysterectomy may be covered only when the person securing the authorization to perform the hysterectomy has complied with the notification requirements of 42 CFR 441 Subpart F 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).
- 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.

STERILIZATION

Human Reproductive Sterilization

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 procedures which have as their intent the sterilization of an individual for mentally incompetent or institutionalized individuals or for individuals under age 21.

(For information about gender dysphoria services, please see that supplement.)

A procedure intended to sterilize the individual will be covered under the Program only if the following conditions are met:

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

Note: A patient must be 21 years old to give consent to a procedure intended to sterilize the individual. 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 legally incapacitated by a 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.
- 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.

- 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.

Informed Consent Process for Sterilization

Informed consent must be obtained per the guidance of 42 CFR 441.257(b).

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 practitioner 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 Practitioner Manual.

VACCINES FOR CHILDREN PROGRAM

Please refer to EPSDT Supplement B.

For detailed information related to the VFC program and which vaccines are available or not available, contact VDH: https://www.vdh.virginia.gov/immunization/vvfc/.

VACCINE ADMINISTRATION – Members Over the Age of 19

Reimbursement for the administration of vaccines for members not eligible for VFC (i.e. those over the age of 19) 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 vaccine product billing code. Providers

must use privately purchased vaccine when requesting reimbursement for vaccine cost.

DMAS will not reimburse for an administration fee using CPT 90460-90461.

MEDICAL COVERAGE FOR NONRESIDENT ALIENS

Please refer to the Emergency Medicaid Supplement attached to this manual.

EXHIBIT: ROUTINE PATIENT COSTS FURNISHED IN CONNECTION WITH PARTICIPATION IN A QUALIFYING CLINICAL TRIAL

Covered Items and Services

DMAS covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Routine patient costs are defined as any item or service provided under a qualifying clinical trial: 1) to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver; and/or 2) required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Examples of routine costs include otherwise covered physician services or laboratory or medical imaging services that assist with prevention, diagnosis, monitoring or treatment of complications arising from clinical trial participation.

Non-covered Items and Services

Items and services considered experimental or investigational and not otherwise covered outside of the clinical trial are not covered. This includes the experimental or investigational drug, item, or service that is the subject of the qualifying clinical trial. Other non-covered items and services include items and services provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that are not used in the direct clinical management of the beneficiary.

Qualifying Clinical Trial

A qualifying clinical trial is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition. The clinical trial must also be one or more of the following:

- A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health (NIH)
    - The Centers for Disease Control and Prevention (CDC)
    - The Agency for Health Care Research and Quality (AHRQ)
    - The Centers for Medicare & Medicaid Services (CMS)
    - A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
- A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Secretary determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
    - The Department of Energy
    - The Department of Veterans Affairs

    - The Department of Defense
- A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or
- A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.

Determination for Coverage

Determination for coverage of routine patient costs furnished in connection with a member's participation in a qualifying clinical trial shall:

- Be expedited by DMAS and completed within 72 hours (equivalent to three business days) of receiving a fully populated "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" form published by CMS;
- Be made without limitation on the geographic location of where the clinical trial is conducted or based on the network affiliation of the principal investigator or provider treating the beneficiary in connection with the clinical trial;
- Be based on attestation of the principal investigator or provider regarding the appropriateness of the qualifying clinical trial; and
- Not require the submission of protocols of the qualifying clinical trial or any other documentation that may be proprietary.

Service Authorization

All SA requirements that apply to services provided outside of a clinical trial also apply to services that meet the definition of routine patient costs furnished in connection with a member's participation in a qualifying clinical trial. For services requiring authorization, the "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" form must be included in the SA request. If a routine patient cost furnished in connection with a member's participation in a qualifying clinical trial does not require a SA outside of a clinical trial, a SA is not required in the context of a clinical trial.

Claims for Services

All claims for routine patient costs furnished in connection with a member's participation in a qualifying clinical trial must include the following:

- HCPCS Q1 (routine clinical service provided in a clinical research study that is in an approved clinical research study); AND
- ICD-10 diagnosis code Z00.6 (encounter for examination for normal comparison and control in clinical research program) in the primary or secondary position; AND

The "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" form, included as an attachment.