Psychiatric Services

Last Updated: 09/07/2022

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Psychiatric Services

General Information

Updated: 2/22/2019

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider “HELPLINE” at:

- 804-786-6273 Richmond Area
- 1-800-552-8627 All other areas

Program Background

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical

Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

General Scope of the Program

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.

- Blood glucose monitors and test strips for pregnant women

- Case management services for high-risk pregnant women and children up to age 1

(as defined in the State Plan and subject to certain limitations)

- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
  - Comprehensive health and developmental history
  - Comprehensive, unclothed physical exam
  - Appropriate immunizations according to age and health history
  - Laboratory tests (including blood lead screening)

- Health education

- Home health services

- Eyeglasses for all members younger than 21 years of age according to medical necessity

- Hearing services

- Inpatient psychiatric services for members under age 21

- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels

- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section "transplant services"

- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity

criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response

System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to

promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:

- Mental Health:

- Crisis stabilization
- Mental health support
- Assertive community treatment
- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Partial hospitalization Program
- Intensive Outpatient Program
- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Use Disorder:

- Residential treatment for pregnant and postpartum women
- Day treatment for pregnant and postpartum women
- Crisis Intervention
- Intensive Outpatient
- Day Treatment
- Case Management
- Opioid Treatment

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- "Organ and disease" panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor's prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.

- Papanicolaou smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- Psychiatric Hospitals for the Aged (65 Years and Older)

- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

- Reconstructive surgery - post-mastectomy (1998)

- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

- Renal dialysis clinic services

- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI

Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services

- School-based services

- Services for individuals age 65 and older in institutions for mental diseases

- Specialized nursing facility services

- Speech-language therapy services

- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.

- Telemedicine for selected services.

- Tobacco Cessation screening, counseling and pharmacotherapies.

- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is

allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care
- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered
- Acupuncture
- Artificial insemination or in vitro fertilization
- Autopsy examinations
- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered

- Custodial care

- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)

- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)

- Experimental medical or surgical procedures

- Eyeglass services for members age 21 and over

- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered

- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay

- Items or services covered under a workers' compensation law or other payment sources

- Meals-on-Wheels or similar food service arrangements and domestic housekeeping

services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)
- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school admission or placement
- Routine foot care
- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

- Services determined not to be reasonable and/or medically necessary
- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent
- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners
- Unkept or broken appointments
- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients
- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.

Managed Care Programs

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in

the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS feefor-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at http://www.dmas.virginia.gov, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**

  Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

  To get the free mobile app, search for Virginia Managed Care on the Apple App Store

or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**

Members can visit the enrollment website for the CCC Plus managed care program at https://cccplusva.com/ to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

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. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is https://www.virginiamanagedcare.com/
- **CCC Plus** (http://www.dmas.virginia.gov/#/cccplusinformation See “Medical Provider Update October 2017”)

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient’s age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO’s contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the feefor-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows: o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence

    of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.

    o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.

- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the

provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

<u>FAMIS Covered Services</u>

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

   Assistive technology

   Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

   Intensive in-home services

   Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a

physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

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

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

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

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Client Medical Management (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC

30-130-820. (See the “Exhibits” section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing

Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring

Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member

eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in "Exhibits" at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in "Exhibits" at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

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

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Provider Manual Updates

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Notice of Provider Responsibility

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key

“0” at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential,

pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30 a.m. Thursday

10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance

In state long distance (toll-free) 1-800-552-8627

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)

- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**

  Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)

- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:

- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.

- Future month information is only available in the last week of the current month.

- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.

- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage

- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber's last name and Medical Assistance provider number. If the prescriber is not

active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-fourhour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg

023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

<u>CITIES</u>

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

985. Southeastern State Hospital
986. Northern Virginia Training Center
987. Virginia Treatment Center
988. Northern Virginia Mental Health Institute

990. Central Virginia Training Center
991. Western State Hospital
992. Southwestern State Hospital
993. Piedmont State Hospital
994. Eastern State Hospital

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary.

Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form.

The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider’s *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member’s drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member’s copy of the referral form or by contacting the

PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card.* Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP 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 PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.

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

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);

- Immunizations (member under age 21);

- Family planning services;

- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;

- Dental services (members under age 21);

- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and

- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. 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.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service

methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code

"03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

Provider Participation Requirements (Psych)

Updated: 1/19/2022

The Virginia Medicaid Program covers Psychiatric Services in both inpatient and outpatient settings. This chapter describes provider requirements for Psychiatric Services. All providers of psychiatric services are responsible for adhering to all DMAS policies, this manual, available on the DMAS website portal, their provider contract with the Managed Care Organization (MCOs) and the Behavioral Health

Services Administrator (BHSA), and state and federal regulations.

Managed Care Organizations (Psych)

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted MCOs and their network of providers. All providers must check Medicaid member eligibility (Refer to Chapter 3) prior to rendering services to confirm whether an individual is enrolled in a Medicaid MCO and which particular MCO. To provide psychiatric services to an individual enrolled in a Medicaid MCO, providers need to be credentialed with the MCO that an individual is enrolled in to provide services to that individual.

There are several different managed care programs (Medallion 3.0, Medallion 4.0 (effective 8/1/2018), and Commonwealth Coordinated Care (CCC) Plus, and Program of All-Inclusive Care for the Elderly (PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- http://www.dmas.virginia.gov/#/med3 (Medallion 3.0)
- http://www.dmas.virginia.gov/#/cccplus (CCC Plus) and
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0)
- http://www.dmas.virginia.gov/#/longtermprograms (PACE)

Even if the individual is enrolled with an MCO, some services may continue to be covered by Medicaid Fee-for-Service (FFS). Providers must follow the FFS rules in these instances where services are "carved-out." The carved-out services vary by managed care program. For example, Early Intervention is carved-out of the Medallion 3.0 program and covered by FFS Medicaid but covered by the CCC Plus and the Medallion 4.0 programs. Refer to each program's website for detailed information and the latest updates.

Commonwealth Coordinated Care (CCC) Plus

CCC Plus is a mandatory integrated care initiative for certain qualifying

individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing

Facility (NF) care, or from one of the Department's home and community-based services (HCBS) 1915(c) waivers.

At this time, individuals enrolled in a Medicaid waiver that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) are enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services continue to be covered through the Medicaid FFS program.

Medallion 4.0

Medallion 4.0 is a new Medicaid Managed Care Program effective August 1, 2018. Individuals enrolled in Medallion 3.0 will transition by region into Medallion 4.0. The Medallion 3.0 program will end on December 31, 2018. Several services, including Community Mental Health Rehabilitative Services (CMHRS) and Early Intervention, that were not included in the Medallion 3.0 contract will be included in the Medallion 4.0 contract. Additional information is available on the DMAS website http://www.dmas.virginia.gov/#/med4 and in Medicaid Memos to providers dated January 8, 2018 and June 11, 2018 available on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

PACE

The Program of All-inclusive Care for the Elderly (PACE) was established to help adults ages 55+ who are living with chronic healthcare needs and/or disabilities receive community-based healthcare services and supports. By providing flexibility in how participants' healthcare needs are met, PACE is often able to assist persons meeting functional nursing home level of care to reside within their own homes and communities longer than would have otherwise been possible.

For additional information, visit: http://www.dmas.virginia.gov/#/longtermprograms.

Magellan of Virginia (Psych)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the FFS behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract or who have questions about credentialing/contracting process with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider. Magellan of Virginia works with DMAS to improve access to quality behavioral health services and improve the value of behavioral health services purchased by the Commonwealth. Magellan of Virginia administers a comprehensive care coordination model, which is expected to reduce unnecessary expenditures. Other benefits of the Magellan of Virginia model include:

- Comprehensive care coordination including coordination with Medicaid/FAMIS managed care plans;
- Promotion of more efficient utilization of services;
- Development and monitoring of progress towards outcomes-based quality measures;
- Management of a centralized call center to provide eligibility, benefits, referral and appeal information;
- Provider recruitment, issue resolution, network management, and training;
- Service authorization;
- Member outreach, education and issue resolution; and
- Claims processing and reimbursement of behavioral health services that

are currently carved out of Medicaid/FAMIS managed care.

Magellan of Virginia is responsible for enrollment and credentialing of FFS behavioral health providers based upon DMAS regulatory requirements.

Magellan of Virginia Call Center has a centralized contact number **(1-800-424-4046**) for Medicaid/FAMIS members and providers. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff include bilingual/multi-cultural representatives who speak English and Spanish. Interpreter services, TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1- 800-424-4048.

All calls related to the fee for service behavioral health services should go to Magellan of Virginia Call Center. Magellan of Virginia staff are available to assist callers with:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,
- claims resolution, and
- grievances and complaints.

Enrolled providers are encouraged to integrate Magellan of Virginia's requirements and procedures into their day-to-day operations as a Medicaid provider.

Verifying Eligibility

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility and MCO enrollment. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Recovery and Resiliency (Psych)

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations (https://www.samhsa.gov/recovery).

A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members. Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

A recovery focus is also a preventive approach that simultaneously supports building resiliency, wellness, measureable recovery and quality of life.

Cultural and Linguistic Competency (Psych)

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

Participation Requirements (Psych)

To be a network provider of behavioral health services in the Virginia Medicaid/FAMIS programs, providers must be credentialed and enrolled according to DMAS standards with the BHSA and/or a Medicaid MCO. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the BHSA and/or a Medicaid MCO prior to rendering services.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership. Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to DMAS or its contractor.

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

For any additional questions about FFS credentialing and contracting with Magellan of Virginia, providers may contact a Magellan of Virginia Provider Network Coordinator at 1- 800-424-4536, or send an email to VAProviderQuestions@MagellanHealth.com. For additional questions about contracting with a Medicaid MCO, providers should contact the MCO directly. Medicaid Managed Care information is available under “Managed Care Benefits” at http://www.dmas.virginia.gov/#/index.

Provider Qualifications (Psych)

Inpatient Hospital

All individuals enrolled in Medicaid may receive inpatient psychiatric care in a psychiatric unit located within an acute care hospital. Individuals over the age

of 65 may also receive services in a freestanding psychiatric hospital. Individuals under the age of 21 may also receive psychiatric services in a freestanding psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also meet state licensure requirements.

Services Provided Under Arrangement

The inpatient psychiatric services benefit shall include services provided under arrangement when furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral. See the chart below for services provided under arrangement with the treating facility that may be billed separately from the per diem for each provider type, provided that the requirements discussed in this section are met. No other services may be billed separately from the inpatient psychiatric per diem for members under age 21 residing in a psychiatric unit located within an acute care hospital or a freestanding psychiatric hospital.

Services Provided Under Arrangement	**Private Freestanding Psychiatric Hospitals and Psychiatric Units located within Acute Care Hospitals**	**State Freestanding Psychiatric Hospitals**
Physician Services	Yes	No

Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	No

Outpatient Hospital Services	Yes	No
Pharmacy services	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	No
Laboratory and radiology services	Yes	No
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	No	No
Vision services	Yes	No
Dental and orthodontic services	Yes	No
Non-Emergency Transportation services	Yes	No

Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes

In order for DMAS to reimburse these services separately from the per-diem rate paid to providers of inpatient psychiatric services, the Centers for Medicare and Medicaid Services (CMS) requires that the provider:

1. arrange for and oversee the provision of all services;
2. maintain all medical records of services provided under arrangement furnished to the member while receiving inpatient psychiatric services;
3. ensure that each member receiving inpatient psychiatric services has a comprehensive plan of care that includes services provided under arrangement; and
4. ensure that all services, including services provided under arrangement, are furnished under the direction of a physician.

If these requirements are not met, DMAS or its contractor will not reimburse for these services and providers may not charge members directly. These requirements apply to both in-state providers and out-of-state providers. These requirements also apply across all contractors who administer claims on behalf of DMAS and reimburse for inpatient psychiatric services.

Requirements for Direct Reimbursement to Providers of Services Provided Under Arrangement

DMAS or its contractors will reimburse services provided under arrangement separately from the per-diem rate paid to inpatient psychiatric provider only if the provider meets all of the following requirements:

1. As required by regulations (42 CFR 441.155; 42 CFR 456.180; and 12 VAC 30-50-130), each initial and comprehensive plan of care must be specific to meet each child’s medical, psychological, social, behavioral and developmental needs.

   Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in the inpatient psychiatric setting, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed

by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement.

2. Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.
3. Each provider must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record. The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. The prescribing provider must be employed or have a contract with the facility. Referrals must be documented when the provider has accepted the referral. A referral should not be documented when the provider does not accept the referral.
4. Providers of services under arrangement must either be employees of the inpatient psychiatric provider or, if they are not employees of the inpatient psychiatric provider, they must have a fully executed contract with the inpatient psychiatric provider prior to the provision of the service, with the exception of emergency services. For emergency services, the contract must be executed before the provider of emergency services bills DMAS for the emergency services.

   The contract must include the following:

   a. if the provider of services under arrangement accepts a referral, it agrees to include the NPI of the referring inpatient psychiatric provider on its claim for payment; and

   b. the provider of services under arrangement agrees to provide medical records related to the member residing in the inpatient psychiatric provider upon request by the inpatient psychiatric provider.

   A fully executed contract requires that a representative of the inpatient psychiatric provider and a representative of the provider of services under arrangement signs the contract and includes their name, title, and date. A letter of understanding or letter of agreement will meet the requirement for a contract, provided that both the inpatient psychiatric provider and provider of services under arrangement sign and date the letter.

5. Each inpatient psychiatric provider must maintain medical records from the provider of services under arrangement in the individual's medical record at the facility. These may include admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings. These records must be requested in writing by the inpatient psychiatric provider within seven (7) calendar days of discharge from or completion of the service provided under arrangement. If the records are not received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested or DMAS or its contractor may retract the per diem reimbursement made to the IPF on behalf of a member during the period of non- compliance.

If there is the potential for retroactive Medicaid eligibility, the inpatient psychiatric provider should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed.

The provider must follow special billing instructions described in Chapter V.

The requirements above are in addition to all other existing requirements for services. For example, providers of services under arrangement must still obtain service authorization for services that otherwise require service authorization.

Special Instructions for Dental, Pharmacy, Emergency Services, Non-Emergency Transportation and Inpatient Acute Care Services

Dental services for Medicaid members are provided through Smiles for Children and are reimbursed by the Department's Dental Benefits Administrator (DBA), DentaQuest. Inpatient psychiatric providers that currently arrange for dental services should continue to do so based on the member's Plan of Care. Inpatient psychiatric providers must have a contract with a Smiles for Children participating dentist and must provide a referral to that dentist's office when the appointment is made for one of their residents/patients. The inpatient psychiatric provider shall provide the name of its contracted dentist to the Department or DentaQuest upon request.

Pharmacies must have a contract with the inpatient psychiatric provider. DMAS will use the prescribing NPI as the referral NPI. The prescription can serve as the referral document. The prescribing provider must be an employee or contractor of the inpatient psychiatric provider.

Inpatient psychiatric providers should include emergency services in the plan of care and contract in advance with the usual providers of emergency services. If the inpatient psychiatric provider uses a non-contracted provider for emergency services, the inpatient psychiatric provider may contract with the emergency

services provider after the fact. The emergency services provider must have a contract in place with the inpatient psychiatric provider provider prior to billing DMAS. A referral is required for emergency services, and the emergency services provider must include the NPI of the IPF in the referring provider locator on the claim for payment.

Some providers are affiliated with hospitals but provide outpatient services as a separate billable item from the hospital charge (such as radiologists, pathologists, anesthesiologists, etc.). The acute-care hospital shall be responsible for providing the referral NPI of the inpatient psychiatric provider to these “hidden” providers. These “hidden” providers must be addressed in the contract between the inpatient psychiatric provider and the hospital that provides the emergency services.

Inpatient psychiatric providers that use the Fee for Service (FFS) Non-Emergency Medical Transportation (NEMT) broker for medical transportation must have a contract with the FFS NEMT broker which allows non-emergency transportation to be provided as a service provided under arrangement. When the member receiving inpatient psychiatric services needs transportation, the IPF should contact the FFS NEMT broker reservation number (866-386- 8331) or use the FFS NEMT broker online request system https://transportation.dmas.virginia.gov in order to arrange transportation services prior to the date transportation is required. Please make the members FFS NEMT reservations five business days in advance. This request for transportation will be considered the “referral”. Inpatient psychiatric providers enrolled with the FFS NEMT broker must 1) inform the FFS NEMT broker that they are an inpatient psychiatric provider; and 2) provide the transportation contractor with the inpatient psychiatric provider name and if needed the NPI number to use as an assigned provider. The inpatient psychiatric provider’s NPI will be used by the broker on the transportation encounter that is submitted to DMAS.

Inpatient admissions to acute care hospitals for treatment of acute care conditions do not require a referral or arrangement from the inpatient psychiatric provider. However, the inpatient psychiatric provider must report all patient discharges from their facility to Magellan or the MCO within one business day. Failure to notify Magellan or the MCO will result in any claims associated with the inpatient acute care stay being denied.

If the inpatient psychiatric provider fails to comply with any one of the requirements listed above, DMAS or its contractor may retract the per diem reimbursement made to the inpatient psychiatric provider on behalf of a member during the period of non-compliance.

An inpatient psychiatric provider may arrange for services for members with providers who are not enrolled with DMAS. As long as these services are included in the plan of care, the inpatient psychiatric provider is in compliance. The inpatient psychiatric provider should not arrange for services with a DMAS enrolled provider without either an employee relationship or an executed contract as this could result in a retraction to the per diem during an audit.

For information on services provided under arrangement to individuals under the age of 21 in Psychiatric Residential Treatment Facilities (PRTFs), please refer to the Residential Treatment Services Manual.

Additional information related to billing for services under arrangement is located in Chapter V of this manual.

Psychiatric Residential Treatment

As of June 30, 2017, Psychiatric Residential Treatment Facility services are defined in the Residential Treatment Services manual.

Treatment Foster Care Case Management

As of August 1, 2018, Treatment Foster Care Case Management services are defined in the Community Mental Health Rehabilitative Services Manual.

Enrolled Psychiatric Services Providers

Only facilities, licensed individuals, Mental Health Clinics, Federally Qualified Health Centers, and Rural Health Clinics enrolled as Medicaid providers may bill Virginia Medicaid for outpatient psychiatric services.

Community Services Boards (CSBs) can provide outpatient psychiatric services where qualifying providers bill under the facility NPI and are not required to operate under the physician-directed model for all services. CSBs can also bill as a mental health clinic for physician-directed services.

Provider Qualifications for Outpatient Psychiatric Services

Outpatient psychiatric services includes an array of therapeutic services designed to provide necessary support and address mental health and behavioral needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

Outpatient psychiatric services may be provided by:

- "Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.
- "LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.
- "LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20- 65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.
- "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

Providers should consult with the Medicaid MCOs to determine if they recognize unlicensed providers (LMHP-R/RP/S) in outpatient psychiatric settings prior to providing services.

Direct Supervision of Residents and Supervisees

When plans of care and psychotherapy or counseling services are provided by a LMHP-R, LMHP-RP or LMHP-S, to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a LMHP-R, LMHP-RP or LMHP-S must be provided under the direct, personal supervision of a licensed, qualified, Medicaid enrolled provider.
- The therapy session must contain at a minimum the dated signature of the LMHP-R,

  LMHP-RP or LMHP-S rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.

- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

Physician Requirement for Mental Health Clinics

This section only applies to providers enrolled with Medicaid as a Mental Health Clinic provider type. Code of Federal Regulations (CFR) §42.440.90 define clinic services as: "Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

a. Services furnished at the clinic by or under the direction of a physician or dentist.
b. Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address."

Federal law requires that each mental health clinic be physician-directed.

"As stipulated by section 1905 (a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic must

spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement."

The requirement for physician supervision of all patient care in the clinic is a condition of participation with Medicaid and as a mental health clinic. The patient care protocols for treatment of individuals enrolled with Medicaid must reflect the role of the physician, and the patient's medical records must document that the physician has ordered the plan of care and is periodically reviewing the need for continued care. This requirement must be met for all clinic services billed to Medicaid by any employee of the mental health clinic.

Adverse Outcomes (Psych)

Providers must notify Magellan of Virginia or the appropriate MCO of member adverse outcomes within one business day following knowledge of the incident. Adverse outcomes are defined as: death; suicide or serious suicide attempt; an incident of violence initiated by the individual; or other incidents resulting in serious harm to the individual or others that includes but is not limited to serious complication from a psychotropic medication regimen that required medical intervention.

Providers must follow notification or reporting processes required by applicable Local, State and Federal regulatory bodies or contracts with the MCOs and BHSA.

Freedom of Choice (Psych)

The individual has the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services or its contractor.

Out-of-State Facilities (Psych)

Inpatient Psychiatric facilities, including psychiatric units within an acute care hospital and freestanding psychiatric hospitals, that are out of state must be enrolled with DMAS or its contractor. Out of state providers must follow the requirements of both this manual, *Psychiatric Services* and of the *Hospital* Provider Manual regarding acute care hospitals providing inpatient psychiatric services.

Freestanding psychiatric hospitals and psychiatric units within an acute care hospital located out of state must abide by the *Psychiatric Services* manual.

Specific Information for Out-of-State Providers (Psych)

Out of state providers are held to the same service authorization processing rules as in-state providers and must be enrolled with DMAS or its contractor prior to submitting a request for out of state services for an individual.

For FFS, if the provider is not enrolled as a participating provider, the provider is encouraged to submit the request to Magellan of Virginia as timeliness of the request will be considered in the review process. Magellan of Virginia will complete the service authorization review and will request the completion of enrollment documentation. If Magellan of Virginia receives the information in response to the provider's enrollment, the request will be completed and the provider will be informed of the status of their enrollment to serve the individual member. If Magellan of Virginia does not receive the information to complete the processing of enrollment within 12 business days, Magellan of Virginia will reject the service authorization request and will not enroll the provider. It may take up to 10 business days to become a participating provider that is only serving a specific individual during the duration of admission.

For individuals enrolled in a Medicaid MCO, the provider should contact the MCO for information.

Out-of-State Provider Requests

Authorization requests for certain services may be submitted by out-of-state providers of freestanding psychiatric hospitals and psychiatric units within an acute care hospital. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in the Commonwealth of Virginia because of the indications below. This requirement is for services authorization requests that are only submitted to the BHSA.

Effective March 1, 2013 out of state providers are to determine and document evidence that one of the following items is met at the time the service authorization request is submitted to the service authorization contractor:

1. The medical services must be needed because of a medical emergency.
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

Services provided out of state for circumstances other than these specified reasons shall not be covered. Please refer to 12VAC30-10-120 and 42 CFR 431.52.

Should the provider not respond or is not able to establish items 1 through 4, the request can be administratively denied. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Provider Screening Requirements

All providers must undergo a federally mandated comprehensive screening as part of their enrollment process. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate" or "high".

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation. This includes when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice. Please refer to the table at the end of this chapter for more information on provider types that may be charged an application fee.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination must be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers with a primary servicing address located outside of the Virginia border and, due to their provider risk-level, require a site visit, must have a site visit conducted by either their state's Medicaid program or by CMS prior to enrollment in DMAS. If the application is received by DMAS prior to the completion of the site visit, as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E), the application will be pended for proof this information.

Revalidation Requirements (Psych)

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, the BHSA or DMAS.

Providers will receive written instructions from the MCOs, the BHSA or DMAS

regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 42 CFR 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

Participation Requirements (Psych)

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Psychiatric Services providers approved for participation in the MCOs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify DMAS, the MCOs, and the BHSA in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify DMAS, the MCOs, and the BHSA prior to the change and include the effective date of the change;
- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS, the MCOs, and the BHSA require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

- Use the MCOs, BHSA and DMAS designated methods for submission of charges;

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge the MCOs, BHSA and DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission, any period of private pay or

a deposit from the individual or any other party;

- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency". The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example, if a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge the MCOs, BHSA, DMAS or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for dual eligible Medicaid enrolled individuals;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;

- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable federal and state laws, whichever period is longer. Providers who are contracted with managed care organizations must follow their contract requirements for record retention. However, if an audit is initiated within the required

retention period, the records must be retained until the audit is completed and every exception resolved;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members;

- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public;

- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients; and

- Providers must comply with the Code of Virginia (§ 54.1-2400.4) mandate to inform their clients of the right to report misconduct to the Department of Health Professions.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity

for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

Utilization of Insurance Benefits

Virginia Medicaid is a "last pay" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. If an eligible individual is treated as the result of an accident, DMAS should be notified promptly so action can be initiated to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Virginia Medical Assistance Program, 600 East Broad Street, Richmond, Virginia 23219.

Assignment of Benefits (Psych)

If an individual enrolled in the Virginia Medical Assistance Program is the holder of an insurance policy which assigns benefits directly to the individual, the facility and/or provider must require that benefits be assigned to the facility or refuse the request for the itemized bill that is necessary for the collection of the benefits.

Use of Rubber Stamps For Physician Documentation (MHS)

For Medicaid purposes, a required physician signature may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric services.

Fraud

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or item of value for services rendered or supposedly rendered to recipients under Medicaid. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Further information on submission of fraudulent claims may be found in Chapter V of this manual.

Termination of Provider Participation (Psych)

DMAS, or the BHSA may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS or the BHSA for services provided to customers subsequent to the date specified in the termination notice. The MCOs have different rules for terminating providers and shall adhere to the contract rules regarding notification.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the all contracted MCOs, the BHSA, the DMAS Director and the DMAS Fiscal Agent – Provider Enrollment Services (PES) 30 days prior to the effective date. The addresses for the DMAS Director and the DMAS Fiscal Agent are:

Director

Department of Medical Assistance
Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid
–PES

PO Box 26803

Richmond, Virginia 23261-6803

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a BHSA/Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325 (D) and (E). The provider may appeal the decision in accordance with the Administrative Process Act (APA) (Virginia Code §2.2-4000 et seq.), the State Plan for Medical Assistance provided for in § 32.1-325 et seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial. This only applies to provider contracts with DMAS for fee-for-service or the BHSA. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

Termination of Provider Participation Upon Conviction of a Felony (Psych)

Section 32.1-325 (D) 2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS , the MCOs, or the BHSA of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law. Providers must also adhere to their contract requirements with the individual MCO.

Provider Reconsideration of Adverse Actions

Service providers seeking to contest an adverse action issued by the MCO or BHSA must follow the MCO's or BHSA's policies and procedures for requesting reconsideration. For information regarding the reconsideration process, providers should consult their agreement with the MCOs or the BHSA. The provider's exhaustion of the BHSA's reconsideration process is a mandatory pre-requisite to filing an appeal with DMAS.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42

C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

   a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

   b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal

request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:

    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;

    - Email to appeals@dmas.virginia.gov; or

    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in

the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals

For client appeals information, see Chapter III of the Provider Manual.

Member Appeals (MCO)

Members or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted or deemed exhausted, due to the failure of the MCO to adhere to the notice and timing requirements, prior to a member filing an appeal with the DMAS Appeals Division.

Any member or member's authorized representative wishing to appeal an adverse

benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. If the member does not request an expedited appeal pursuant to 42 CFR § 438.410, the member shall follow an oral appeal with a written, signed appeal. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. If sent by mail, the appeal request should be mailed to:

DMAS Appeals Division

600 East Broad Street

Richmond, VA 23219

The Department's final administrative appeal decision may be appealed to the

appropriate circuit court by the member accordance with the Administrative Process Act at Virginia Code § 2.2-4025, *et seq*. and the Rules of Court.

Member Appeals (FFS)

Individuals (clients) receiving services through the BHSA may file an appeal directly with DMAS. Providers under contract with the BHSA seeking to file an appeal on behalf of their client should consult their contract with Magellan the Magellan National Provider handbook, the Magellan Virginia Provider handbook, or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@Magellanealth.com or visit the provider website at https://www.magellanofvirginia.com/for-providers/.

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the BHSA's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The BHSA will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the BHSA may not terminate or reduce services until a decision is rendered by the hearing officer.

An appeal may be requested by mail, telephone, email, in person, and through commonly available electronic means within 30 days of receipt of the notice of adverse action. If desired, the client or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at

www.dmas.virginia.gov or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

A written appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street 6th Floor

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N

Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate –Revalidating High – Newly enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating High – Newly enrolling	Y
Home Health Agency - Private Owned	Moderate –Revalidating High – Newly enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating High – Newly enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer’s Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y

Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate –Revalidating High – Newly enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Limited - all others Moderate -- Community Mental Health Centers	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

Member Eligibility

Updated: 2/22/2019

Determining Eligibility

The Department of Medical Assistance Services (DMAS) administers Virginia’s medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant’s eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member’s eligibility must be reviewed when a change in the member’s circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet.

Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as "spenddown," Medicaid provides a limited period of full coverage for

certain groups of "Medically Needy" individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for noninstitutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form (#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See “Exhibits” at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual’s eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person., An married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse’s monthly income may also be allocated to the community spouse if certain criteria are met. Atthe time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patent pay responsibility.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children’s Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

 Assistive technology

 Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

 Intensive in-home services

 Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services

- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Member Eligibility Card

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under “Exhibits” at the end of this chapter.

<u>Eligibility must be confirmed each time service is rendered.</u> Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier
The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person
An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member.

Member's Eligibility Number
The member's complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a “key” in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth
The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex
The member's gender is indicated on the card.

Card #
The sequential number of the member’s card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date

02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic “swipe” mechanism.

Cardholder’s Signature (signature line on back)
The signature line provides another element of verification to confirm identity

Verification of Member Eligibility

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. The member does not relinquish the card when coverage is cancelled. Replacement cards must be requested.

Program/Benefit Package Information

Members’ benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-forservices, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit 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’s Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group’s Medicaid verification provides the message, “PLAN FIRST - FAMILY PLANNING SERVICES ONLY.” See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.
- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

The FAMIS member co-pays are:

Service*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Insurance Information The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department’s managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/#/med3
- Medallion 4.0:

http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus): ttp://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/#/longtermprograms

Member Without an Eligibility Card

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

Medicaid Applications -- Authorized Representative Policy

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant’s situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant’s legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant’s behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated “his/her mark” and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian,

or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. <u>Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.</u>

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. <u>Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.</u>

Non-Medicaid Patient Relationship

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

Newborn Infant Eligibility

All newborn days, including claims for “well babies,” must be submitted separately. “Well baby” days cannot be processed as part of the mother’s per diem, and no information related to the newborn must appear on the mother’s claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn’s mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child’s birth.

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link “E213”. Any hospital staff that have approval from their hospital and have access to the portal may report the newborn’s birth and receive the newborn’s Member ID within 2 business days via email. The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I: General Information for more information on eligibility verification.

Medicaid Eligibility for Hospice Services

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

Guidelines on Institutional Status

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and

- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and postdisposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- Juvenile who is in a detention center due to criminal activity
- Juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center. A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- The individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
  - individuals admitted under a TDO
  - individuals arrested then admitted to a medical facility
  - inmates out on bail
  - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
  - juveniles in a detention center due to care, protection or in their best interest.

Member Appeals

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized

representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person’s date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer’s decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer’s decision, he/she may appeal it directly to the circuit court in the city or county of residence.

Covered Services and Limitations (Psych)

Updated: 7/27/2021

The Virginia Medicaid Program covers a variety of psychiatric services under the Addiction and Recovery Treatment Services (ARTS), Community Mental Health Rehabilitation Services (CMHRS) and Psychiatric Services benefits for eligible members.. This chapter describes the requirements for the provision of Inpatient and Outpatient Psychiatric Services, including Mental Health Clinic Services.

All providers of psychiatric services are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the Managed Care Organizations (MCOs) and the Behavioral Health Services Administrator (BHSA), all DMAS policies and state and federal regulations.

Behavioral Health Services Administrator (Psych)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the Fee for Service (FFS) behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; perform utilization management of services; and, provide care coordination for members receiving Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan. DMAS shall retain authority for and oversight of Magellan entity or entities.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at: www.magellanprovider.com.

Medicaid Managed Care Organizations (Psych)

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS)

CCC Plus is a managed long-term services and supports (MLTSS) program. This mandatory

Medicaid MCO program serves individuals with disabilities and complex care needs.
Target Population:

1. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible).
2. Individuals who receive Medicaid services in a facility or through the CCC Plus Waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence Waivers, known as the Developmental

Disabilities (DD) Waiver, enroll for their non-waiver services only. At this time, DD Waiver services continue to be covered through Medicaid FFS.

3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups.

Additional information about the CCC Plus Program can be found at: http://www.dmas.virginia.gov/#/cccplus.

MEDALLION 3.0

Medallion 3.0 is a statewide mandatory Medicaid MCO program for Medicaid and FAMIS members. The Medallion 3.0 MCOs serve primarily children, pregnant women and adults who are not enrolled in Medicare. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver. The Medallion 3.0 program will end on December 31, 2018.

Additional information about the Medicaid MCO Medallion 3.0 program can be found at http://www.dmas.virginia.gov/#/med3.

MEDALLION 4.0

Medallion 4.0 is a new Medicaid MCO program effective August 1, 2018. Individuals enrolled in Medallion 3.0 MCOs will transition by region into Medallion 4.0 MCOs. Several services, including Community Mental Health Rehabilitative Services (CMHRS) and Early Intervention, that were not included in the Medallion 3.0 contract will be included in the Medallion 4.0 contract. Additional information is available on the DMAS website at http://www.dmas.virginia.gov/#/med4 and in Medicaid Memos to providers dated January 8, 2018 and June 11, 2018 available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

For MCO members, most Medicaid services are provided through the member's MCO.. Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Certain services, however, are carved out of managed care and will continue to be obtained through FFS (such as Dental Services, School Based Health Services and Residential Treatment Services). A complete list of carved out services are located in the MCO contracts posted online under Managed Care Benefits at: http://www.dmas.virginia.gov/#/index .

Transportation (Psych)

Non-emergency transportation for the individual receiving services to medical appointments, including psychiatric appointments, must be authorized by and billed to the Medicaid transportation broker or the member's assigned MCO broker and is not included as part of the psychiatric service. Individual providers and agencies, with the exception of state psychiatric hospitals, may seek mileage reimbursement through the transportation broker for services under which transportation is not covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

The current FFS transportation broker is LogistiCare and can be contacted at https://member.logisticare.com or by calling the LogistiCare reservation line at 1-866-386-8331 in order to arrange transportation services and complete forms for gas reimbursement. For more information regarding time frames for making reservations please refer to the LogistiCare website (www.logisticare.com). Individuals enrolled in an MCO must contact the individual's MCO broker directly in order to arrange transportation. Additional transportation information for individuals enrolled in managed care can be found by clicking on the "Managed Care Benefits" link on the DMAS website, http://www.dmas.virginia.gov/#/index.

Psychiatric Services Medical Records Requirements

For information on medical record requirements, please refer to Chapter VI of this manual.

Inpatient Psychiatric Services (Acute Care Hospital & Freestanding Psychiatric Hospital) (Psych)

DEFINITIONS

- "Active Treatment" means implementation of a professionally developed and supervised individual Plan of Care.
- "Ambulatory Care" means services provided in the individual's home community, which may include but is not limited to: outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- "Licensed Mental Health Professional" or "LMHP" is as defined in 12VAC35-105-20 in addition to a licensed psychiatric/mental health nurse practitioner.

PSYCHIATRIC CARE IN ACUTE CARE HOSPITALS

Inpatient Acute Psychiatric services are available to individuals of all ages in psychiatric units of general acute care hospitals. Inpatient care is a covered service under the Medicaid program if it is reasonable and medically necessary for 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. Refer to the Hospital Provider Manual, Chapter IV, for specific, additional requirements for acute care facilities.

All medical necessity decisions about proposed admission and/or treatment for members in the FFS benefit are made by the LMHP/Care Manager with Magellan of Virginia after receiving a sufficient description of the current clinical features of the individual's condition that have been gathered from a face-to-face evaluation of the individual by a qualified LMHP. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual's socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. The Magellan of Virginia medical necessity criteria is posted online at: https://www.magellanofvirginia.com/for-providers/provider- tools/magellan-medical-necessity-criteria/. In instances when Magellan of Virginia recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan of Virginia will support the individual through extra-contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual's essential needs for safe and effective treatment. See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia.

For members enrolled in a Medicaid MCO, providers must adhere to the MCO's requirements for service authorization. As provided in 42 CFR § 438.210 (a)(5)(i), the MCO's medical necessity criteria shall not be more restrictive than the Department's criteria. Contact the member's MCO for specific service authorization information.

SERVICE REQUIREMENTS

Intensity of Treatment Required

1. The active plan of care must relate to the admission diagnosis and reflect the need for:

a. At least one of the following:

1. Physical restraint/seclusion/isolation; or
2. Suicidal/homicidal precautions; or
3. Escape precautions; or
4. Drug therapy (any route) requiring specific close medical supervision; and

b. All of the following:

1. A LMHP provides individual/group or family therapy on at least five out of seven days, in addition to the therapy session, at least one appropriate treatment intervention occurs on the same five out of seven days. No more than one individual therapy session per day is billable, and there is a maximum of ten individuals per group therapy session. On days when there is no individual, group, or family therapy, there must be at least two appropriate treatment interventions. Treatment interventions may include, but are not limited to psychoeducational groups, socialization groups, behavioral interventions, play/art/music therapy, and occupational therapy. Therapeutic treatment interventions may be facilitated by nurses, social workers, psychologists, mental health workers, occupational therapists, and other appropriately prepared hospital staff; and
2. The family, caretaker, or case manager is involved on an ongoing basis with treatment planning and family members participates in family therapy at a minimum of once per week unless documentation demonstrates, based on the plan of care, why it is not feasible and addresses alternative involvement in therapy; and
3. Active treatment and discharge planning begin at admission.

2. Medical record documentation must include all of the following:

a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; and

b. Continued necessity for skilled observation, structured intervention, and support that can only be provided at the hospital level of care; and

c. Concurrent documentation of therapeutic interventions (billable psychotherapy and non- billable interventions that meet the weekly requirement) as provided, including individual treatment, according to the plan of care, specific to hours and number of days provided, topics covered, and response to the therapy; and

d. Dated signatures of qualified providers; and

e. All medical documentation must also include the time the notations are made; and

f. If the minimum treatment outlined above is not provided, document why the individual was unable to participate.

3. Therapeutic Passes:

a. One therapeutic day pass is allowed if the goals of the day pass are documented prior to the day pass and if, on return, the effect of the day pass is documented. If the first day pass is determined not to have reached the goals and indications exist, a second day pass may be permitted. Day passes, which are not a part of the written plan of treatment or documented as to expected and experienced therapeutic effect, are not permitted.

b. Overnight passes are not permitted.

4. Expected Outcome/Discharge - Continued hospital level-of-care is not appropriate and will not be covered when a lower level of care is appropriate to meet the individual's treatment needs.

FREESTANDING PSYCHIATRIC HOSPITALS

AGES 21-64 LIMITATION (INSTITUTION FOR MENTAL DISEASES (IMD) EXCLUSION)

Services for individuals, ages 21 to 64, are not reimbursable by Medicaid FFS in an IMD. "Institution for Mental Diseases" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an IMD.

This exclusion does not apply to individuals enrolled in Medicaid MCOs. Contact the individual's MCO for additional information.

CERTIFICATION OF NEED FOR CARE IN FREESTANDING PSYCHIATRIC HOSPITALS

The criteria for Medicaid reimbursement for freestanding inpatient psychiatric services has been established based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335 et seq and §§ 37.2-809 of the Code of Virginia. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital must be certified as requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

A physician must certify for each individual that inpatient services in a freestanding psychiatric hospital are needed. The certification must be made within four hours of admission . If an individual applies for Medicaid assistance while in a freestanding psychiatric hospital, and becomes eligible for Medicaid during the hospitalization, the physician must certify the need for inpatient services before Medicaid or its contractor authorizes payment. Federal regulations (42 CFR §441.152) require certification by an independent team that inpatient psychiatric services are needed for any individual applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility. The certification must be current, within 30 days prior to placement. The independent team (42 CFR §441.153): includes a physician; who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and; has knowledge of the individual's situation. The team must sign the Certificate of Need/DMAS 370 form (See the "Exhibits" section at the end of Chapter IV for a sample form). The

justification for certification must be individual-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

According to 42 CFR §441.152, a Medicaid-reimbursed admission to a freestanding psychiatric facility can only occur if the independent team can certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the individual;
2. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification of need for freestanding psychiatric hospital admission must be documented on the Virginia Preadmission Screening Report, or similar form, which must be signed and dated by the screener and the physician (http://www.dbhds.virginia.gov/behavioral-health/mental- health-services/protocols-and-procedures). It is not sufficient to merely check on the Virginia Preadmission Screening Report that each of the above Certification-of-Need criteria has been met. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

Any available medical, social, and psychiatric evaluations must be submitted with the Certification of Need to the freestanding inpatient psychiatric hospital. The Certification of Need must be completed and dated prior to admission and the request for authorization.

For individuals younger than 21 years of age, the need for inpatient psychiatric services should be identified as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening. For emergency acute care admissions, federal regulation (42CFR §441.153) allows up to 14 days for the team responsible for the Plan of Care in the facility to certify the admission. The certification must meet the criteria listed above. The team must meet the criteria for the treatment team (42CFR §441.156) listed in this chapter under the Comprehensive Individual Plan of Care (CIPOC) section. An emergency acute care admission is defined as a psychiatric hospitalization that is required, because the individual is a danger to himself or others or when the individual is incapable of developmentally appropriate self-care due to a mental health problem. The admission follows a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

For individuals who apply and become eligible for Medicaid while inpatient in the facility or program, the certification shall be made by the team responsible for the CIPOC and

certification of need, within 14 days from admission. The certification shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. The facility will not receive DMAS reimbursement approval until the certification of need is received by DMAS or its contractor.

A physician, physician's assistant, or nurse practitioner, acting within the scope of practice and under the supervision of a physician, must recertify for each individual that inpatient psychiatric services are needed. This recertification must be made at least every 60 calendar days that an individual continues to require inpatient psychiatric services per 12VAC30-60-25. For members enrolled in managed care, the provider shall consult with the specific MCO for certification and recertification requirements.

MEDICAL, PSYCHIATRIC, SOCIAL EVALUATIONS, AND ADMISSION REVIEW - FREESTANDING PSYCHIATRIC HOSPITALS

Prior to admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each individual's need for care in the hospital. In addition, appropriate professional personnel must make a psychiatric and social evaluation. Each medical evaluation must include:

1. Diagnoses;
2. Summary of present medical findings;
3. Medical history;
4. Mental and physical functional capacity;
5. Prognosis; and
6. A recommendation by a physician concerning admission to the freestanding psychiatric hospital or continued care in the hospital for individuals who apply for Medicaid while in the freestanding psychiatric hospital.

INITIAL PLAN OF CARE - FREESTANDING PSYCHIATRIC HOSPITALS

In accordance with federal requirements (42 CFR § 441.155), prior to admission to a freestanding psychiatric facility or before authorization for payment, the attending physician or staff physician must establish a written Plan of Care for each individual. The Plan of Care must include:

- The diagnosis, symptoms, and complaints indicating the need for admission;
- A description of the functional level of the individual;
- Individual-specific treatment objectives with short- and long-term goals;
- Orders for medications, treatments, therapies, etc.;
- Plans for continuing care, including review of the Plan of Care;
- Prognosis; and
- Discharge plans.

The attending or staff physician and other personnel involved in the individual's care must review each Plan of Care at least every 30 calendar days per 42 CFR § 441.156.

Development of the Comprehensive Individual Plan of Care (CIPOC) (Psych)

The Comprehensive Individual Plan of Care (CIPOC) is an individualized written plan of active treatment, designed to achieve the individual's discharge from inpatient psychiatric services at the earliest possible time.. In accordance with 42 CFR §441.154, the CIPOC must be developed and implemented no later than 14 calendar days after admission to a freestanding psychiatric hospital and must include the dated signatures of the team members specified in the federal requirements (42 CFR §441.156). The CIPOC must be developed by a team of professionals in consultation with the individual and the individual's parents, legal guardians, or others in whose care the individual will be released after discharge. In accordance with federal requirements (42 CFR § 441.156), the team must include one of the following:

- A Board-eligible or Board-certified psychiatrist; or
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases; and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

The team must also include one of the following:

- A psychiatric social worker; or
- A registered nurse with specialized training, or one year's experience, in treating individuals with mental illness; or
- An occupational therapist who is licensed, if required by the state, and who has specialized training, or one year of experience, in treating individuals with mental illness; or

- A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

The CIPOC must be completed before requesting continued stay. The CIPOC must meet the following requirements as set forth in 42 CFR § 441.155:

- Be based on diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care;
- Be developed by a team of professionals in consultation with the individual, and the individual's parents, legal guardians, or others in whose care the individual will be released after discharge;
- State individual-specific psychiatric treatment objectives that must include measurable short- and long-term goals with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to the meet the stated objectives; and
- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to achieve the individuals' discharge from inpatient status at the earliest possible time and ensure continuity of care with the individual's family, school, and community upon discharge.

The CIPOC must include the dated signatures of the professionals designated in 42 CFR

§441.156, including the physician, and will be effective at the time of the last dated signature.

In addition, each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in a psychiatric facility, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

See the "Exhibits" section at the end of Chapter IV for a sample form. The sample form is not required to be used as shown, but the CIPOC must, at a minimum, include all elements of the sample.

The diagnostic evaluation upon which the CIPOC is developed may include medical, social, and psychological evaluations that were completed prior to the individual's admission to the freestanding psychiatric hospital and submitted with the Certification of Need as well as current medical and psychological evaluations. The social evaluation must include the psychosocial assessment and an evaluation of home plans and available community resources.

The CIPOC must be reviewed every 30 calendar days by the team specified in 42 CFR §441.156 listed above. The purpose of the review is to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the individual's overall adjustment as an inpatient.

Independent Assessment, Certification and Coordination Teams (IACCT) Referral Process: Transfer from Inpatient Psychiatric Services to Residential Treatment Services (Psych)

For information about the IACCT process for individuals transferring from inpatient psychiatric services to residential treatment services, please refer to the Magellan of Virginia website at: https://www.magellanofvirginia.com/for-providers/residential-program-process/. Additional information about the IACCT process is also available in the DMAS Residential Treatment Services Manual.

Psychiatric Residential Treatment Facility Services (Psych)

As of June 30, 2017, Psychiatric Residential Treatment Facility services are defined in the Residential Treatment Services Manual.

Treatment Foster Care - Case Management (TFC-CM)

As of August 1, 2018, Treatment Foster Care - Case Management (TFC-CM) services are defined in the Community Mental Health Rehabilitative Services Manual.

Outpatient Psychiatric Services (Psych)

Outpatient psychiatric services are provided in a practitioner's office, mental health clinic, individual's home, or nursing facility. If services are provided in a setting other than the office or a clinic, this must be documented. All psychiatric services, including medication management shall be medically prescribed treatment, documented in an active written plan of care designed, signed, and dated by a LMHP.

Definitions:

- "Licensed mental health professional" or "LMHP" is as defined in 12VAC35-105- 20 in addition to a licensed psychiatric/mental health nurse practitioner.
- "LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.
- "LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125- 20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.
- "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140- 20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

Physician Direction of Mental Health Clinics

This section only applies to providers enrolled with Medicaid as Mental Health Clinic provider types.

Federal law requires that each mental health clinic be physician-directed. The physician does not have to be a psychiatrist. Under this policy, LMHPs, LMHP-Rs, LMHP-RPs, and LMHP-Ss may render reimbursable services without the direct personal supervision of a physician present.

However, each mental health clinic must ensure that the federal requirement for the physician direction of the clinic is fully met. LMHP-Rs, LMHP-RPs and LMHP-Ss must also receive supervision as required by the appropriate licensing board. The clinic is required to maintain personnel files that include a copy of credentials for all staff that provide Medicaid-reimbursed services.

The State Medicaid Manual § 4320B, published by the Centers for Medicare and Medicaid Services (CMS), summarizes the federal requirements for physician direction.

> “The requirement for physician supervision of all patient care in the mental health clinic is a condition of Medicaid reimbursement for mental health clinic services. The physician must have a face-to-face visit with the individual, prescribe the type of care provided, and if services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when individuals are receiving covered services, the physician must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic must spend as much time in the facility as is necessary to ensure that individuals are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement.
>
> The patient care protocols for treatment of Medicaid members must reflect the role of the physician. The individual’s medical records must document that the physician personally reviewed the individual’s medical history, conducted a thorough assessment, confirmed or revised the diagnosis, saw the individual face-to-face, reviewed and signed the plan of care, and is periodically reviewing the need for

continued care. The LMHP, LMHP-R, LMHP-RP, or LMHP-S must conduct an intake interview with the individual, record the medical history, conduct the intake assessment, record a diagnosis, and develop the plan of care. If the plan of care is implemented, there must be no more than three sessions or no more than thirty days, whichever is least, before the face-to-face interview with the physician. If the individual is an existing patient of the physician and the physician has had a face-to-face interview within the past 30 days, the face-to-face meeting may be waived. However, the physician must still review the medical history and intake assessment, confirm the diagnosis, and review and sign the plan of care. The physician must document a review of progress and need for continued care every six months. This requirement must be met for all mental health clinic services billed to Medicaid."

Medical Necessity Criteria

Outpatient psychiatric services shall be considered appropriate when an individual meets all of the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels that have been impaired; and

b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities; and
c. Is at risk for developing or requires treatment for maladaptive coping strategies; and
d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

A psychiatric diagnostic interview examination may occur prior to the start of services. The psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory, or other medical diagnostic studies. Review of records or reports are included in the interview examination.

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Individuals who are experiencing a co-occurring substance use and mental health disorder may experience greater impairments in functioning. Thus providers who are trained and practicing within the scope of their practice, in working with individuals with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained in treatment of both substance use and mental health disorders, they should refer the

member to an appropriate service provider. Both providers should obtain a release of information from the member so they can collaborate to coordinate effective treatment.

For persons with co-occurring psychiatric and substance use disorders, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance use disorder services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented.

Effective April 1, 2017, DMAS will implement Addiction and Recovery Treatment Services (ARTS) program for all members. For more information on the services, criteria, and staffing requirements, refer to the ARTS Provider Manual.

PLAN OF CARE (ELEMENTS OF THE INITIAL AND ONGOING PLAN OF CARE)

A Plan of Care (POC) is required for all psychiatric services, including medication management. Requirements for the POC include:

- The initial Plan of Care (POC) shall be developed at the first appointment to address the immediate service, health, and safety needs for the member in outpatient psychiatric settings based on the licensed practitioner assessment in collaboration with the member..
- The focus of the POC must be related to the diagnosis. The individual must have a current documented DSM-psychiatric diagnosis which is documented along with the individual's current mental status in the medical progress notes.
- The POC must indicate:
  - individual-specific goals related to symptoms and behaviors;
  - treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation);
  - estimated length that treatment will be needed;
  - frequency of the treatments/duration of the treatment; and,
  - documentation of the family/caregiver participation.
- A LMHP must sign and date the plan of care. If the plan of care was developed by an LMHP-R, LMHP-RP or LMHP-S, the plan of care must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the plan. The direct supervisor can be the licensed program supervisor/manager for the agency
- The POC must be reviewed by the qualified provider every 90 calendar days or every sixth session, whichever time frame is shorter, from the date of the provider's signature. The review may be incorporated into the progress notes, but must be identifiable as a review of the POC. The review includes the following:

- Has there been a relapse?

- Has there been a significant change in the environment?
- Is the individual at risk for moving to a higher level of care?
- Positive/negative changes relative to the symptoms.
- Documented review of the plan of care by the qualified provider.

- The POC must be amended as needed throughout the time of treatment.

SPECIFIC SERVICE LIMITS

Beginning on July 26, 2017 outpatient psychiatric services do not require service authorization Service limits are based on medical necessity.

The individual must participate and benefit from treatment in accordance to the plan of care.

There is a maximum of ten individuals per group session. Groups are expected to be held for a minimum of 30 minutes.

Family therapy is expected to be held for a minimum of 30 minutes.

Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with an intellectual disability prior to admission to a nursing facility, or any placement issue. Medical records must document the medical necessity for these tests.. The provider must support the units billed with documentation as to the medical necessity for the testing and a list of the specific tests conducted..

Separate payment is allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

NON-COVERED SERVICES

The following are non-covered services:

- Multiple-family group therapy.
- Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy.
- Broken appointments;

- Remedial education (tutoring, mentoring);
- Day care;
- Psychological testing done for purposes of educational diagnosis or school admission or placement;
- Occupational therapy;
- Teaching “grooming” skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered;
- Telephone consultations;
- Mail order prescriptions;
- Case management as part of outpatient therapy services;
- Treatment team meetings;
- Interpretation of examinations, procedures and data, and the preparation of reports are non-covered services. This includes CPT code 90885 (psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes).
- Medical hypnotherapy and environmental intervention.

TELEHEALTH SERVICES

Coverage of services delivered by telehealth are described in the “Telehealth Services Supplement."

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

Care Coordination (Psych)

Care coordination is essential in the process of assisting a person experiencing a mental illness to access a range of different services in a way that helps them get better, improves access to care and works towards their recovery. It involves interactions between different clinicians and health care providers, the individual, their caregivers, family members and other significant persons.

The goal of care coordination is to improve the health and functioning of people with mental health issues. Care coordination may include working with multidisciplinary teams, psychosocial support providers and self-management, in addition to clinical treatment. DMAS encourages providers to coordinate care with other behavioral health providers for the benefit of the member and as appropriate. Care coordination has two (2) main goals: 1) to improve the health and wellness of individuals with complex and special needs; and 2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Please contact Magellan of Virginia or the member’s MCO for additional

resources to assist with care coordination.

Billing Instructions (Psych)

Updated: 8/22/2018

Behavioral Health Services Administrator (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the Fee for Service (FFS) behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Medicaid Managed Care

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through Medicaid Managed Care Organizations (MCOs). Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Psychiatric services providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Billing Instructions

All providers must be under contract with Magellan of Virginia and/or a Medicaid MCO. Providers must follow Current Procedural Terminology (CPT) guidelines for billing Psychiatric Services.

Magellan of Virginia enrolled providers must contact Magellan of Virginia directly for information on reimbursement and claims processing instructions. All claims processing and reimbursement information can be found by contacting Magellan of Virginia at 1-800-424-4046 or by email at VAProviderQuestions@MagellanHealth.com or by visiting the Magellan of Virginia website at https://www.magellanofvirginia.com/for-providers/.

Providers under contract with a Medallion 3.0, a Commonwealth Coordinated Care (CCC) Plus and/or Medallion 4.0 (effective 8/1/2018) MCO should contact the MCO for billing information. Additional information is located on the DMAS website at:

- http://www.dmas.virginia.gov/#/med3 (Medallion 3.0)
- http://www.dmas.virginia.gov/#/cccplus (CCC Plus) and
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0)

ICD-10 (Psych)

In accordance with CMS requirements, DMAS and its contractors exclusively use ICD-10 CM diagnostic coding structure for electronic diagnosis and billing purposes. ICD-10CM is the only recognized HIPAA compliant coding system; therefore, it will be the only one accepted on electronic forms and transactions for Medicaid claims. In addition, in Section I of the DSM5 titled 'Use of the Manual' and in the subsection called the 'Coding and Reporting Procedure', the paragraph informs clinicians about ICD10. To assist providers, the corresponding ICD10 diagnosis codes are provided alongside the listed DSM5 diagnosis codes.

Billing Requirements for Services Under Arrangement

When a provider of services under arrangement submits a claim for their services to DMAS or one of its contractors, the NPI of the referring inpatient psychiatric provider must be submitted on the claim. The claim will deny or be retracted if no referring NPI is submitted. This referral number will be required as indicated below.

Please refer to Magellan of Virginia or the MCO's billing instructions for managing services provided under arrangement.

CMS-1500: Locator 17 - Name of Referring IPF Locator 17b **-** Enter the National Provider Identifier (NPI) of the inpatient psychiatric provider

UB 04: Locator 78 Other Provider Name and Identifiers - Enter the NPI for the inpatient psychiatric provider.

EDI 837 Professional:

Loop	Segment	Data Element	Comments
2310A-Referring Provider Name	NM1	NM109-Referring Provider Identifier	Submit the referring inpatient psychiatric provider's NPI in this field.
2310A – Referring Provider Name	NM1	NM108 – Referring Provider Identification Code	Use 'XX' for NPI

EDI 837 Institutional:

Loop	Segment	Data Element	Comments
2310F- Referring Provider Name	NM1	NM101 – Entity Identifier Code	Should always be 'DN' for the NPI of referring provider.
2310 F – Referring Provider Name	NM1	NM108 – Identification Code Qualifier	Use 'XX' for NPI
2310F- Referring Provider Name	NM1	NM109 – Identification Code	Submit the referring inpatient psychiatric provider's NPI in this field.

Billing Requirements and Edits for Ordering, Referring and Prescribing (ORP) Providers

To ensure that DMAS is meeting the mandated requirements from CMS, edits related to the ORP providers have been created. DMAS has established these claim edits to ensure that all ORP and Attending provider NPI's are submitted on claims and that the NPI listed is actively enrolled for the date(s) of service in the Virginia Medicaid program. Effective July 1, 2014, any claims submitted with invalid data will deny the claim.

The edits are:

DMAS Edit/ESC	Description	HIPAA Codes	Resol/Action Effective 04/01/2014	Resol/Action Effective 06/28/2014	Comments

0191	Provider Referral Required	CO/207/N286	EOB	Denial	This edit will validate that the ORP's NPI is enrolled in DMAS. Refer to the Attachment A for providers required to have referral.
0194	Attending Provider Not on File	CO/16/N253	EOB	Denial	This edit will validate that the attending NPI is valid and actively enrolled in DMAS. Attending Provider NPI must be on all UB/837I/DDE institutional claims.

0195	Referring Provider Not on File	CO/207/N286	EOB	Denial	This edit will validate the referring NPI is valid and actively enrolled in DMAS
0196	Referring Provider Not Eligible on Date of Service	CO/207/N286	EOB	Denial	This edit will set if the Referring NPI is not enrolled and active for the dates of service on the claim.
0197	Attending Provider Required	CO/16/N253	EOB	Denial	This edit will set if the Attending NPI on claim is missing.

0198	Attending Provider Same as Billing Provider	CO/16/N253	EOB	Denial	This edit is checking to ensure the Attending NPI on the intuitional claim is not the billing provider. The Institution is expected to be the billing provider.
0199	Attending Provider Not Eligible on Date of Service	CO/16/N253	EOB	Denial	This edit will validate that the attending NPI is valid and actively enrolled in DMAS for the dates of service(s) on claim. Attending Provider NPI must be on all UB/837I/DDE institutional claims.

Utilization Review and Control (Psych)

Updated: 8/22/2018

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of care and services paid by Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

Financial Review and Verification

The purpose of financial review and verification of services is to ensure that the provider bills only for

those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

Compliance Reviews (Psych)

The Department of Medical Assistance Services and its contractors routinely conduct compliance reviews to ensure that the services provided to Medicaid enrolled individuals are medically necessary and appropriate and are provided by the appropriate provider. Managed Care Organizations (MCOs) conduct audits for services provided to Members enrolled in Managed Care. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and individuals are subject to periodic and unannounced utilization reviews, as well as identified for review by system- generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider's peer group.

To ensure a thorough and fair review, trained professionals employed by DMAS or its contractors review all cases using available resources, and make on-site reviews of medical records, as necessary.

Statistical sampling may be used in a review. The Department or its contractor will use a random sample of paid claims for the audit period to calculate any excess payment. Overpayments will also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS may restrict or terminate the provider's participation in the program.

Psychiatric Services Medical Records Requirements

Documentation for each psychiatric service must be written at the time the service is rendered and must include the dated signature of the professional rendering the service. Medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author.

A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used. For additional information on physician signatures, refer to the Medicaid *Physician Manual*.

When plans of care and psychotherapy or counseling services are provided by one of the following: "Residents" under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10), to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a Resident or Supervisee must be provided under the direct, personal supervision of a qualified, Medicaid enrolled provider.
- The therapy session must contain at a minimum the dated signature of the Resident or Supervisee rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.
- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

Inpatient Acute Care (Psych)

General Acute Care Hospital Audits

The audits for General Acute Care Hospitals for psychiatric stays shall consist of a review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR §§ 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in the 42 CFR §§

   456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and lists of attendees to determine that the Committee is meeting according to its utilization management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§ 456.141 through 456.145.

5. Topic of one ongoing Medical Care Evaluation Study to determine if the hospital is in compliance with the 42 CFR § 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification, recertification if applicable, and written plan of care for each selected stay to determine the hospital's compliance with 42 CFR §§

   456.60 and 456.80. If any of the required documentation does not meet the requirements found in the 42 CFR §§ 456.60 through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the *Administrative Process Act* (§§ 2.2- 4000 et seq., of the Code of Virginia) and the provider appeal regulations (12VAC 30–20–500 et. seq.) any adverse decision resulting from such audits, which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

All medical record entries must also include the time of the entry, as well as the dated signature of the provider of any service or intervention. All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This includes, but is not limited to, orders, progress notes, procedure notes, patient assessments, H&Ps, treatment interventions, and any other service or treatment provided.

Free-Standing Psychiatric Hospital Audits

Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric hospital consistent with 42 CFR Section 456.160.
2. The physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days that the individual continues to require inpatient services in a psychiatric hospital.
3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician must perform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42CFR 456.170.
4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each individual as cited in 42CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the freestanding psychiatric hospital that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

The audits for freestanding psychiatric facilities shall consist of a review of the following:

a. Copy of the freestanding psychiatric facility's Utilization Management Plan to determine compliance with the regulations found in 42 CFR Sections 456.200 through 456.245.

b. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in 42 CFR Sections 456.205 through 456.206.

c. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the Committee is meeting according to their Utilization Management meeting requirements.

d. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR Sections 456.241 through 456.245.

e. Topic of one on-going Medical Care Evaluation Study to determine that the hospital is in compliance with 42 CFR Section 456.245.

f. From a list of randomly selected paid claims, the free-standing psychiatric facility must provide a copy of the certification for services; a copy of the physician admission certification for services, independent team certification if applicable; a copy of the required medical, psychiatric, and social evaluations; and the written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* Sections 16.1-335 through 16.1-348 and 42 CRF Sections 441.152, 456.160, and Sections 456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

g. A physician must certify at the time of admission, or at the time the hospital is

notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric facility consistent with 42 CFR Section 456.160.

h. The physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days that the individual continues to require inpatient services in a psychiatric facility.
i. Validation of documentation received during the preauthorization process.
j. All required provision of services must be fully documented in the medical record.
k. Compliance with restraint and seclusion regulations will be reviewed (42 CFR §§ 483.350 – 483.376).

The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

- The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;
- The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;
- The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;
- The referral to the service provided under arrangement was not present in the patient's freestanding psychiatric hospital record;
- The service provided under arrangement was not supported in that provider's records by a documented referral from the freestanding psychiatric hospital;
- The medical records from the provider of services under arrangement (i.e., admission and discharge documents, plans of care, progress notes, treatment

summaries, and documentation of medical results and findings) (i) were not present in the patient's freestanding psychiatric hospital record or had not been requested in writing by the freestanding psychiatric hospital within seven days of completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of completion of the service or services, but had not been received within 30 days of the request, and had not been re- requested; or

- The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services hospital provider prior to submission of the ancillary provider's claim for payment.

The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

Absence of any of the required documentation for either freestanding facilities or acute care hospitals may result in retraction of payment. Services not documented in the individual’s record as having been provided will be determined not to have been provided, and retractions may be made.

Utilization Review Process

DMAS or its contractors conduct utilization review audits on providers of inpatient psychiatric services for Medicaid individuals within freestanding psychiatric facilities and acute care psychiatric facilities. These audits are conducted to determine that the provider is in compliance with the regulations governing mental hospital utilization found in 42 CFR, Section 456.150 and general acute care hospitals found in 42 CFR, Section 456.50-456.145. These audits can be performed either on-site or as a desk audit. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

Criteria for Reimbursement

Psychiatric services that fail to meet Medicaid criteria are not reimbursable. Such non- reimbursable services will be denied upon service authorization or at the time of the post- payment utilization review.

Medicaid criteria for reimbursement of inpatient psychiatric services are found throughout the provider manual and include, but are not limited to:

- A Pre-Admission Screening Report, signed by the required team members, with a recommendation to admit the individual to inpatient services and an indication of why community resources do not meet the individual's needs;
- Certificate of need or independent team certification for admission that is completed and dated prior to admission and the request for authorization;
- Provision of all ordered services in the individual's written plan of care by qualified professionals;
- Written Plan of Care completed by specified professionals and addressing the components listed in Chapter IV of this manual;
- Timely review of the written Plan of Care;
- Dated signatures of qualified service providers on all medical documentation; and
- Medical records sufficient to document fully and accurately the nature, scope and details of the health care provided.

Upon completion of an on-site review the utilization review analyst(s) may meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review, and based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of an on-site or desk review, DMAS will respond to the provider in writing and cite federal or state regulations and policy and procedures that were not followed outlining any retractions necessary.

If DMAS requests a corrective action plan, the provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

Outpatient Psychiatric Services (Psych)

DMAS or its contractor will conduct periodic, utilization review on-site or as desk reviews of individuals currently receiving psychiatric services, including Mental Health Clinic Services. DMAS or its contractor may also review a sample of closed medical records. DMAS or its contractor may also conduct an on-site investigation as follow-up to any complaints received.

Documentation Criteria

Providers of outpatient psychiatric services are expected to document the requirements outlined in this manual, as well as the following:

- History, to include:
    - The onset of the diagnosis and functional limitations;
    - Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment;
    - Reasons that may require consideration (foster care, dysfunctional family);
    - Previous treatment and outcomes;
    - Medications, current and history of;
    - Medical history if relative to current treatment;
    - Treatment received through other programs (Department of Aging and Rehabilitative Services, day treatment, Special Education, Community Services Board/Behavioral Health Authority, or the Department of Behavioral Health and Developmental Services clinics.
    - Functional limitations; if any
- Plan(s) of Care (POC), and review of the plan of care signed and dated by the LMHP. An initial plan of care is required to be completed at the start of services. The POC may be incorporated in the Psychiatric Diagnostic Interview.
- Medical Evaluation (evidence of coordination with the primary care physician (PCP), if applicable, or documentation that it is not applicable). The purpose of the evaluation is to rule out any underlying medical condition as causing the symptoms, and to ensure that any underlying medical conditions are being treated. The provider is expected to have the results of a medical evaluation in the individual's medical record or indicate that the individual's condition either does not warrant an evaluation or an evaluation was recommended and for what reasons.
- Results of a Diagnostic Evaluation done within the past year.
- Documentation of a psychiatric diagnosis that is current, within the past year.
- Progress Notes for each unit (must be individual-specific, must describe how

the activities of the session relate to the individual -specific goals, describe the therapeutic intervention, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual, medication management], the progress or lack thereof toward the goals, and the plan for the next treatment and must contain the dated signatures of the providers).
- Evidence of discharge planning and discharge summary.

Outpatient psychiatric services that fail to meet Medicaid criteria are not reimbursable. Such non-reimbursable services will be denied upon service authorization or at the time of the post-payment utilization review.

Upon completion of an on-site review the utilization review analyst(s) may meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review, and based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of an on-site or desk review, DMAS or its contractor will respond to the provider in writing and cite federal or state regulations and policy and procedures that were not followed outlining any retractions necessary.

If DMAS or its contractor requests a corrective action plan, the outpatient psychiatric service provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

Medical Record Retention (Psych)

The provider must recognize the confidentiality of individuals' medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The individual's written consent is required for the release of information not authorized by law. Documentation in all current individual medical records and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's clinical/medical record.

Records of all outpatient psychiatric services must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the

name of the individual to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). **Refer to 42 CFR 485.721 for additional requirements**.

Upon the transfer of ownership or closure of a service provider or facility, the current provider or facility is required to notify DMAS Provider Enrollment and the supervisor of the MHUR/Hospital Utilization Review Unit in writing within 30 days of the effective date of the change. Information required concerning the change includes, but is not restricted to, the effective date of the change and who will have custody of the files/records. Send notice to:

Department of Medical Assistance Services
Hospital Utilization Review Supervisor 600 E.
Broad Street, Suite 1300

Richmond, Virginia 23219 Or

Department of Medical Assistance Services Provider
Enrollment

600 E. Broad Street, Suite 1300

Richmond, Virginia 23219

Providers must notify Magellan of Virginia via VAProviders@MagellanofVirginia.com and any contracted Medicaid MCO.

The facility or agency must maintain medical records on all individuals in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information.

Fraudulent Claims (Psych)

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law. Some examples of falsifying records include, but are not limited to:

- Creation of new records when records are requested
- Back-dating entries

- Post-dating entries
- Writing over, or adding to existing documentation (except as described in late entries, addendums or corrections, which would include the dated signature of the amendments)

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The Virginia Medicaid Program, DMAS, maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations, Medicaid Memos, the provider agreement, Magellan of Virginia and MCO contract if applicable, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee or business contractor providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Integrity

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 692-0480

Investigations of allegations of provider fraud are the responsibility of the Medicaid

Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit Office of
the Attorney General

900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Reports may be made to Magellan of Virginia via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

Member Fraud

Allegations about fraud or abuse by individuals are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (DSS) or to the DMAS Recipient Audit Unit at (804)786-0156. Reports are also accepted at the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the

RAU email address: memberfraud@dmas.virginia.gov or forwarded to:

Program Manager, Recipient Audit Unit Program
Integrity Division

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Referrals to the Client Medical Management Program (PP)

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred clients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and pharmacy in the Client Medical Management (CMM) Program. See “Exhibits” at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate clients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit Division
of Program Integrity

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

Fax: (804) 371-8891

When making a referral, provide the name and Medicaid number of the client and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Appendix C: Procedures Regarding Service Authorization of Psychiatric Services

Updated: 8/22/2018

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some may begin prior to requesting authorization.

Purpose of Service Authorization (Psych)

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Magellan of Virginia handles service authorization requests for fee for service behavioral health service providers. The Medicaid Managed Care Organizations (MCOs) handle the service authorizations for their enrolled members.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

DMAS contractors will approve, pend, reject, or deny all completed service authorization requests. When a final disposition is reached the service authorization entity notifies the individual and the provider in writing of the status of the request.

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

Retro Medicaid Eligibility

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the individual. When retroactive eligibility is obtained, the request for authorization must be submitted to the service authorization contractor no later than 30 days from the date notified of Medicaid eligibility; if the request is submitted later than 30 days from the date of notification, the request will be authorized beginning on the date it was received.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid MCOs, Magellan of Virginia will honor the Medicaid MCO service authorization if the individual has been disenrolled from the MCO. Similarly, the MCO will honor Magellan of Virginia's authorization based upon proof of authorization from the provider, DMAS or Magellan of Virginia that services were authorized while the individual was eligible under fee-for-service (not MCO enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted MCO.

Service authorization decisions by the MCOs and Magellan of Virginia are based upon medical necessity review and decisions apply to the individuals benefit for dates of service requested. DMAS contractors' decisions do not guarantee Medicaid eligibility or enrollment. It is the provider's responsibility to verify the individual's eligibility and to check for MCO enrollment versus fee-for-service enrollment. For MCO enrolled individuals, the provider must follow the MCO's service authorization policy and billing guidelines.

Communication

Provider manuals are located on the DMAS and Magellan of Virginia's websites. The DMAS website has information related to the service authorization processes for fee-for-service and MCO enrolled members.

DMAS contractors provide communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard- of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual. Providers should consult

with the member's MCO or Magellan of Virginia with any questions or issues about service authorizations.

Individuals Who are Enrolled with DMAS Contracted Managed Care Organizations (Psych)

Many Medicaid individuals are enrolled with one of DMAS' contracted Managed Care Organizations (MCO) including Medallion 3.0, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 (effective 8/1/2018). In order to be reimbursed for inpatient acute psychiatric, outpatient psychiatric, and outpatient substance use treatment services provided to an MCO enrolled individual, providers must contract with and follow their respective contract with the MCO. The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For detailed information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at:

- http://www.dmas.virginia.gov/#/med3 (Medallion 3.0)
- http://www.dmas.virginia.gov/#/cccplus (CCC Plus) and
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0)

Information regarding MCO coverage of Residential Services is available in the Residential Treatment Services Manual. Information regarding MCO coverage for Community Mental Health Rehabilitative Services (CMHRS) and Treatment Foster Care Case Management (TFC- CM) is located in the CMHRS Manual.

Service	**In MCO Contract?**	**Comments**
Inpatient psychiatric services including free-standing psychiatric services.	Yes	For MCO enrolled individuals, the provider must follow their respective contract with the MCO. Contact the MCO directly.
Outpatient psychiatric services including Mental Health Clinic Services	Yes	Same as above

Service Authorization Process for Psychiatric Services

Inpatient Acute Psychiatric Services (Acute Hospitals and Acute Freestanding Hospitals)

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require service authorization. To request service authorization for psychiatric services, contact Magellan of Virginia or the MCO. Planned/scheduled admissions must be service authorized within 24 hours of admission, or on the next business day after admission. Obtaining service authorization prior to admission is encouraged. Unplanned/urgent or emergency admissions must be service authorized within 24 hours of admission, or on the next business day after admission.

Prior to the expiration of the initial assigned length of stay, if the individual requires continued inpatient hospital care, the health care provider must contact Magellan of Virginia or the MCO, to initiate the concurrent review process. The provider must be able to provide the medical indications and plan of care for continued hospitalization. The review analyst will apply medical necessity criteria to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient hospitalization. Concurrent review will continue in the same manner until the individual is discharged. Providers need to contact the MCOs or Magellan of Virginia for questions regarding medical necessity criteria.

Outpatient Psychiatric Services

Effective July 26, 2017, outpatient psychiatric services, including Mental Health Clinic Services, no longer require service authorization and sessions are no longer limited to 26 annually per member. This change applies to dates of service beginning July 26, 2017.

Providers are strongly encouraged to use the APA CPT code book for clarification of the codes and their usages. DMAS and its contractors do not advise providers about how to code or bill for the services they provide.

Program criteria for this service are described in detail in Chapter IV of this manual. Provider criteria are described in detail in Chapter II of this manual.

For individuals with co-occurring psychiatric and substance use disorder conditions, providers are expected to integrate the treatment. Psychiatric and substance use

disorder services may be provided concurrently if medical necessity criteria are met for each service. Collaboration and coordination of care among all treating practitioners shall be documented.

For more information on substance use disorder services, refer to the *ARTS* Provider Manual.

Effective 8/1/2018, TFC-CM has been moved to the CMHRS Manual.

Timeliness of Submissions by Providers (Psych)

All requests for services must be submitted prior to services being rendered. This means that if a provider is untimely submitting the request, DMAS or its contractor will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Specific Information for Out-of-State Providers (Psych)

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to DMAS or its contractor. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to DMAS or its contractor, as timeliness of the request will be considered in the review process.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers of RTC- Level C services and freestanding psychiatric hospitals (Provider Type PCT003) for service type 0093. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out of state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine item 1 through 4 at the time of the request to the DMAS contractor. If the provider is unable to establish item number 3 or 4, the provider will need to follow up with the DMAS contractor to determine what will need to be provided for coverage of the member in this out of state setting.

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively deniedbased on 12VAC30-10-120 and 42 CFR 431.52.

EPSDT Review Process:

Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the department. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

Temporary Detention Orders Supplement

Updated: 8/25/2022

This supplement provides claims processing information for Temporary Detention Orders (TDOs) issued pursuant to section §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia. Once a TDO has been issued for an individual, an employee or a designee of the local community services board shall determine the facility of temporary detention in accordance with the provisions of §37.2-809 and §16.1-340.1 of the Code of Virginia. Transportation shall be provided in accordance with §37.2-810 and §16.1-340.2 and may include transportation of the individual to such other medical facility as may be necessary to obtain further medical evaluation or treatment prior to the detention placement as required by a physician at the admitting temporary detention facility.

The duration of temporary detention shall be in accordance with §16.1-335 et seq. of the Code of Virginia for individuals under age eighteen and §37.2-800 et. seq. for adults age eighteen and over.

TDO facility admissions may occur in acute care hospitals, private and state run psychiatric hospitals and 23-hour crisis stabilization and residential crisis stabilization unit (RCSU) providers. Limited TDO coverage is included in the contracts for the Program of All-

Inclusive Care for the Elderly (PACE), Medallion 4.0 and Commonwealth Coordinated Care (CCC Plus) programs. Medicaid coverage for TDOs by the Fee For Service (FFS) contractor managing the behavioral health services benefit for individuals enrolled in FFS, currently Magellan of Virginia, the Medicaid Managed Care Organization (MCO) for individuals enrolled in managed care, or PACE for individuals enrolled in the PACE program is limited by the type of placement and age of the member. TDOs not covered by the FFS contractor, the Medicaid MCOs or PACE are covered by the TDO Program. See the chart below for additional information.

Type of TDO Placement	**Non-Medicaid eligible**	**Medicaid and FAMIS FFS**	**Medallion 4.0 CCC Plus (Medicaid and FAMIS)**	**PACE Program**
23-hour and Residential Crisis Stabilization Providers (effective 12/1/2021)	Covered by TDO Program	Covered by FFS contractor	Covered by MCO	Covered by PACE Program
Psychiatric Unit of Acute Care Hospital	Covered by TDO Program	Covered by FFS contractor	Covered by MCO	Covered by PACE Program
Freestanding Psychiatric Hospital – private and state (ages 21 – 64)	Covered by TDO Program	Covered by TDO Program	Covered by TDO Program	Covered by TDO Program
Freestanding Psychiatric Hospital – private and state (under 21 and over 64)	Covered by TDO Program	Covered by FFS contractor	Covered by MCO*	Covered by PACE Program

*if MCO does not cover individuals enrolled in FAMIS under enhanced benefit, defaults to TDO program.

Refer to the claims processing section of the supplement for information on submitting claims.

Federal "In Lieu Of" Managed Care Rule

The Federal Medicaid managed care rule allows MCOs to provide coverage in an Institution for Mental Disease (IMD), within specific parameters, including for adults between the ages of 21 and 64. These parameters includes rules in which MCOs may provide coverage in an IMD setting "in lieu of" providing services in an inpatient psychiatric unit of an acute care hospital. The Federal managed care rule also sets a 15-day per admission, per capitation month limit on the number of days an MCO may receive reimbursement for delivering IMD services to an adult between the ages of 21 and 64. It is important to clarify that the members benefit plan is not limited to 15 days per admission, instead the limit is applied to the MCO's capitation payment for delivering the IMD service. Therefore, adults may receive behavioral health services in an IMD as an "in lieu of" service as allowed in 42 CFR §438.3 (e)(2) and an adult member aged 21-64 may receive services for longer than 15 days per admission when medically necessary.

Individuals between the ages of 21 and 64 enrolled in Medallion 4.0 and CCC Plus who are admitted to a freestanding psychiatric facility under a TDO will remain in the Medicaid managed care health plan during the TDO period. For members in a Medicaid MCO, the MCO will manage the continued stay, including the transfer to a participating provider or securing single case agreements with out of network providers. Coordination between the TDO setting with the MCO related to ongoing services, discharge planning and follow up care is expected. The Medallion 4.0 and CCC Plus health plans shall provide coverage for the continued stay period after the expiration of the TDO if the "in lieu of" criteria is met.

Pursuant to §438.6(e) of the Managed Care Regulation, states can receive federal financial participation and make capitation payments on behalf of adults ages 21-64 that spend part of the month as a patient in an IMD, if specific conditions are met. Pursuant to 42 CFR §438.3 (e)(2), an MCO may cover services or settings that are "in lieu of" services or settings covered under the State plan as long as the provision of this service meets the four conditions for "in lieu of" services. These conditions are stated in §438.3(e)(2) as:

a. The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
b. The member is not required by the MCO to use the alternative service or setting;

c. The approved **in lieu of** services are authorized and identified in the MCO contract, and will be offered to members at the option of the MCO; and
d. The utilization and actual cost of **in lieu of** services are taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

If these four conditions are met, MCOs may provide coverage in an IMD setting "in lieu of" providing services in an inpatient psychiatric unit of an acute care hospital. The length of stay shall be limited to **no more than** fifteen (15) calendar days in any calendar month. Reference 42 CFR §§438.3 and 438.6(e).

TDO Claims Processing

Hospitals and physicians should contact the FFS contractor, the Medicaid MCO or PACE for information on claims processing for TDOs covered through the FFS contractor, the Medicaid MCO or PACE. For TDO services that are covered by the TDO Program, providers should follow the claims processing instructions in the following section of this supplement (see chart below for information on TDO claims submission by type of placement and age). The medical necessity of the TDO service is established and DMAS or its contractor cannot limit or deny services specified in a TDO.

Following expiration of the TDO, the FFS contractor, the Medicaid MCO or PACE will manage the individual's treatment needs based on the individual's eligibility.

Non-Medicaid Eligible Individuals

The TDO Program will cover TDO services during the duration of the TDO for individuals without insurance but will not cover services once the TDO has expired. Individuals uninsured at the time of the TDO placement must be determined eligible for Medicaid and enrolled to receive Medicaid coverage for services once the TDO has expired. TDO Program claims for non-Medicaid eligible individuals with a primary insurance may also be submitted for secondary coverage through the TDO Program. TDO Program claims are subject to DMAS Third Party Liability (TPL) criteria in accordance with § 37.2-809(G) of the Code of Virginia, see Claims Processing for Services Reimbursed by the TDO Program for additional information.

Out of Network Providers

When an out-of-network provider, to include out of state providers, provides TDO services covered by FFS, the Medicaid MCO, or PACE, the FFS contractor shall be responsible for FFS reimbursement of these services, the MCO shall be responsible for reimbursement of

these services for individuals enrolled in managed care and PACE shall be responsible for reimbursement of these services for individuals enrolled in PACE. Out of network providers of TDO services covered by the TDO program, shall be reimbursed by the TDO program. In the absence of an agreement otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid FFS rate in effect at the time the service was rendered.

TDO Claims Submission

Type of TDO placement	**Non-Medicaid eligible**	**Medicaid and FAMIS FFS**	**Medallion 4.0 CCC Plus (FAMIS and Medicaid)**	**PACE Program**
23-Hour and Residential Crisis Stabilization providers (effective 12/1/2021)	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO	Submit claims to PACE Program
Psychiatric Unit of Acute Care Hospital	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO	Submit claims to PACE Program
Freestanding Psychiatric Hospital – private and state (ages 21 – 64)	Submit claims to TDO Program	Submit claims to TDO Program	Submit claims to TDO Program	Submit claims to TDO Program
Freestanding Psychiatric Hospital – private and state (under 21 and over 64)	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO*	Submit claims to PACE Program

*if MCO does not cover individuals enrolled in FAMIS under enhanced benefit, submit claims to TDO program.

Claims Processing for Services Reimbursed by the TDO Program

Charges must be submitted on a UB-04 (CMS -1450) claim form or CMS-1500 (08-05) claim form. DMAS will accept only the original claim forms.

For dates of service between March 1, 2020 and November 30, 2021, DMAS will reimburse TDO services provided by Crisis Stabilization Units under the HCPCS code H0018 with HK modifier through the TDO Fund. Effective for dates of service December 1, 2021 and after, providers must submit TDO claims for these services to the FFS Contractor for individuals in FFS or the individual's MCO for individuals enrolled in managed care using the HCPCS codes for 23-hour crisis stabilization and RCSU (see the Comprehensive Crisis Services Appendix of the Mental Health Services Manual).

DMAS will only reimburse for TDO services provided by 23-hour crisis stabilization and RCSU providers through the TDO Fund for individuals without insurance or TDO claims that are subject to secondary coverage. 23-hour crisis stabilization and RCSU providers shall submit these claims for TDO services to DMAS using the CMS-1500 (08-05) claim form using the appropriate HCPCS code:

Description	Billing Code	Modifier	Unit
23-Hour Crisis Stabilization – Emergency Custody Order	S9485	32	Per Diem
23-Hour Crisis Stabilization – Temporary Detention Order	S9485	HK	Per Diem
RCSU – Emergency Custody Order	H2018	32	Per Diem
RCSU – Temporary Detention Order	H2018	HK	Per Diem

Photocopies or laser-printed copies of claim forms will not be accepted because the individual signing the forms is attesting to the statements made on the reverse side of the forms. These statements become part of the original billing invoice.

All TDO Program claims must have the TDO form attached to the claim with the pre-printed case identification number. Failure to provide the TDO form will result in claims being returned to the provider for incomplete information. The Execution section on the TDO form must be signed by the law enforcement officer and dated to be valid. Copies of the TDO form are acceptable.

Processing of TDO Program claims includes both Medicaid eligible and non-Medicaid eligible patients. The TDO Program is the payer of last resort:

- In settings covered by the FFS contractor, Medicaid MCO or PACE (see chart above), the provider must bill the FFS contractor, Medicaid MCO or PACE prior to billing the TDO Program. Any payment by the FFS contractor, Medicaid MCO or PACE must be considered payment in full and any balances cannot be billed to the TDO Program or to the member.
- All TDO claims for individuals with Third Party Liability (TPL) insurance coverage, including claims submitted by 23-hour crisis stabilization and RCSU providers are subject to DMAS TPL criteria in accordance with § 37.2-809(G) of the Code of Virginia. Providers will need to submit documentation of amount of payment or non-payment by the primary carrier when TPL is listed on the Medicaid member's file. Once the claim has been processed by the primary carrier, providers may submit claims to the TDO Program as a secondary payer source, however payment would be contingent on any amount issued by the primary payer and will not exceed the Medicaid reimbursement rate.
- The State and Local Hospital Program (SLH) does not have to be billed prior to submitting a TDO claim.

The actual processing of the TDO Program claim will be processed by the DMAS fiscal agent. Each claim will be researched for coverage by any other resource. If the individual has other resources, the claim will be returned to the provider. When claims are returned to the provider, there will be an attached letter advising the provider to bill the other available payment resource.

TDO Claims are processed by DMAS when:

- The TDO is not covered by the FFS contractor, Medicaid MCOs, PACE (see charts in previous sections of this supplement) or other third party insurance; or,
- TDO days have been reimbursed by a primary insurance and are subject to secondary coverage by the TDO Fund

Mail all TDO claims to:

Department of Medical Assistance Services

TDO - Payment Processing Unit

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Reimbursement

Payments for services rendered will be paid at the Medicaid allowable reimbursement rates established by the Board of Medical Assistance Services.

Weekly remittance advice will be sent by our fiscal agent. The remittance voucher will be mailed each Friday and the reimbursement check will be attached or reimbursement will be made by Electronic Fund Transfer.

Make inquiries related to the TDO claims processing, coverage, or reimbursement to the DMAS Helpline at 1-800-552-8627 or 804-786-6273.

UB-04 BILLING INSTRUCTIONS TDO

Instructions for Completing the UB-04 CMS-1450 Universal Claim Form

The UB-04 CMS-1450 is a universally accepted claim form that is required when billing DMAS for covered services. This form is readily available from printers. The UB-04 CMS-1450 **will not** be provided by DMAS.

General Information TDO

The following information applies to Temporary Detention Order claims submitted by the provider on the UB- 04 CMS-1450:

All dates used on the UB- 04 CMS-1450 must be two digits each for the day, the month, and the year (e.g., 070100) with the exception of Locator 10, Patient Birthdate, which requires four digits for the year.

New claims submitted for TDO cannot be completed by Direct Data Entry (DDE) as an enrollee identification number has not been assigned.

TDO does not cover the day of the hearing.

NOTE: NO SLASHES, DASHES, SPACES, DECIMAL POINTS OR DOLLAR SIGNS.

Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

When coding ICD-10-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

Continue to submit outpatient laboratory charges on the CMS-1500 (08-05) billing form as required by Medicaid. These charges will only be reimbursed if done in conjunction with an Emergency Room visit outside of the facility providing inpatient hospital care. Emergency Room services must be included on the inpatient hospital invoice if the same facility provides both services. Emergency Room services are not covered for medical screenings.

To adjust or void a claim:

> To adjust a previously paid claim, complete the UB- 04 CMS-1450 to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 0117 for inpatient hospital services or code 137 for outpatient services, and in Locator 64, enter the 9-16 digit Internal control number (reference number) of the original paid claim. Enter an explanation for the adjustment in Remarks, Locator 80. The number of days cannot be adjusted. The claim must be voided and re-billed correctly.

> To void a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 0118 for inpatient hospital services or code 138 for outpatient services, and in Locator64, enter the 9-16 digit Internal control number (reference number) of the original paid claim. Enter an explanation for the adjustment in Remarks, Locator80.

The professional fee is not a reportable item on the UB-04 CMS-1450 for general or psychiatric hospitals (inpatient or outpatient). The professional components must be billed utilizing the CMS-1500 (08-05) billing form. See Professional Billing Instructions section of

this supplement for additional information.

Voids and Adjustments can be completed via DDE. For instructions related to DDE, please access the DMAS web portal, Provider Resources, Claims DDE.

UB-04 Invoice Instructions

The following description outlines the process for completing the UB-04 CMS -1450. It includes Temporary Detention Order (TDO) specific information and must be used to supplement the material included in the *State UB-04 Manual*.

Note: For locators 76-79, if an NPI is not available, due to the provider not enrolling or sharing their NPI with DMAS, you will need to attach a written explanation to your claim and submit to:

Department of Medical Assistance Services

Attn: Manager, Payment Processing Unit

600 E. Broad Street – Suite 1300

Richmond, VA 23219

Note: Hospitals with one NPI must use one of the taxonomy codes below when submitting claims for the different business types noted below:

Service Type Description	Taxonomy Code(s)

Hospital, General	282N00000X
Rehabilitation Unit of Hospital	223Y00000X
Psychiatric Unit of Hospital	273R00000X
Private Mental Hospital (inpatient)	283Q00000X
Rehabilitation Hospital	283X00000X
Psych Residential Inpatient Facility	323P00000X – Psych Residential Treatment Facility
Crisis Stabilization Units	251C00000X 261QM0801X
Transportation – Emergency Air of Ground Ambulance	3416A0800X – Air Transport 3416L0300X – Land Emergency Transport
Independent Physiological Lab	293D00000X

If you have any questions related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

PROFESSIONAL BILLING AND 23-HOUR CRISIS STABILIZATION AND RESIDENTIAL CRISIS STABILIZATION UNIT (RCSU) PROVIDERS PER DIEM BILLING INSTRUCTIONS

Services can only be billed for services related to the specific time frame of the TDO or for an Emergency Custody Order (ECO). The below listed locators are instructions related specifically for TDO/ECO services.

LOCATOR		SPECIAL INSTRUCTIONS
1	**REQUIRED**	**Enter an "X" in the OTHER box.**
1a	**REQUIRED**	**Prior Authorization (PA) Number –** Enter the TDO number pre-assigned to the TDO or ECO form that is obtained from the magistrate authorizing the TDO/ECO
2	**REQUIRED**	**Patient's Name - Enter the name of the member receiving the service.**
3	**REQUIRED**	**Patient's Birth Date –** Enter the 8 digit birth date (MM DD CCYY) and enter an 'X' in the correct box for the sex of the patient.
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	**REQUIRED**	**Other Insured's Name:** Write the appropriate name for the detention order, either TDO or ECO. This will allow DMAS to identify that the claim is for this program.
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name

10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used.** If modifier '22' is used, documentation is to be attached to provide information that is needed to process the claim. Note: If the only attachment is the actual TDO or ECO order, you do not need to use this locator.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay"
11d	**REQUIRED If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED If applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	**Name of Referring Physician or Other Source** – Enter the name of the referring physician.
17a shaded red	**REQUIRED If applicable**	**I.D. Number of Referring Physician -** The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	**REQUIRED If applicable**	**I.D. Number of Referring Physician -** Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED If applicable**	**Additional Claim Information** Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury -** Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. -OPTIONAL 0=ICD-10-CM – Dates of service 10//1/15 and after**
22	**REQUIRED If applicable**	**Resubmission Code – Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	not required	

Psychiatric Services

24A lines 1-6 open area

24A lines 1- 6 red shaded

24B open area

24C

24D open area

24E open area

24F open area

24G open area

24H open area

24I open

24I red-shaded

24J open

24J red-shaded

25

26

27

28

29

30

31

32

32a open

32b Red shaded

33

REQUIRED

REQUIRED If applicable

REQUIRED

REQUIRED

REQUIRED

REQUIRED

REQUIRED

REQUIRED

REQUIRED If applicable

REQUIRED If applicable

REQUIRED If applicable

REQUIRED If applicable

REQUIRED If applicable

NOT REQUIRED

REQUIRED

NOT REQUIRED

REQUIRED

REQUIRED If applicable

NOT REQUIRED

REQUIRED

REQUIRED If applicable

REQUIRED If applicable

REQUIRED If applicable

REQUIRED

Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

DMAS requires the use of qualifier 'TPL'. This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required.

DMAS requires the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.

NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity
Unit of Measurement Qualifier Codes:
F2 – International Units
GR – Gram
ML – Milliliter
UN – Unit
Examples of NDC quantities for various dosage forms as follows:
a. Tablets/Capsules – bill per UN
b. Oral Liquids – bill per ML
c. Reconstituted (or liquids) injections – bill per ML
d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
e. Creams, ointments, topical powders – bill per GR
f. Inhalers – bill per GR

BILLING EXAMPLES:
TPL, NDC and UOM submitted:
TPL3.50N412345678901ML1.0
NDC, UOM and TPL submitted:
N412345678901ML1.0TPL3.50
NDC and UOM submitted only:
N412345678901ML1.0 TPL submitted only:
TPL3.50

Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples) All supplemental information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:
• If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.
• If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. **An EOB/documentation must be attached to the claim to verify nonpayment**.
• If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.

Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.

Emergency Indicator - Enter 'Y' for YES

Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided.
Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.

Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.

Charges - Enter your total usual and customary charges for the procedure/services.

Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.

EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.
1 Early and Periodic, Screening, Diagnosis and Treatment
Program Services
2 Family Planning Service

NPI – This is to identify that it is a NPI that is in locator 24J

ID QUALIFIER –The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.

Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.

Rendering provider ID# - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.

Federal Tax I.D. Number

Patient's Account Number – Up to **FOURTEEN** alpha-
numeric characters are acceptable.

Accept Assignment

Total Charge - Enter the total charges for the services in 24F lines 1-6

Amount Paid – For personal care and waiver services only – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.

Reserved for NUCC Use

Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.

Service Facility Location Information – Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.

NPI # - Enter the 10 digit NPI number of the service location.

Other ID#: - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.

Billing Provider Info and PH # - Enter the billing name as
first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid.
NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.

For Information on submitting Void and Adjustment invoices on the CMS-1500 please see Chapter V of the Physician/Practitioner Manual.

Special Note: All TDO and ECO claims covered by the Medicaid TDO Program (see chart earlier in this supplement) are submitted to the following address:

Department of Medical Assistance Service

Attention: TDO Program

600 E. Broad Street Suite 1300

Richmond, Virginia 23219

Telehealth Services Supplement

Updated: 4/1/2022

Definitions (TH)

Audio only

The use of real-time telephonic communication that does not include use of video.

Distant Site

The distant site is the location of the Provider rendering the covered service via telehealth.

Originating Site

The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates (i.e., where the data are collected). Examples of originating sites include: medical care facility; Provider's outpatient office; the member's residence or school; or other community location (e.g., place of employment).

Provider

For purposes of this manual supplement, the term "Provider" refers to the billing provider – either a qualified, licensed practitioner of the healing arts or a facility – who is enrolled with

DMAS.

Remote Patient Monitoring

Remote Patient Monitoring (RPM) involves the collection and transmission of personal health information from a beneficiary in one location to a provider in a different location for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

Store-and-Forward

Store-and-forward means the asynchronous transmission of a member's medical information from an originating site to a health care Provider located at a distant site. A member's medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site Provider via synchronous or asynchronous communications.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are covered in the dental manuals.

Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

Virtual Check-In

A Virtual Check-In is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed.

Reimbursable Telehealth Services

Attachment A lists covered services that may be reimbursed when provided via telehealth.

Specifically:

Table 1 –

- Table 3 list Telemedicine and Store-and-Forward services
- Table 4 lists Remote Patient Monitoring services
- Table 5 lists Virtual Check-In services
- Table 6 lists audio only services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted in Table 1 – Table 6 in this Supplement;
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to Managed Care Organization (MCO)-enrolled individuals, Providers must follow their respective contract with the MCO. Additional information about the Medicaid MCO programs can be found at https://www.dmas.virginia.gov/#/cccplus and https://www.dmas.virginia.gov/#/med4.

Additional modality-specific conditions for reimbursement are provided, below.

Telemedicine

- Services delivered via telemedicine must be provided with the same standard of care as services provided in person.
- Telemedicine must not be used when in-person services are medically and/or

clinically necessary. The distant Provider is responsible for determining that the service meets all requirements and standards of care. Certain types of services that would not be expected to be appropriately delivered via telemedicine include, but are not limited to, those that: are performed in an operating room or while the patient is under anesthesia; require direct visualization or instrumentation of bodily structures; involve sampling of tissue or insertion/removal of medical devices; and/or otherwise require the in-person presence of the patient for any reason.

- If, after initiating a telemedicine visit, the telemedicine modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the "Reimbursable Telehealth Services" section, the Provider shall provide or arrange, in a timely manner, an alternative to meet the needs of the individual (e.g., services delivered in-person; services delivered via telemedicine when conditions allow telemedicine to meet requirements stipulated in the "Reimbursable Telehealth Services" section). In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

Remote Patient Monitoring

- The Provider must have an established relationship with the member receiving the RPM service, including at least one visit in the last 12 months (which can include the date RPM services are initiated).
- The member receiving the RPM service must fall into one of the following five populations, with duration of initial service authorization in parentheses as per below:
  - Medically complex patient under 21 years of age (6 months);
  - Transplant patient (6 months);
  - Post-surgical patient (up to 3 months following the date of surgery);
  - Patient with a chronic health condition who has had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months (6 months); and/or a
  - High-risk pregnant person (6 months).
- All service authorization criteria outlined in the DMAS Form "DMAS-P268" are met prior to billing the following CPT/HCPCS codes:
  - Physiologic Monitoring: 99453, 99454, 99457, 99458, and 99091
  - Therapeutic Monitoring: 98975, 98976, 98977, 98980, and 98981
  - Self-Measured Blood Pressure: 99473, 99474
- Providers must meet the criteria outlined in the DMAS Form "DMAS-P268" and submit their requests to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. See Appendix D of the *Physician/Practitioner* manual for details on the current service authorization contractor and accessing the provider portal.
- Service authorization requests must be submitted at least 30 days prior to the scheduled date of initiation of services.

- Reauthorizations will be permitted for select services, as appropriate and as per criteria in the DMAS Form "DMAS-P268".

Virtual Check-In

- Services must be patient-initiated.
- Patients must be established with the provider practice.
- Must not be billed if services originated from a related service provided within the previous 7 days or lead to a service or procedure within the next 24 hours or at the soonest available appointment.

Reimbursement and Billing for Telehealth Services

Telemedicine

Distant site Providers must include the modifier **GT** on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would *have normally been provided*, had interactions occurred in-person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Store-and-Forward

Distant site Providers must include the modifier **GQ**.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location where the distant site provider is located at the time that the service is rendered.

Remote Patient Monitoring

No billing modifier is required on claims for services delivered via RPM.

Devices used to satisfy conditions for CPT 99453 and 99454 must automatically digitally upload patient data (i.e., not self-recorded or reported by patients) and automatically transmit either daily recordings of the beneficiary's physiologic data OR the device must

record daily values and transmit an alert if the beneficiary's values fall outside predetermined parameters for 16 days in a 30-day period. Devices used to satisfy conditions for CPT 98975, 98976 and 98977 must be used to monitor data for 16 days in a 30-day period. These codes cannot be used for monitoring of parameters for which more specific codes are available (i.e., CPT 93296, 93264, 94760).

Services billed for using CPT 99457, 99458 and 99091 may involve review of data collected in conjunction with codes CPT 99453, 99454, or physiologic data manually captured and submitted by the patient/caregiver for billing providers to review. Services billed for using CPT 98980 and 98981 may involve review of data collected in conjunction with codes 98975, 98976, 98977, or therapeutic data (including self-reported data) manually captured and submitted by the patient/caregiver for billing providers to review.

Time requirements associated with CPT 99457, 99458, 98980, 98981, and 99091 can include time spent furnishing care management services, if not billed for under other reported services, as well as time spent on required direct interactive communication. Interactive communication is defined as real-time synchronous, two-way audio interaction. Time spent on a day when the billing provider reports an E/M service (office or other outpatient services) shall not be included. Time counted toward time requirements of other reported services must also not be counted toward the time requirements of the aforementioned codes.

Only providers eligible to bill CMS Evaluation & Management (E&M) services are eligible to bill for RPM services. Clinical staff members—who work under the supervision of the eligible billing provider and are allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who do not individually report that professional service—are allowed to assist in delivery and satisfaction of appropriate RPM service requirements for 99453, 98975, 99457, 99458, 98980, and 98981, but not 99091.

Codes including the provision of RPM devices (99454, 98976, 98977) shall not be billed if patients supply their own device, or have been separately provided relevant durable medical equipment by DMAS.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting,

shall reflect the location in which patients would *normally be evaluated*. For example, if the member would have come to a private office to discuss management of the condition being monitored via RPM, a POS 11 would be applied. Providers should not use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

An individual provider must not bill for more than one set of RPM services per patient at any given time.

Virtual Check-In

No billing modifier is required on claims for the covered Virtual Check-In codes listed, in Table 5 of Attachment A.

Virtual Check-In services do not require service authorization.

Only physicians and other qualified health care professionals – previously defined by the American Medical Association as being an individual who by education, training, licensure/regulation, and facility privileging (when applicable) performs a professional service within his/her scope of practice and independently reports a professional service – may furnish and bill for Virtual Check-In services.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which patients would have received services had the service occurred in-person and not virtually. For example, if the member would have come to a private office to discuss management of the condition being addressed via virtual check-in, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Originating Site Fee (TH)

Telemedicine

In the event it is medically necessary for a Provider to be present at the originating site at the time a synchronous telehealth service is delivered, said Provider may bill an originating site fee (via procedure code Q3014) when the following conditions are met:

- The Medicaid member is located at a provider office or other location where services can be received (this does not include the member's residence);
- The member and distant site Provider are not located in the same location; and
- The Provider (or the Provider's designee), is affiliated with the provider office or other location where the Medicaid member is located and attends the encounter with the member. The Provider or designee may be present to assist with initiation of the visit but the presence of the Provider or designee in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

All telehealth modalities

Originating site Providers, such as hospitals and nursing homes, submitting UB-04/CMS-1450 claim forms, must include the appropriate telemedicine revenue code of 0780 ("Telemedicine-General") or 0789 ("Telemedicine-Other"). The use of these codes is currently not applicable for services administered by Magellan of Virginia.

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If approved, these facilities may serve as the Provider or originating site and bill under the encounter rate. The encounter rate methodology for FQHCs and RHCs is described in 12VAC30-80-25; the encounter rate for IHCs (including Tribal clinics) is the All Inclusive Rate set by Indian Health Services.

Service Limitations (TH)

Unless otherwise noted in Attachment A, limitations for services delivered via telehealth are the same as for those delivered in-person.

Provider Requirements (TH)

All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a Provider located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to

Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment (888-829-5373) or the Medicaid MCOs for more information.

Documentation Requirements (TH)

Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site Provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient's medical record.

When billing for an originating site, the originating site and distant site Providers must maintain documentation at the originating Provider site and the distant Provider site respectively to substantiate the services provided by each. When the originating site is the member's residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled Providers are conducted by DMAS, the designated contractor or the Medicaid MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the Provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

Member Choice and Education (TH)

Before providing a telehealth service to a member, the Provider shall inform the patient about the use of telehealth and document verbal, electronic or written consent from the patient or legally-authorized representative, for the use of telehealth as an acceptable mode of delivering health care services. This documented consent shall be maintained in the medical record. When obtaining consent, the Provider must provide at least the following information:

- A description of the telehealth service(s);
- That the use of telehealth services is voluntary and that the member may refuse the telehealth service(s) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of the member's benefits;
- That dissemination, storage, or retention of an identifiable member image or other

information from the telehealth service(s) shall comply with federal laws and regulations and Virginia state laws and regulations requiring individual health care data confidentiality;

- That the member has the right to be informed of the parties who will be present at the distant (Provider) site and the originating (member) site during any telemedicine service and has the right to exclude anyone from either site; and
- That the member has the right to object to the videotaping or other recording of a telehealth consultation.

If a Provider, whether at the originating site or distant site, maintains a consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services including the information noted above, this shall meet DMAS's required documentation of patient consent.

Telehealth Equipment and Technology

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to in-person encounter for professional medical services.

Equipment utilized for Remote Patient Monitoring must meet the Food and Drug Administration (FDA) definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act.

Providers must be proficient in the operation and use of any telehealth equipment.

Telehealth encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under HIPAA. Providers shall follow OCR HIPAA rules with the member, including services provided via telehealth. Providers are responsible for ensuring distant communication technologies meet the requirements of the HIPAA rules.

Attachment A (TH)

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.

Table 1. Medicaid-covered medical services authorized for delivery by telemedicine*

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Colposcopy		• 57452, 57454, 57455, 57456, 57460, 57461
Fetal Non-Stress Test		• 59025
Prenatal and Postpartum Visits	• Synchronous audio-visual delivery is permissible for the prenatal and postpartum services stipulated in CPT 59400, 59410, 59510 and 59515; delivery services for those codes must be completed in person. • Providers should complete at least one in-person visit per trimester for which they bill prenatal services for the purposes of appropriate evaluation, testing, and assessment of risk.	• 59400, 59410, 59425, 59426, 59430, 59510, 59515
Radiology and Radiology-related Procedures		• 70010-79999 and radiology related procedures as covered by DMAS; GQ modifier if store and forward**
Obstetric Ultrasound		• 76801, 76802, 76805, 76810, 76811-76817
Echocardiography, Fetal		• 76825, 76826
End Stage Renal Disease		• 90951 - 90970
Remote Fundoscopy		• 92250; TC if applicable; GQ modifier if store and forward • 92227, 92228; 26 if applicable; GQ modifier if store and forward
Speech Language Therapy/Audiology		• 92507†, 92508† , 92521, 92522, 92523, 92524
Diagnosis, analysis cochlear implant function		• 92601-92604, 95974
Cardiography interpretation and report		• 93010
Echocardiography		• 93307, 93308, 93320, 93321, 93325
Genetic Counseling		• 96040
Maternal Mental Health Screening		• 96127, 96160††, 96161††
Physical therapy / Occupational therapy		• 97110†, 97112†,97150† • 97530†, S9129†
Medical Nutrition Therapy		• 97804
Evaluation & Management (Office/Outpatient)		• 99202-99205, 99211-99215; GQ modifier if teledermatology and store and forward
Evaluation & Management (Hospital)		• 99221-99223, 99231-99233; GQ modifier if teledermatology and store and forward
Evaluation & Management (Nursing facility)		• 99304-99306 • 99307-99310
Discharge planning (Nursing facility)		• 99315, 993169

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Evaluation & Management (Assisted living facility)		• 99334, 99335, 99336
Respiratory therapy	• Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the clinical team. Restricted to outpatient respiratory therapy.	• 99503, 94664
Education for Diabetes, Smoking, Diet		• G0108, 97802, 97803
Early Intervention	• Must have family member/caregiver, service coordinator, or member of the clinical team physically present with member during visit. • Initial assessment (T1023) must be in-person with each assessing member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery. • Initial service visit (G* codes) must be in-person with a member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.	• T2022 • w/ or w/o U1: T1023, T1024, T1027, G0151, G0152, G0153, G0495

Table 2. Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Diagnostic Evaluations		• 90791-90792
Psychotherapy		• 90832, 90834, 90837
Psychotherapy for Crisis		• 90839-90840
Pharmacologic counseling		• 90863
Psychotherapy w/ E&M svc		• 90833, 90836, 90838
Psychoanalysis		• 90845
Family/Couples Psychotherapy		• 90846-90847
Group Psychotherapy		• 90853
Prolonged Service, in office or outpatient setting		• 99354-99357
Psychological testing evaluation		• 96130, 96131
Neuropsychological testing evaluation		• 96132, 96133
Psychological or neuropsychological test administration & scoring		• 96136, 96137, 96138, 96139, 96146
Neurobehavioral Status Exam		• 96116, 96121
Add-on Interactive Complexity		• 90785
Health Behavior Assessment		• 96156

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Health Behavior Intervention (Individual, group, family)		• 96158-96159 • 96164-96165 • 96167-96168 • 96170-96171
Evaluation & Management (Outpatient)		• 99202-99205, 99211-99215
Evaluation & Management (Inpatient)		• 99221-99223, 99231-99233
Smoking and tobacco cessation counseling		• 99406-99407
Alcohol/SA structured screening and brief intervention		• 99408-99409
OTP/OBOT Specific Services		• H0004, H0005, H0014*, G9012
SUD Case Management		• H0006
Mental Health Case Management Services		• H0023
IACCT Initial Assessment		• 90889 HK
IACCT Follow-Up Assessment		• 90889 TS
Mental Health Skill Building		• H0046
Crisis Stabilization		• H2019 (ended 11/30/2021)
Crisis Intervention		• H0036 (ended 11/30/2021)
Mobile Crisis Response	Assessment only (See Appendix G to the Mental Health Services Manual)	• H2011 (effective 12/1/2021)
Community Stabilization	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	• S9482 (effective 12/1/2021)
23 Hour Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• S9485 (effective 12/1/2021)
Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• H2018 (effective 12/1/2021)
Assertive Community Treatment		• H0040
Psychosocial Rehabilitation		• H2017
Intensive In-Home Services		• H2012
Therapeutic Day Treatment		• H2016
Behavioral Therapy Program		• H2033 (ended 11/30/2021)
Applied Behavior Analysis (ABA)	97151 and 97152 may be provided through telemedicine for reassessments only.	• 97151-97158 (effective 12/1/2021)
Multisystemic Therapy (MST)		• H2033 (effective 12/1/2021)
Functional Family Therapy (FFT)		• H0036 (effective 12/1/2021)
Foster Care Case Management		• T1016
Peer Recovery Support Services (PRSS)		• H0024, H0025, S9445, T1012
Mental Health Partial Hospitalization Program		• H0035
Mental Health Intensive Outpatient Program		• S9480
SUD Partial Hospitalization Program		• S0201
SUD Intensive Outpatient Program		• H0015

Table 3. Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage

Procedure Title (Reduced Length)	CPT Code
Fine needle aspiration; with imaging guidance	10022
Biopsy of breast; percutaneous, needle core, using image guidance	19102
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device	19103
Preoperative placement of needle localization wire, breast	19290
Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration	19295
Arthrocentesis, aspiration, and/or injection; major joint or bursa	20610
Transcatheter occlusion or embolization (eg, for tumor destruction, other)	37204
Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage	47011
Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49083
Electrocardiogram, routine ecg with at least 12 leads; with interpretation	93000
Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only	93010
Echocardiography, transthoracic, real-time with image documentation (2d)	93306
Duplex scan of extremity veins including responses to compression and other	93970
Duplex scan of extremity veins including responses to compression and other	93971
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93976

Table 4. Medicaid-covered services authorized for delivery via Remote Patient Monitoring

Procedure Title (Reduced Length)	Code
Collection & interpretation of physiologic data digitally stored/transmitted 30 min per 30d	99091
Remote monitoring of physiologic parameter(s); set-up and education on use of equipment	99453
Remote monitoring of physiologic parameter(s); device(s) supply & daily recording(s) or programmed alert(s) transmission, each 30 days	99454
Remote physiologic monitoring treatment management services; interactive communication with the patient/caregiver during the month; first 20 minutes	99457
Each additional 20 minutes	99458
Remote therapeutic; initial set-up and patient education on use of equipment	98975
Respiratory system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98976
Musculoskeletal system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98977

Remote therapeutic monitoring treatment management services; interactive communication with the patient or caregiver during the calendar month; first 20 minutes	98980
Each additional 20 minutes	98981
Self-measured blood pressure; patient education/training and device calibration	99473
Self-measured blood pressure; reported 2x daily for 30d w/ clinician review and communication of treatment plan	99474

Table 5. Virtual Check-In Services

Service	Code
Virtual check-in, E&M-eligible providers, 5-10 min	G2012
Virtual check-in, non-E&M-eligible providers, 5-10 min	G2251
Virtual check-in, E&M-eligible providers, 11-20 min	G2252
Remote evaluation of recorded video and/or images, E&M-eligible providers	G2010
Remote evaluation of recorded video and/or images, non-E&M-eligible providers	G2250

Table 6. Audio Only Services*

Service	Code
Telephone evaluation and management service provided by a physician; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician; 21-30 minutes of medical discussion	99443
Telephone assessment and management service provided by a qualified nonphysician health care professional; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional; 21-30 minutes of medical discussion	98968

* All fee-for-service claims for audio only codes should be billed directly to DMAS, including those delivered in the context of mental health and substance use disorder services. See

Chapter V of the Physician/Practitioner Manual for detailed billing instructions.