Covered Services and Limitations (Hospital)

Last Updated: 06/03/2022

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Updated: 3/4/2020

INPATIENT HOSPITAL SERVICES

General Information

Patients covered under the Medicaid Program are entitled to have payment made on their behalf for covered inpatient hospital services in a participating hospital subject to the limitations described below.

Inpatient Defined

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

Covered Inpatient Care

Inpatient care is a covered service under the Medicaid Program if it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. The service must be consistent with the diagnosis or treatment of the patient's condition and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury or to the functioning of a malformed body member is not covered.

Inpatient services do not include:

- Behavior modification;
- Remedial education;
- Day care;
- Psychological testing done for any or all of the following purposes:
    - educational diagnosis, school recommendations, institution admission or institutional placement; and
- Alcoholism and drug abuse therapy

Inpatient Acute Services in acute hospitals require service authorization. On admission, the patient must meet severity of illness and intensity of service criteria for inpatient hospitalization and have a treatment plan in place that requires an inpatient level of care.

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require service authorization. Refer to Appendix D, Service Authorization for more detailed information.

Claims with an alcohol/drug rehabilitation and detoxification ICD-CM procedure code will no longer deny for “services not covered” if there is a service authorization on file. Alcohol and drug rehabilitation and detoxification remain non-covered services under the Virginia Medicaid program.

However, the Department of Medical Assistance Services

(DMAS) recognizes that medical detoxification is, at times, part of a medically appropriate treatment plan. DMAS will conduct retrospective audits of these authorizations to ensure that the criteria for medical necessity are met.

Admission of MEDALLION 3.0 Members

Medallion 3.0 clients and MCO providers must adhere to the MCO's requirements regarding referrals and service authorizations. Service authorization from the members's MCO is required for any out of state network services, *except for emergency and family planning services*. The provider is responsible for ensuring that proper referrals and service authorizations are obtained. The provider must seek authorization from the respective MCO for inpatient services.

Edits on Inpatient Admissions for Claims

Hospitals must submit documentation of medical justification for these claims:

- Admissions for psychiatric services when the length of stay exceeds the 21-day limit on hospitalizations within a 60-day period for a member 21 years of age or older; and the requirement for abortion, hysterectomy, and or sterilization form.
- Out of state claims: Emergency room records (if applicable), the physician history and physical, operative notes and the discharge summary are required.
- Mandatory outpatient procedures performed as an inpatient: History and physical, operative note and discharge summary are required. When sending documentation with inpatient claims, be certain that the documentation is attached to the invoice. If billing electronically, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits, Chapter V).

DMAS will perform desk or on-site audits of the hospital's utilization review activities. Refer to chapter VI for further details related to hospital UR.

Covered Days

DMAS limits coverage for psychiatric inpatient hospitalizations as follows:

- Psychiatric admissions for individuals over the age of 21 are limited to 21 days within 60 days. Psychiatric admissions and lengths of stays must be service authorized by the Service Authorization Contractor.

Physician's Note: Payments for hospital visits are limited to the appropriate number of approved hospital days.

Certification of Covered Days

The number of covered days of hospital care shall be determined through periodic certification of the need for care by the attending physician and through the DMAS approved utilization review plan in effect for each hospital (see Chapter VI).

Coverage of Day of Admission and Day of Discharge

The day of admission is covered as a full day of inpatient care, regardless of the time of admission. The day of discharge is not an authorized day of care by Medicaid and cannot be reimbursed. The midnight-to-midnight method shall be used in reporting days of care.

Coverage of Day of Death

The day of death is the day of discharge. If an admission was medically necessary and appropriate and there was a reasonable expectation that the patient would remain at least overnight and occupy a bed, the admission shall be authorized as a day of inpatient care, even if the patient is discharged later the same calendar day.

Coverage of Pre-Surgical Days

An inpatient hospital stay before non-emergency surgery cannot precede the admission day unless medically justified. It is expected that the provider will ensure that all pre-surgical services will be rendered in an outpatient setting unless there is medical justification for rendering these services in an inpatient setting

Late Discharge

Medicaid will not pay for a continued hospital stay if the continued stay is for personal, non-medical reasons, or a patient chooses to continue to occupy the hospital accommodation beyond the checkout time. If the continued stay is caused by the patient's medical condition, the stay beyond the discharge hour is covered by Medicaid.

Leave of Absence

The day on which the patient begins a leave of absence or furlough is treated as a day of discharge and is not considered a day of inpatient care. The day the patient returns from a leave of absence or furlough is treated as a day of admission and is considered a day of inpatient care if the patient returns to the hospital by midnight. A new service authorization will be required once the patient returns to the hospital.

It should be noted that leaves of absence are permitted for therapeutic purposes only. The objectives of the leave of absence must be documented prior to the leave, and the goals obtained and an evaluation of the leave must be documented upon the patient's return. Leaves of absence for procedures which are not available at the treating facility (for example, CAT scan, or renal dialysis) are considered medical therapeutic leaves.

Non-Covered Days

Hospitals must bill for all days and charges for surgical or medical diagnosis even if a portion of an inpatient stay is not covered by Medicaid because this may affect the DRG part of cost settlement and reimbursement.

Ineligible Days

If a member becomes eligible or loses their eligibility during a psychiatric inpatient hospitalization, Medicaid will only reimburse the number of days the member is eligible for Medicaid. For medical/surgical inpatient admissions, reimbursement will be based on the DRG payment methodology; and therefore, the entire hospitalization will be paid as long as the member is eligible for Medicaid for a portion of the hospital stay.

Accommodations

Accommodations refers to the room in which the patient is housed while a hospital inpatient. Medicaid will pay for the reasonable cost of semi-private or ward accommodations (two or more patients).

Private Room Accommodations

Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semi-private only when such accommodations are medically necessary.

Private rooms are considered medically necessary when the patient's condition requires isolation for the patient's health or for that of others. Physician certification of the medical necessity for the private room must be on file prior to discharge. Reimbursement will also be provided for care in special units, such as intensive care and coronary care, if the care is medically necessary. If private room accommodations have been furnished the patient but are not medically necessary, reimbursement shall be provided at the most prevalent semiprivate rate. The most prevalent semi-private rate is the rate which applies to the greatest number of semi-private beds.

Private room accommodations furnished at the request of the patient are **not covered** by DMAS. Billing to DMAS must be at the most prevalent semi-private rate. Providers are not allowed to bill or collect from the patient or family the difference in charges between private and semi-private accommodations.

Nursing Services

Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered. These costs are covered on a reasonable cost basis as a part of inpatient routine care provided under accommodations.

Not covered are the services of a private-duty nurse or other private-duty attendants, the patient's personal physician, and other practitioners not employed by the hospital. Physician visits and or services to inpatients must be billed separately using the CMS-1500 Universal Claim form.

Services of Interns or 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

ANCILLARY SERVICES

Drugs and Biologicals

Drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

Blood and Blood Components

Whole blood and equivalent quantities of packed red blood cells are covered by Medicaid when not available from other sources.

Other components of whole blood (e.g., plasma, gamma globulin, etc.) are covered biologicals.

Supplies, Appliances, and Equipment

Supplies, appliances, and equipment ordinarily furnished by the hospital for the care and treatment of the member solely during his or her inpatient stay in the hospital are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the inpatient stay are covered even though they leave the hospital with the patient when he or she is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, artificial limbs, and tracheostomy or drainage tubes that are temporarily installed in or attached to the patient's body while he or she is receiving treatment as an inpatient and which are also necessary to permit or facilitate the patient's release from the hospital.

Supplies, appliances, and equipment furnished to an inpatient member for use outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item which is medically necessary to permit or facilitate the patient's departure from the hospital and which is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

Physical Therapist Services

To be reimbursable by DMAS, inpatient and outpatient physical therapy must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment regimen designed by the physician after any needed consultation with the licensed physical therapist;
- The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the judgment and skills of a qualified physical therapist are required;
- The services must, in fact, be performed by or under the direct supervision of a licensed physical therapist (i.e., a licensed physical therapist must be present on the premises when services are rendered);
- The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition; and
- The services must be reasonable and necessary for the treatment of the patient's condition.

Many hospital inpatients who do not require physical therapy services, as defined above, do require services involving physical modalities and procedures which are routine, in the sense that they can be rendered by supportive personnel (e.g., aides or nursing personnel without the supervision of a licensed physical therapist). Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general modification), are never reimbursable as physical therapy. However, since they constitute an essential and integral part of good patient care, the cost of such services may be included in the routine allowable costs of the institution.

Since DMAS' definition of reimbursable physical therapy is essentially the same as that for Medicare, the same documentation required for Medicare is accepted by DMAS.

Speech and Hearing Services

Certified hospitals which have speech and hearing departments or appropriate arrangements with qualified speech therapists and audiologists (including independent speech and hearing centers) may be reimbursed by Medicaid on a cost basis for inpatient speech and hearing services ordered by a physician. Reimbursement is limited to those services related to a medical diagnosis, such as stroke or post-laryngectomy.

Long-term speech therapy, such as may be required for a child with cerebral palsy, is not covered under Medicaid during an inpatient hospital stay.

Diagnostic testing performed by a qualified audiologist is covered when a physician orders such testing for the purpose of mandated initial newborn hearing screens, or obtaining additional information necessary for his or her evaluation of the need for, or appropriate type of, medical or surgical treatment for a hearing problem. For example, diagnostic services performed by a qualified audiologist to measure a hearing loss or to identify the factors responsible for the loss are covered

when such services are necessary to enable the physician to determine whether otologic surgery is indicated.

For the purpose of Medicaid, a qualified audiologist or speech therapist is one who has been granted a Certificate of Clinical Competence in the appropriate area by the American Speech and Hearing Association or who has completed the academic and practicum requirements for certification and who is in the process of accumulating the necessary supervised work experience required for certification.

Other Diagnostic or Therapeutic Items or Services

Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed above as covered inpatient hospital services. With respect to items that leave the hospital with the patient upon discharge (such as splints or casts), the rules for determining whether the item is covered are the same as the rules set forth for "Supplies, Appliances, and Equipment" of this chapter.

When any service is provided by a salaried member of the staff of a hospital, the individual's diagnostic or therapeutic services to inpatients of that hospital are covered on a reasonable cost basis in the same manner as the services of other non-physician hospital employees.

PSYCHIATRIC HOSPITAL SERVICES

Short-Term Inpatient Services

Short-term inpatient psychiatric services are covered in general hospitals when certified by the hospital utilization review committee and service authorized by the BHSA contractor as outlined earlier in this chapter. These committees are charged with the responsibility of determining the level of care that best meets the patients' medical needs. These committees should be reasonable in their determinations, should review the patients' needs as they would any other illness, and should, within a reasonable time, transfer these patients to a lower level of care or to a suitable long-term facility.

Long-Term Services

Long-term psychiatric and tuberculosis services are covered only for individuals 65 years of age or over and only in facilities for mental diseases that have been appropriately licensed or certified, or both, and enrolled as a provider with DMAS.

Inpatient Psychiatric Services for Members Under Age 21 Through the EPSDT Program at Free-Standing Psychiatric Facilities

Medicaid will pay for inpatient psychiatric services for individuals under age 21 who have been identified by a physician as having a condition of mental illness which can be ameliorated or corrected through inpatient psychiatric services. Inpatient psychiatric services are not covered through the *State Plan for Medical Assistance*, but are available only for those individuals under the age of 21 whose needs have been identified through the EPSDT Program. Requests for authorization for admission must be submitted to the BHSA contractor, as described in the *Psychiatric Services*

Manual. DMAS pays an all-inclusive rate. However, the professional component for the psychiatric care may be billed separately.

OTHER SERVICES

Inpatient Rehabilitation Services

Medicaid covers inpatient rehabilitation services in facilities that are certified as rehabilitative hospitals or rehabilitation units of a general acute care hospital. The facility must also have a current provider agreement for rehabilitation services with DMAS. Refer to the *Rehabilitation Manual* issued by DMAS for criteria on covered services and the service authorization requirements. Requests for authorization must be submitted to the Service Authorization contractor.

Transplant Surgery

Information related to Transplant Surgery is found in Appendix D.

Maternity Care

DMAS will cover the day of delivery plus an additional two days for a normal, uncomplicated vaginal delivery without requiring documentation of medical necessity or service authorization. DMAS will cover the day of delivery plus an additional four days without requiring documentation of medical necessity for cesarean births. Claims that exceed the above number of days must be medically justified, for admission and length of stay and have service authorization by the Service Authorization Contractor.

If the mother and newborn are discharged earlier than 48 hours after the day of delivery, DMAS will cover an early discharge follow-up visit as recommended by the physician, in accordance with the following 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 follow below.

CRITERIA FOR EARLY DISCHARGE OF MOTHER AND INFANT MOTHER

Uncomplicated Vaginal, Full Term Delivery Following a Normal Antepartum Course Postpartum observation has sufficiently documented a stable course, including the following observations:

- Uterine fundus is firm, bleeding (lochia) is controlled, of normal amount and color;
- Hemoglobin is greater than 8, hematocrit is greater than or equal to 24, and estimated blood loss is not greater than 500 cc. or blood loss does not result in the patient's being symptomatic for anemia (i.e., lightheadedness, syncope, tachycardia, or shortness of breath);
- Episiotomy/repaired laceration is not inflamed, and there is no evidence of infection or hematoma;

- Tolerating prescribed diet post delivery;
- Voiding without difficulty and passing flatus. Bowel sounds present; and
- If not previously obtained, ABO and Rh typing must be done and, if indicated, the appropriate amount of Rho(D) immunoglobin must be administered.

Infant

The newborn must be deemed normal by physical examination and stable meeting the following criteria:

- Term delivery and weight are considered normal;
- Infant is able to maintain a stable body temperature under normal conditions;
- Infant is able to take and tolerate feedings by mouth and demonstrates normal sucking and swallowing reflexes;
- Laboratory data must be reviewed to include:

  a. Maternal testing for syphilis and hepatitis B surface antigen;
  b. Cord or infant blood type and direct Coombs test (if the mother is Rho(D) negative, or is type O, or if screening has not been performed for maternal antibodies);
  c. Hemoglobin or hematocrit and blood glucose determinations, as clinically indicated; and
  d. Any screening tests required by law; and
  e. Initial hepatitis B vaccine must have been administered.

Mother and Infant

- Family members or other support person(s) must be available to the mother for the first few days following discharge;
- The mother has demonstrated the ability to care for her infant including feeding, bathing, cord care, diapering, and body temperature assessment and measurement with a thermometer;
- The mother or caretaker has been taught basic assessment skills including neonatal well-being and recognition of illness. She verbalizes understanding of possible complications and has been instructed to notify the appropriate practitioner as necessary;
- A physician-directed source of continuing medical care for both mother and baby must be identified and arrangements made for the baby to be examined within 48 hours of discharge; and
- The follow-up visit must be provided as directed by a physician. The provider of the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge. Minimum requirements for the follow-up visit are in the *Physician Manual* issued by DMAS.

NEWBORN INFANT CARE

Virginia Medicaid provides coverage for the high-risk infant who requires medically necessary stays in a hospital's newborn nursery or in a licensed neonatal intensive care unit (NICU).

Refer to Chapter V of this manual for the required billing procedures for newborn infant care.

ABORTIONS, HYSTERECTOMIES AND STERILIZATIONS

The Department of Medical Assistance Services, in its coverage of abortions, hysterectomies, and sterilization procedures, must meet strict federal and state requirements. The consent and certification requirements for these procedures are discussed in Chapter VI of this manual (see "Exhibits" at the end of this chapter for the ICD-10-CM list).

SERVICES TO PROMOTE FERTILITY (Hospital)

Virginia Medicaid does not cover services to promote fertility. Medicaid will not pay for the medical procedure if its only goal is 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. The following surgical procedures apply:

- Repairs of spermatic cord and epididymis;
- Transplantation of spermatic cord;
- Other repair of spermatic cord and epididymis;
- Repair of vas deferens and epididymis;
- Reconstruction of surgically divided vas deferens;
- Epididymovasostomy;
- Removal of ligature from vas deferens;
- Other repair of vas deferens and epididymis;
- Repair of fallopian tube;
- Simple suture of fallopian tube;
- Salpingo – oophorostomy;
- Salpingo – salpingostomy;
- Salpingo – uterostomy;
- Other repair of fallopian tube; and
- Implantation or replacement of prosthesis of fallopian tube.

CONTRACEPTIVE CAPSULES

Virginia Medicaid will reimburse its usual allowance for the insertion, removal, or removal with reinsertion of implanted contraceptive capsules regardless of any other services performed. When a woman has contraceptive implants inserted and paid for by Medicaid, she may no longer be eligible for Medicaid when it is time to remove the implants. There is no process that would allow Medicaid

reimbursement for the removal of the implants when the member is not Medicaid-eligible on the date of removal.

Long Acting Reversible Contraceptives (LARC)

Effective for dates of service on or after January 1, 2017, DMAS is updating its policy to include reimbursement for LARCs provided after delivery in inpatient hospitals. This is applicable for Medicaid and FAMIS Fee-for-Service members as well as those Medicaid and FAMIS members enrolled in a Medicaid Managed Care Organization (MCO). The reimbursement for the LARC will be considered a separate payment and will not be included in the Diagnostic Related Group (DRG) reimbursed to the Facility.

LARC Device J Codes to be covered for separate facility reimbursement at inpatient hospitals are:

IUD:

- J7297 – Liletta
- J7298 – Mirena
- J7301 – Skyla
- J7300 – Paragard

Implant

- J7307 – Implanon/Nexplanon

Prior authorization is not required on any of the above J codes.

Detailed information related to claim submission for LARC can be found in See Chapter 5.

COSMETIC SURGERY (Hospital)

Information related to Cosmetic Surgery and Elective Surgery is found in Appendix D.

OUTPATIENT HOSPITAL SERVICES

Outpatient Defined

When a hospital uses the category "day patient" (i.e., an individual who received hospital services during the day and is not expected to be lodged in the hospital at midnight), the individual is classified as an outpatient. Note: If the procedure is performed as an inpatient, separate service authorization by the DMAS Service Authorization Contractor is required for inpatient admission.

Outpatient Hospital Services

Services furnished by or under the direction of a physician in the hospital's outpatient department or clinic are covered by Medicaid, and for claims with dates of services on or after January 1, 2014, DMAS reimburses using the Enhanced Ambulatory Patient Group (EAPG) methodology developed and

licensed by 3M. EAPGs consist of allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed in an outpatient setting. Each EAPG shall be assigned an EAPG weight that reflects the relative average cost for each EAPG compared to the relative cost for all other EAPGs.

- The assignment of EAPGs is based primarily on HCPCS/CPT procedure codes. Some EAPGs also utilize the primary diagnosis for assignment. The assignment of a payment percentage to each EAPG is based on the payment action determined within the 3M software.
- The EAPG methodology consolidates multiple significant procedures. When a patient has multiple significant procedures, some of the procedures may require minimal additional time or resources. This consolidation refers to the collapsing of multiple significant procedures into a single EAPG for the payment determination.
- Covered diagnostic services include: hematology chemistry, diagnostic x-rays, isotope studies, EKG, pulmonary function studies, thyroid function test, etc.
- Other outpatient services include: use of emergency room, observation beds, medical supplies, dressings, oxygen, ointments, splints, special therapy treatments, etc.

Under the EAPG methodology each service or procedure may not be separately payable. The total payment will reflect the average payment amount for all services billed. Outpatient hospital services reimbursed through EAPG will be subject to Medicaid's National Correct Coding Initiative (NCCI) Facility edits.

DMAS will accept outpatient billings for the medically necessary ancillary services that would have been rendered on an outpatient basis but are provided during a denied inpatient stay. Outpatient billings are limited to those ancillary services performed within the first three days of hospitalization for any inpatient hospital denials.

Vaccines for Children

The cost of immunizations will no longer be reimbursed for vaccines eligible under the VFC Program.

National Drug Code (NDC)

Hospital providers who administer drug products in **outpatient hospital settings** will be required to include valid NDCs on claims submissions. A valid NDC is defined as a correctly formatted number using the 5-4-2 format, i.e., 5-digits, followed by 4-digits, followed by 2-digits (99999888877). Each NDC must be an **11-digit code** unique to the manufacturer of the specific drug or product administered to the member. If the provider is billing for a compound medication with more than one NDC included in the medication dispensed, each applicable NDC must be submitted as a separate claim line to include both prescription and over-the-counter ingredients. Outpatient hospital claims submitted without a valid NDC will have the revenue code line reduced to a non–covered service line.

DMAS will monitor and edit all outpatient hospital claims to ensure that the pharmacy revenue codes are submitted with an NDC. Claims submitted without the NDC will be reduced. Each claim (line) submitted with an N4 qualifier MUST have the associated NDC and revenue code billed on that line. Providers participating in the 340B drug discount program must submit each drug line with modifier

UD on the revenue line with the HCPCS/CPT procedure code and NDC for revenue codes 0250 through 0259 and 0636 through 0639. All providers, including those not participating in the 340B discount program, must continue to submit NDC codes for revenue codes 250 through 259 and 636 through 639 and applicable HCPCS/CPT codes for each drug submitted.

Observation Beds

Observation services are those services furnished on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

DMAS will pay for observation bed services when billed on an outpatient invoice under the following conditions:

- Observation bed services are covered if they are reasonable and necessary to evaluate a medical condition to determine the appropriate level of treatment.
- Non-routine observation for underlying medical complication after surgery or diagnostic services is covered. Medical documentation of the complication is required.
- Services are billed as outpatient status. A hospital may bill for observation bed services for up to 23 hours. A patient stay of 24 hours or more will require inpatient precertification where applicable.
- When inpatient admission is required following observation services, observation charges will be combined with the appropriate inpatient admission and shown on the inpatient bill. Observation bed charges and inpatient hospital charges will not be reimbursed for the same day.

The following services are **not** considered observation bed services and, therefore, are **not** covered:

- Services which are not reasonable or necessary for the diagnosis or treatment of the patient, but are provided for the convenience of the patient or physician.
- Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services. For example, services for routine post-operative monitoring during a normal recovery period (less than 8 hours) would not be covered.
- Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which are managed by a physician other than the original emergency physician.
- Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

Therapy Services

Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals shall include service limits for up to 5 visits per rehabilitative service annually. Limits are per member, regardless of the number of providers

rendering services. "Annually" is defined as July 1 through June 30 for each member. The provider must maintain documentation to justify the need for services. Services which exceed the 5 visit service limits annually require service authorization by the DMAS Service Authorization Contractor prior to rendering the 6th visit. Refer to the Rehabilitation Manual, Appendix D, for more information regarding service authorization of outpatient rehabilitation services.

Note: A visit is defined as the duration of time that a rehabilitation therapist or other health worker is with a client to provide covered services prescribed by a physician**.** Visits are not defined in measurements or increments of time. The furnishing of any services by a particular health worker on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services in the home on the same day, this constitutes two visits. If a therapist furnishes several services during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy sessions in the same day (e.g., a morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed. For claims with dates of service on or after January 1, 2014, hospitals should not bill individual modalities.

The following are valid therapy service procedure codes and revenue combinations for claims with dates of service on or after January 1, 2014:

Revenue Code	Procedure Code	Procedure Code Description
0421	97110	Therapeutic procedure (PT) Note: unit = a visit
0423	97150	Therapeutic procedure(s) (PT), group Note: unit = a group session
0424	97001	Physical therapy evaluation Note: unit = an evaluation
0431	97530	Therapeutic activities (OT) Note: unit = a visit
0433	S9129	Therapeutic procedure(s) (OT), group Note: unit = a group session
0434	97003	Occupational therapy evaluation Note: unit = an evaluation
0421	97110	Therapeutic procedure (PT) Note: unit = a visit
0423	97150	Therapeutic procedure(s) (PT), group Note: unit = a group session
0424	97001	Physical therapy evaluation Note: unit = an evaluation
0431	97530	Therapeutic activities (OT) Note: unit = a visit
0433	S9129	Therapeutic procedures(s) (OT), group Note: unit = a group session

0434	97003	Occupational therapy evaluation Note: unit = an evaluation
0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual Note: unit = one treatment session
0443	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group (2 or more individuals) Note: unit = one treatment session
0444	92521-92524	Evaluation of speech, language, voice, communication, and/or auditory processing Note: unit = an evaluation

When service authorization is requested, the Service Authorization Contractor will inform the provider of the status of the request (approved, partial approved, deny, pend, reject). If the request is approved, the PA Contractor will indicate the amount of time approved. If treatment is needed beyond this time frame, the provider must call and request service authorization prior to the end of the previously approved time period. In the event that treatment has continued with a lapse in authorizations, authorization may begin on the day it is requested if the criteria are met Services provided without service authorization will not be reimbursed.

The following codes are to be used when requesting rehabilitation therapy beyond the 5 visits a year:

National Revenue Code	*Description*
0421	Physical Therapy, Follow-Up Visit
0423	Physical Therapy, Group Session
0424	Physical Therapy Evaluation/Re-Evaluation
0431	Occupational Therapy, Follow-up Visit
0433	Occupational Therapy, Group Session
0434	Occupational Therapy Evaluation/Re-Evaluation
0441	Speech/language, Follow-Up Visit
0443	Speech/language, Group Session
0444	Speech Therapy Evaluation/Re-Evaluation

Effective April 1, 2012, three revenue codes are available for out of state general hospital providers and out of state rehabilitation hospital providers to use. These codes require service authorization through KePRO. See the DMAS Memo dated March 9, 2012, titled **"**Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service

Authorization, *effective April 1, 2012"***.** Refer to the "Submitting Requests for Service Authorizations" section in the Physician/Practitioner Manual, Appendix D for details.

0420: Physical Therapy (P.T.)-General; 1 unit = 1 visit 0430:
Occupational Therapy (O.T.)-General; 1 unit = 1 visit 0440: Speech
Language Pathology-General; 1 unit = 1 visit.

Outpatient Rehabilitation Services

Rehabilitation services rendered to outpatients are covered if they meet the conditions specific in the policy statement on Criteria for Coverage of Rehabilitation Services. Refer to the *Rehabilitation Manua*l issued by DMAS for criteria on covered services.

DMAS categorizes general physical outpatient rehabilitation into two subgroups: acute conditions and long-term, non-acute conditions. Acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration of less than 12 months and in which progress toward established goals is likely to occur frequently. Long-term, non-acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration greater than 12 months and in which progress toward established goals is likely to occur slowly.

Covered outpatient rehabilitative services for acute conditions and long-term, non-acute conditions include physical and occupational therapy and speech/language pathology services. Any of these services shall not be contingent upon the provision of another service.

A physician recertification is required at least every 60 days for acute rehabilitative services and at least annually for long-term, non-acute rehabilitative services. The physician review and recertification of the plan of treatment must be completed at least every 62 days for all patients, according to federal requirements. The physician certification (plan of care) prior to the start of services and the required periodic recertification (plan of care renewal) must be signed and dated by the physician prior to the initiation or the continuation of service. The physician who reviews the plan of care and certifies or recertifies the need for service must sign the document.

Defining a condition as acute or as long-term, non-acute is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of care remains unchanged. Plans of care must still include measurable long-term goals with anticipated dates of achievement. Plans of care must be renewed by the physician at any time long-term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual patient.

Effective April 1, 2012, three revenue codes are available for out of state general hospital providers and out of state rehabilitation hospital providers to use. These codes require service authorization through KePRO. See the DMAS Memo dated March 9, 2012, titled **"**Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"***.** Refer to the "Submitting Requests for Service Authorizations" section in the Physician/Practitioner Manual, Appendix D for details.

0420: Physical Therapy (P.T.)-General; 1 unit = 1 visit 0430:
Occupational Therapy (O.T.)-General; 1 unit = 1 visit 0440: Speech

Language Pathology-General; 1 unit = 1 visit.

Outpatient Psychiatric and Substance Abuse Services

Outpatient psychiatric and substance abuse (SA) services are provided in a practitioner's office, mental health clinic, patient's home, or nursing facility. If services are provided in a setting other than the office or a clinic, this must be documented. Services shall be medically prescribed treatment, which is documented in an active written treatment plan designed, signed, and dated by a Licensed Mental Health Provider (LMHP). Psychiatric and substance abuse medication management requires a plan of care. A separate plan is required for psychiatric services and SA services when service authorization is requested separately. The primary diagnosis should indicate the focus of treatment. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed with the expectation the clinician will bill for the primary presenting problem.

Outpatient psychiatric and substance abuse services require service authorization after 26 sessions in the first year of treatment. During the first year of treatment, there may be an additional 26 sessions when service authorized. The initial 26 sessions can be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 sessions in subsequent years, but these sessions must be service authorized. The 26-session restriction does not apply to the psychiatric diagnostic interview examination. However, each provider may only bill one psychiatric diagnostic interview examination within a 12-month period. The examination must meet medical necessity criteria. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through the EPSDT program and must be service authorized. See Appendix C in the Psychiatric Services Manual for instructions on service authorization. Medication management does not require service authorization and is not subject to the session limit.

EMERGENCY ROOM CLAIMS

For dates of service on or after January 1, 2014, outpatient Emergency Room claims will pay by EAPG methodology. Outpatient hospital claims will no longer pend for medical records. Medical records will no longer be requested or needed for outpatient emergency room services.

For dates of service on or after July 1, 2015, Emergency Room physician claims will pay based on the DMAS allowed rate. Medical records will no longer be requested or needed for emergency room physician claims.

For Medicaid members in the Client Medical Management (CMM) program:

- The Emergency Room process for CMM will continue;
- CMM referrals will still be required;
- CMM non-emergency visits will be denied.

Effective for dates of service on or after January 1, 2014, laboratory services performed during an emergency room visit must be billed on the UB-04.

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.

CLIENT MEDICAL MANAGEMENT PROGRAM (Hospital)

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.
- On written referral from the primary health care provider using the Practitioner Referral form (DMAS-70). This also applies to covering physicians.
- For other services covered by Medicaid which are excluded from the Client Medical Management Program requirements.

EMERGENCY ROOM SERVICES UNDER CLIENT MEDICAL MANAGEMENT (Hospital)

General Information

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 Code (see
"exhibits" at the end of this chapter for the list.)

CMM members must have a written primary care provider (PCP) referral in order for nonemergency services provided in the emergency room to be reimbursed under the EAPG methodology. 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 99281-99285 and enters "1" in Block 24I. When the PCP has referred the member to the emergency room, place the PCP's identification number in Block 17A on the CMS1500 (08-05) and attach the Practitioner Referral Form, DMAS-70. Write "attachment" in Block 10D When billing for emergency room service, the hospital must place the PCPs identification number in block 78 of the UB-04. **PCP referral IS required for reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting.**

Outpatient Laboratory Procedures

Effective for dates of service on or after January 1, 2014, laboratory services performed during an outpatient hospital visit must be billed on the UB-04. Reference laboratory services will continue to be billed on the CMS-1500 by enrolled independent laboratory providers. Hospital laboratories performing reference laboratory services must enroll and bill as independent laboratory providers. Payment for laboratory services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The hospital laboratory may bill for the handling or conveyance of specimens sent to another laboratory by using Current Procedural Terminology (CPT) Code 99001. Only one specimen handling fee is allowed per outpatient visit. Laboratory procedures performed by outside sources at no charge to the practitioner or laboratory are not to be billed to Medicaid. ClaimCheck edits are applicable to laboratory codes and, depending on the codes billed, may result in the denial of CPT 99001. See Exhibits at the end of Chapter 5 for specifics regarding the ClaimCheck/Correct Coding Initiative (CCI) edits.

Whenever laboratory tests are performed that are generally a part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested. This includes, but is not limited to, chemistry and hematology testing: The CPT/HCPCS coding system delineates tests that are frequently done as part of a chemistry profile. When **two** or more of these lab tests are performed on the same specimen, in any combination, the lesser automated rate is to be billed regardless of how the specimen is tested. CPT/HCPCS codes 8004880076 are to be used, and the code used must correlate with the number of tests performed. Only one panel code is to be used per specimen. If only one procedure is performed, use the appropriate CPT/HCPCS procedure code which describes the individual test.

- Whenever **four** or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code is to be used (85025-85027).

If fewer than four components of a hemogram are performed, they are to be billed using the appropriate individual CPT/HCPCS codes. The following laboratory 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 (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. Payment will be made only for the culture.

Results must be recorded in the patient's chart for all tests billed to Medicaid. Qualitative test results must be recorded as positive or negative. 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
87116	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only
87117	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB,

	mycobacteria); concentration plus isolation
87118	Culture, mycobacteria, definitive identification of each organism.
87190	Sensitivity studies, antibiotic, tubercle bacillus (TB, AFB), each drug
87250	Virus, identification; inoculation of embryonated eggs, or small animal, includes observation and dissection

Payment Methodology

The Deficit Reduction Act of 1984 requires Medicare to establish fee schedules for clinical laboratory procedures, including specimen handling and collection. Federal regulations (42 CFR 447.342) limit Medicaid reimbursement to no more than the amount allowed by
Medicare for the same procedure. Therefore, Medicaid reimbursement for clinical laboratory procedures will not exceed the Medicare fee schedule in the aggregate. In the past, somelaboratory fees exceeded the Medicare allowance.
Payment under EAPG for laboratory services in the aggregate shall be calculated to reflect the **lowest of**:

- The Program's fee schedule;
- The National Clinical Laboratory fee cap, implemented July 1, 1986.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service required.

CLAIMCHECK/CORRECT CODING INITIATIVE (CCI) (Hospital)

The implementation of Medicaid-specific National Correct Coding Initiative (NCCI) edits through ClaimCheck/CCI was effective June 1, 2013. Effective January 1, 2014, all outpatient hospital claims shall be subject to National Correct Coding Initiative edits with dates of service on or after that date. NCCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck/CCI edits are based on the following global claim factors: same member, same provider, same date of service or date of service is within established pre- or postoperative time frame. DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck/CCI process. The member's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. The Division of Program Integrity will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers. DMAS has provided a listing of the modifiers, examples of common CCI and ClaimCheck edits and

ClaimCheck edit error reason codes at our website www.DMAS.virginia.gov, under Provider Services, Claims and Billing.

- PTP Edits:

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:

DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Modifiers:
- Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC,

LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

RECONSIDERATION (Hospital)

Providers that disagree with the action taken by an EAPG edit may request a reconsideration of the process via email (HospitalEAPG@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Hospital EAPG

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice

containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

BENEFICIARY COPAYMENTS (Hospital)

The Virginia Medical Assistance Program requires copayment for certain services. This policy statement describes the application of copayment requirements to inpatient and outpatient hospital patients.

General

Members are required to share the cost of inpatient and outpatient hospital care. These copayments are:

$100 per hospital admission
$3 per non-emergency outpatient hospital visit

Copayment does not apply to an emergency or life-threatening condition. If an emergency or life-threatening condition exists, enter the appropriate code in Locator 14 of the UB-04 CMS-1450 to ensure that the copayment will not be deducted from the calculated payment.

Copayments for Children under Age 21

The Virginia Medical Assistance Program prohibits imposition of copayment requirements for any services rendered to children under age 21.

Other Copayment Exclusions

No copayment is to be collected for any service,which is pregnancy-related (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).

No copayment is to be collected for family planning services.

There are no copayments for services rendered to individuals who are residents of hospices, intermediate care facilities for the mentally retarded, nursing homes, tuberculosis, or mental hospitals.

Services to a member cannot be denied 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.

Inpatient Services for Medicare-Eligible Patients

A $100 copayment must be collected by the hospital for members who receive nonemergency inpatient hospital services, including those who have Medicare Part A coverage.
A $100 Medicaid hospital copay will automatically be subtracted from the Medicare Part A deductible

charge submitted on the Medicare part A crossover claim to Medicaid..

No Medicaid hospital deductible will be collected for admissions which are deemed by the attending medical staff to constitute an emergency. If the Medicare Part A deductible charge submitted on the Medicare crossover claim & locator 15 of the UB-04, has appropriate codes, and the claim includes charges for Emergency services, no copay will be deducted, includes charges for emergency services. In the absence of a medical emergency condition notation on the Medicare crossover claim, the $100 Medicaid deductible will automatically be subtracted from the Medicaid payment and will appear in the copay column of the Hospital Remittance Voucher.

Bill Medicaid for the total hospitalization for Medicaid dually eligible members who exhausted their Medicare coverage while hospitalized. Any payments made by Medicare or Medicaid must be placed on the UB- 04. Refer to the Billing Instructions, Chapter V, for additional information.
Medicaid handles and processes Medicare Advantage Plans the same way as traditional Medicare. DMAS does not process the Medicare Advantage Plans as Third Party Liability (TPL). Claims for Medicare Advantage Plan Deductibles and co-insurance should be submitted on the claim form that you submit to bill traditional Medicare.

Those members with Qualified Medicare Beneficiary (QMB) only coverage, the Medicaid payment is limited to the Medicare co-insurance and deductible. If Medicare covers the service, Medicaid will consider any Medicare deductible and or co-insurance amount. The Medicaid payment is limited to the Medicaid allowed amount. If Medicare does not cover the service, the service cannot be billed to Medicaid.

Those members with QMB Extended Coverage, are eligible for Medicaid coverage of premiums, deductibles and coinsurance plus all other Medicaid covered services. Medicaid will consider the Medicare deductible and co-insurance for benefits. The member is also eligible for all medically necessary Medicaid covered services.

Outpatient Services for Medicare-Eligible Patients

A $3 copayment must be collected from Medicaid members for non-emergency hospital services billed under Medicare Part B, unless they are subject to the exemptions outlined below.

Medicare Part B hospital charges must be separated from Medicare Part A charges on the Medicaid Title XVIII Invoice (DMAS-30) or Adjustment (DMAS 31). The DMAS-30 is only used for Medicare Part B charges.
A $3 copay will be subtracted automatically for medically needy members from the Part B charges on the Medicaid XVIII Invoice and will appear in the copay column of the Hospital Remittance Voucher. If the Part B charges include charges for emergency services, the notation "Emergency/Accident Treatment" must be placed in the "Remarks" section of the invoice to avoid having the copay subtracted automatically. In addition, indicate the line item on the invoice to which the emergency notation applies.

INPATIENT DENTAL SERVICES (Hospital)

If a patient is hospitalized solely for covered dental treatment, the professional services of the dentist

and the inpatient hospital services are covered if the appropriate authorizations have been obtained and approval given by the PA Contractor. The only exception to this policy is a covered service resulting from an accidental injury. In this instance, the dentist and the hospital may obtain retro-authorization.

When a patient is hospitalized for dental treatment, but hospitalization is required to ensure proper medical management, control, or treatment of a non-dental impairment, the inpatient hospital services must be authorized by the PA Contractor for all inpatient admissions. An example is a patient with a history of repeated heart attacks who must have all of his or her teeth extracted. The physician responsible for the treatment or management of the non-dental impairment must certify to the necessity for the patient's hospitalization. The certification must be completed at the time of admission and according to the guidelines for admission certification for acute care as specified in Chapter VI of this manual.

MANDATORY OUTPATIENT SURGICAL AND DIAGNOSTIC PROCEDURES PROGRAM

Program Requirements

Certain selected surgical and diagnostic procedures may be effectively performed on an outpatient basis. Therefore, the Commonwealth of Virginia mandated the implementation of a Mandatory Outpatient Surgical and Diagnostic Procedures Program. For all practitioner billings [CMS-1500)] and inpatient hospital billings (UB- 04 CMS-1450), Virginia Medicaid will not reimburse the hospital or practitioner for the selected outpatient surgical or diagnostic procedures listed in Mandatory Outpatient Surgical Procedures when performed on an inpatient basis unless it meets one of the exceptions to this policy.) This policy applies to all Medicaid-eligible patients regardless of any other medical coverage.

Exceptions

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 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 that 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.

For inpatient hospital billings, DMAS will reimburse the hospital for these procedures if service authorization for the inpatient admission has been obtained. Practitioners must still attach

documentation of medical necessity to the CMS -1500 when billing for these services.

Note: For any inpatient claim denied, the hospital may submit ancillary services performed for the inpatient denial within the first three days of hospitalization on an outpatient invoice.

Outpatient surgical procedures do not require service authorization unless the procedure codes are usually cosmetic or cosmetic in nature, experimental, etc. For a listing of the codes, refer to the "Procedure Codes Requiring Service Authorization by DMAS' Service Authorization Contractor" in Appendix D.
All 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 be approved only when appropriate justification for inpatient necessity is provided with the CMS-1500 physician claim.

Note: **Physicians** billing on the CMS-1500 (12-90) billing form must continue to use the **CPT/HCPCS** list of codes.

Hospitals billing on the Inpatient Hospital Invoice (UB-04CMS-1450) must use the **ICD** list of codes.

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, outpatient 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 (Hospital)

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 (Hospital)

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, if applicable
- 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 (Hospital)

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 NON-RESIDENT ALIENS

Outpatient dialysis services for non-resident 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 out patient dialysis services. Members who have additional services that are not directly related to dialysis services (emergency room visits, planned outpatient hospital service, inpatient admission) must have these additional services authorized by DMAS in order to be reimbursed by DMAS.

The following information has been moved to Appendix D:

- Medicaid In-patient Psychiatric Services Criteria
- In-patient Service Authorization Request Form
- Procedure Codes Requiring Service Authorization by DMAS' Service Authorization Contractor
- Transplant Procedure Codes
- CPT Codes for CAT, PET, MRI scans

Exhibits (Hospital)

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Please use this link to search for DMAS Forms:

https://vamedicaid.dmas.virginia.gov/provider/library