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https://dmas.virginia.gov

MEDICAID BULLETIN

Last Updated: 02/11/2025

Per Diem Inpatient Billing for Psychiatric and Rehabilitation Services – Effective February 11, 2025

The purpose of this bulletin is to clarify inpatient billing for inpatient psychiatric, including IMD admissions eligible for Fee-for-Service (FFS) coverage, and inpatient rehabilitation services when members transition between FFS and Managed Care Organizations (MCO) during the inpatient hospitalization. These services are reimbursed using a per-diem rate per day of eligibility.

Per Diem Requirements

When the member is enrolled in FFS at admission and transitions to MCO enrollment, providers are to bill the appropriate entity (FFS/MCO) based on the member's enrollment on the date(s) of service. Enrollment transitions from FFS to managed care during the hospital admission will require the provider to bill FFS for the dates of service in which the member was covered by FFS and separately bill the MCO for the dates of service that covered the member under the MCO. Providers are also required to separately bill each MCO that covered the member for that timeframe during the hospital stay.

Per Diem Billing Example:

Scenario: A member is enrolled in FFS at the time they are admitted to inpatient psych on 8/17/24. The member remains admitted to the inpatient psych and is discharged on 10/12/24. The member is enrolled with an MCO during dates of service 9/1/24 – 10/12/24.

Billing: The provider bills the FFS portion of the hospitalization from 8/17/24 - 9/01/24, with bill type 111 and discharge status of 01. Since the member will transition from FFS to managed care on 9/1/24, 9/1/24 is the last bill date under FFS as this is considered the 'discharge date' for the FFS portion of the member's stay to ensure the provider is paid through 8/31/24 under FFS. The provider bills the assigned MCO from 9/1/24 - 10/12/24.

Explanation: The last date on the claim is typically the discharge date. Providers are not paid a per diem for the member's discharge day. In this example, the provider will bill FFS through 9/1/24 since that is the date the member transitions from FFS to managed care. This results in the provider being paid under FFS for 8/31/24 and under the MCO beginning 9/1/24. Claims must be billed this way to ensure correct reimbursement and to prevent the claims from suspending for edits.

Service Authorization

When a provider submits a FFS service authorization (SA) request for a member who has a pre-assignment to an MCO and the requested dates of service span into the MCO assignment month, the FFS SA request and date span will authorize based on medical necessity. The resulting approved dates of service may include dates with FFS coverage and dates within the pending MCO coverage time period. This will allow for continuity of care, which is a routine function, and it ensures that a member's authorized services will be covered by both FFS and the members MCO when any member transfers benefit plans between FFS to MCO or during MCO to FFS transitions.

Continuity of Care and Existing Service Authorizations

To ensure continuity of care, Cardinal Care health plans will honor existing service authorizations for their enrolled members until the service authorization ends or for 30 days after the Member's MCO enrollment begin date, whichever is sooner. Providers must contract with the member's health plan or have a single case agreement in place in order to receive reimbursement for services rendered to Cardinal Care MCO enrolled members. The continuity of care period serves to ensure seamless and effective member transitions. Non-contracted providers should contact the plans to ensure that they have an out-of-network agreement in place for claim payment purposes.

Following this 30-day continuity of care period, health plans have the option of transitioning the member to a provider in their network or continuing to pay the provider on an out-of-network basis. Contracting and credentialing contacts for each of the Cardinal Care health plans are available by region on the DMAS website, MCO Directories at: https://www.dmas.virginia.gov/for-providers/cardinal-care/provider-health-plan-resources/.

APR DRG Requirements

For APR-DRG billing requirements, please reference DMAS Medicaid Memo dated 10/17/2023.

Eligibility at Time of Service

Effective on and after July 1, 2024, in accordance with federal policy guidance, DMAS will reimburse ONLY the portion of the per-diem payment hospitalization for which the member has been determined Medicaid/FAMIS eligible.

Verification of Member Eligibility and Managed Care Enrollment:

DMAS provides multiple ways for providers to verify the Member's eligibility and managed care enrollment, including through the automated phone system using MediCall (1-800-884-9730, or 804-965-9732), through the Virginia Medicaid provider portal (MES), or using the 270/271 electronic data interchange (EDI) transaction. For additional information, visit the MES Provider Resources web page.

To avoid disruption to claims payment through FFS and the MCOs providers must periodically check the DMAS provider portal, also known as the Provider Services Solution (PRSS), to ensure that the provider's enrollment, contact information, and license information is up to date, for all of the provider's respective service locations. Under federal rules, MCOs and DMAS are prohibited from paying claims to network providers who are not enrolled in PRSS. Additional information is provided on the MCO Provider Network Resources webpage and includes links to resources, tutorials and contact information to reach Gainwell with any provider enrollment or revalidation related questions. Dental providers should continue to enroll directly through the DMAS Dental Benefits Administrator, DentaQuest.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Cardinal Care Managed Care	https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/
PACE	Program of All-inclusive Care (virginia.gov)
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627

Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html 1-800-279-1878
Anthem HealthKeepers Plus	http://www.anthem.com/ 1-800-901-0020
Molina Complete Care	1-800-424-4518 https://www.molinahealthcare.com/providers/va/medicaid/home.aspx
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers
United Healthcare	www.uhcprovider.com/ 1-844-284-0149
Dental Provider DentaQuest	1-888-912-3456
Fee-for-Service (POS) Prime Therapeutics	https://www.virginiamedicaidpharmacyservices.com/ 1-800-932-6648
Acentra Health Behavioral Health and Medical Service Authorizations	https://vamedicaid.dmas.virginia.gov/sa 1-804-622-8900