# Covered Services and Limitations (RD)

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Medicaid coverage is secondary to Medicare for the treatment of end-stage renal disease. Supervision of dialysis and kidney transplantation is covered by **Medicaid only when the patient is not eligible for Medicare benefits.** (Medicaid will withhold payment until a determination is made concerning the patient's Medicare eligibility.) If the recipient has Medicare, Medicare must be billed first; Medicaid will be responsible only for coinsurance and deductibles.

Professional staff in the Medicare-certified facility will have responsibility for the management of the treatment program and will determine the appropriate type of services needed; e.g., outpatient, home, or nursing facility treatments.

Dialysis centers enrolled in the Virginia Medicaid Program are responsible for submitting charges for outpatient and home dialysis services.

## Clinical Laboratory Improvement Amendment (CLIA)

Under the Clinical Laboratory Improvement Amendment (CLIA) of 1988, providers must have a CLIA certificate and identification number to bill for laboratory services. To obtain a CLIA certificate or to obtain information about CLIA, send a request to:

Virginia Department of Health Office of
Health Facility Regulation 3600 Centre Ste
216

3600 West Broad Street Richmond,
Virginia 23230

DMAS will deny laboratory claims of providers that bill for services outside of their CLIA type, reason 480 (provider not CLIA certified to perform procedure).

## Vaccines For Children Program

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, childhood

immunizations and annual influenza vaccinations are covered according to the most current Advisory Committee for Immunization Practices (ACIP) schedule.

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

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

**Requirement to Enroll in VFC**

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

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

**Billing Codes for the Administration Fee**

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

**Billing Medicaid as Primary Insurance**

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

**Reimbursement for Children Ages 19 and 20**

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

provided under the VFC Program to this age group.

**VFC Coverage of Other Vaccines**

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

**Vaccines Not Available Under VFC**

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

**Situations Where Vaccines Are Not Covered Under VFC**

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

**Vaccines Provided Outside of the EPSDT Periodicity Schedule**

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. See Supplement B - EPSDT for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid cannot reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

**Questions**

For questions relating specifically to the VFC program, call the Virginia Department of

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

## Non-Covered Services (RD)

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

## Copayments (RD)

Recipients with Special Indicator C on their cards are required to share in the cost of each dialysis treatment. A $1.00 copayment for each treatment must be paid by the recipient to the dialysis center. However, **no copayment** is to be collected for service rendered to recipients under the following conditions:

- An emergency or life-threatening condition exists. If this condition exists, mark an "X" in Locator 24 I (Accidental Injury) on the HCFA-1500 (12-90);
- Any pregnancy-related service;
- Recipient is under 21 years of age;
- Recipient resides in a long-term care facility; or
- Recipient is in a hospice program.

If any of these conditions exist, no copayment will be deducted from the provider's calculated payment.

Services to recipients cannot be denied solely because of their inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.

## Medicare Catastrophic Coverage Act of 1988 (Podiatry)

[Effective Date: January 1989]

The Medicare Catastrophic Act of l988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible only for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE

COINSURANCE AND DEDUCTIBLE." Medicaid does not make payment for any recipient of this group for pharmacy, non-emergency transportation, medical supplies, or any service not covered by Medicare.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

# Client Medical Management Program (RD)

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

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient.

- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.

- For other services covered by DMAS which are excluded from Client Medical Management Program requirements.

Renal dialysis clinics are excluded, which means that restricted recipients are not required to obtain a written referral from the designated primary care physician, and there are no special billing instructions for renal dialysis services. Clinic providers are encouraged, however, to coordinate treatment with the primary care physician whose name appears on the recipient's eligibility card, since other services and medications are monitored routinely by primary care providers.

## Preauthorized Services For Retroactive Eligibility

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.