Home Health

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Home Health

General Information

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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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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.

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.

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				

CITIES

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 (Home Health)

Updated: 1/19/2022

Managed Care Enrolled Members

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization

for the member to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

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

There are several different managed care programs (Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (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:

Ø Medallion 3.0:

http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
Ø Commonwealth Coordinated Care (CCC):
http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
Ø Commonwealth Coordinated Care Plus (CCC Plus):
http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
Ø Program of All-Inclusive Care for the Elderly (PACE):
http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

At this time, individuals enrolled in the three HCBS waivers 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) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. 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: www.virginiamedicaid.dmas.virginia.gov. 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.

Participating Provider (Home Health)

A participating provider is an institution, facility, agency, person, partnership, corporation, or association that is certified to provide home health services by the Virginia Department of Health (VDH), or a provider that has been granted Deemed Status by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and has a current, signed

participation agreement with the Department of Medical Assistance Services (DMAS). Out-of-state home health agencies may apply for Virginia Medicaid enrollment if they are Medicare-certified or licensed by the state in which they operate.

Provider Enrollment (Home Health)

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign the appropriate Participation Agreement via electronic signature on the online enrollment application or sign the paper enrollment application and return it to the Provider Enrollment and Certification Unit. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

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.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Please read the entire manual before signing the agreement, and keep it available for reference and review during continuing participation. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Requests for Enrollment

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

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

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 our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our 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 (Home Health)

Providers approved for participation in the Medical Assistance Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Xerox - Provider Enrollment Services (Xerox/PES), in writing, of any change in the information that the provider previously submitted to Xerox-PES.

- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Medicaid Program at the time the service was performed.

- Ensure the recipient'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 ground of race, color, or national origin.

- Provide services, goods, and supplies to recipients 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 recipients of the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 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." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established 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, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference. A provider may not charge DMAS or a recipient for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to 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 not less than five years

  from the date of service or as provided by applicable state laws, whichever period is longer. 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. (Refer to the section titled "Documentation of Records," page 4.)

- 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 recipients of Medicaid.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

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

Participation Conditions (Home Health)

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of

participation outlined in their individual provider agreements. The paragraphs which follow outline special participation conditions which must be agreed to by certain types of providers.

Certification and Recertification (Home Health)

Home health services provide periodic care under the direction of a physician. Such services are provided by participating home health providers.

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or oversee **all categories** of health care. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice and economic considerations.

Prior to the delivery of home health services, the physician must certify the patient for the prescribed treatment. Recertification is required at intervals of at least once every 60 days.

Requirements Of Section 504 of the Rehabilitation Act (Home Health)

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.

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.

Documentation of Records

The Provider Agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the direct personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

Utilization of Insurance Benefits (Rehab)

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 is discussed below. Medicaid is the payer of last resort.

Workers' Compensation

Items and services, to the extent that payment has been made or can reasonably be expected to be made under the workers' compensation laws of Virginia, are not reimbursable by the Virginia Medicaid Program.

Other Health Insurance

When a recipient has other health insurance such as Trigon or Medicare, Medicaid requires that these benefits be used first. Supplementation shall be made by the 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

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Virginia Code. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the recipient reports a third-party responsibility (other than those cited on the Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the Home Health provider is requested to forward the DMAS-1000 to:

Third- Party Liability Unit

Department of Medical Assistance Services

600 East Broad, Suite 1300

Richmond, Virginia 23219

A copy of this form is provided in the Exhibits section following this chapter.

Assignment of Benefits (Rehab)

If a Virginia Medicaid recipient is the holder of an insurance policy that assigns benefits directly to the patient, the Home Health provider must require that benefits be assigned to the Home Health provider (or the hospital if the Home Health provider is hospital-based), or refuse the request for the itemized bill that is necessary for the collection of benefits.

Termination of Provider Participation (Rehab)

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox-PES 30 days prior to the effective date. The addresses 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

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the

termination notice.

Subsection (c) of § 32.1-325 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 the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 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.

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.

Medicaid Program Information

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive a provider manual and Medicaid memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the Xerox - Provider Enrollment Services Unit requires the provider to complete the Mail Suppression Form and return it to:

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, Xerox – PES will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

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	Y
	High – Newly enrolling	
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Home Health Agency - Private Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating	Y
	High – Newly enrolling	
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	Y
	High – Newly enrolling	
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	Y - only for Mental Health Clinics
	Moderate -- Community Mental Health Centers	
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.

Eligibility must be confirmed each time service is rendered. 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

Service*	Co-pay Status 1	Co-pay Status 2
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. 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.

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. 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.

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 (Home Health)

Updated: 7/27/2021

GENERAL INFORMATION AND COVERED SERVICES

General Information

This chapter describes the home health services available under the Commonwealth of Virginia's *State Plan for Medical Assistance* (Medicaid). Home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy participants determined to be eligible for assistance. Home health services under Virginia Medicaid must not be of any less or greater duration, scope, or quality than that provided participants not receiving state and/or federal assistance for those home health services covered by Virginia Medicaid.

For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting.

Freedom of Choice

Medicaid eligible participants, by federal requirements must be offered 1) the choice of service provider(s) and 2) choice of where services are offered, in the home or clinic and these choices must be documented in the file of the participant.

Advanced Directives

Home health providers participating in the Medicare and Medicaid Programs must provide adult participants written information upon the initial receipt of home health services of the right to make medical care decisions including the right to accept or refuse medical treatment and the right to formulate advance directives.

The term “advance directive” shall have the same meaning as provided in the Health Care Decision Act (§54.1-2981 et seq., which means (i) a witnessed written document voluntarily executed by the declarant and in accordance with (ii) a witnessed statement, made by a declarant subsequent to the time he is diagnosed or suffering from a terminal condition. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive and does not require participants to execute an advance directive.

Under the law, the home health agency must:

- Provide all adult participants with written information about their rights under State law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform participants about the home health provider's policy on implementing advance directives;
- Document in the participant's medical record whether he/she has signed an advance directive;
- Not discriminate against an participant based on whether he/she has executed an advance directive; and

- Provide staff and community education on advance directives.

Managed Care Enrolled Individuals (Home Health)

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through contracted Managed Care Organizations (MCOs) and their network of providers. All providers should check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled in. The MCO may require a referral or prior authorization for the individual to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

If the individual enrolls with an MCO, some of the services may continue to be covered by Medicaid fee-for-service. Providers must follow the fee-for-service rules in these instances where services are "carved out." The carved out services vary by managed care program. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), Program for All-Inclusive Care for the Elderly (PACE)) for Medicaid individuals. DMAS has different health plans participating in these programs. Go to the websites below to find which health plan participates in each managed care program in your area:

- Medallion 4.0: https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/
- Commonwealth Coordinated Care Plus (CCC Plus): http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):

  http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA. pdf

Medicaid Managed Care

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through

Medicaid Managed Care Organizations (MCOs). MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. 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. home health providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Medallion 4.0

Medallion 4.0 is a statewide mandatory Medicaid program that operates under a CMS §1915(b) waiver. The Medallion 4.0 program provides acute and primary care services with the key program focus areas of prenatal care, postpartum care, case management, care for infants and children including Early Intervention services, immunizations, screening and preventative care.

Target Population include:

1. Pregnant women,
2. Low-income families with children (LIFC),
3. Those receiving temporary assistance for needy families (TANF), and
4. Expansion adults.

Additional information is available at https://www.dmas.virginia.gov/#/med4

Commonwealth Coordinated Care (CCC) Plus

CCC Plus is a managed long-term services and supports (MLTSS) program. This mandatory Medicaid managed care program serves individuals with complex care needs through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports.

Target Population:

5. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible),

6. Individuals who receive Medicaid LTSS in a facility or through CCC Plus Waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, will enroll for their non-waiver services only. At this time, DD waiver services will continue to be covered through Medicaid fee-for-service.

7. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals previously enrolled in the Medallion 3.0 program.

Additional information is available at: http://www.dmas.virginia.gov/#/cccplus.

All services furnished by a home health agency, whether provided directly by the agency's qualified staff or under contractual arrangements with others, must be furnished or under the supervision of qualified personnel as required by Part 484 of Title 42 of the *Code of Federal Regulations* and professional licensing requirements as required by the *Code of Virginia*.

DMAS requires the following for fee-for-service coverage of Home Health Services:

- The participant meets Change Healthcare criteria upon initial and recertification review. These criteria may be obtained through:

  Change Healthcare

  275 Grove Street

Suite 1-310

Auburndale, MA 02466-2283

Telephone: 617-273-2800

Fax: 617-273-3777

Website: ChangeHealthcare.com

Home Health Services Provider Requirements

Face-to-Face Encounter Requirements for Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for initiation of home health services (as defined in 12VAC30-50-160) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) within 90 days prior to when the individual enrolled in Medicaid begins the services or within 30 days after the individual begins the services. The Medicaid face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires home health services.

The face-to-face encounter must be conducted by one of the following five (5) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist who is legally authorized to practice and act within the scope of his or her license;
- A certified nurse midwife who is legally authorized to practice and act within the scope of his or her license;
- A licensed physician assistant working under the supervision of the physician who orders the individual's services; or
- For individuals admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering practitioner. For the home health services that exceed five (5) visits and require service authorization, home health providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met.

Face-to-face encounters may occur through telemedicine, which is defined as the 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 shall not include by telephone or email.

Providers **may** use the **sample form** (found in Chapter 6) to document these new requirements. If a provider does not use the DMAS sample form or the CMS-485 (with the F2F elements clearly included) to document the F2F encounter, any supporting documentation must be clearly titled and easily recognizable as documentation of the F2F encounter and include the required elements listed below.

Providers who opt to use their own forms or systems to document the face-to-face encounter must include:

1. The date of the face-to-face encounter;
2. The practitioner, including full name and credentials, who conducted the face-to face encounter;
3. The primary reason the Medicaid individual requires home health services;
4. Any communication between the ordering practitioner and the practitioner who conducted the face-to-face encounter, if such individuals are different;
5. The date of the order and the ordering practitioner's full name and signature.

Practitioner Supervision and Certification

Participants of home health services must be under the care of a practitioner, which is defined as a physician, nurse practitioner, clinical nurse specialist and physician assistant, who is legally authorized to practice and act within the scope of his or her license. The practitioner may be the participant's private physician, nurse practitioner, clinical nurse specialist or physician assistant, a practitioner on the staff of the home

health agency, practitioner working under an arrangement with the assisted living facility (ALF) which is the participant's residence or, if the agency is hospital-based, a physician on the hospital staff.

A written practitioner's statement, which may be on the home health certification plan of care/treatment, in the form of practitioner orders, in the medical record, must indicate that:

- The participant needs licensed skilled nursing care, home health aide services, physical therapy, occupational therapy, or speech-language pathology services; and

- A plan for furnishing such services to the participant has been established and is periodically reviewed and signed by a physician.

The initial plan of care (certification) must be reviewed by the attending physician or practitioner. The practitioner must sign the initial certification before the home health provider may bill DMAS. A practitioner shall review and recertify the plan of care every 60 days. DMAS will not reimburse the home health agency for services provided prior to the date of the practitioner's signature.

A practitioner recertification shall be performed within the last five days of each current 60-day certification period, i.e. between and including days 56-60. The practitioner recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. The practitioner must sign the recertification before the home health provider may bill DMAS. DMAS will not reimburse the home health agency for services provided prior to the date of the practitioner's signature.

If a participant is admitted to home health care before Medicaid eligibility is effective, the Medicaid enrollment date is considered the date of admission to services and will determine when the next certification is due.

Nursing Services

Nursing services may be provided by contract with a licensed registered nurse in geographic areas where there is no licensed home health agency. Nursing services may be provided on an intermittent or PRN basis to any participant who requires home health care. Nursing care must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse who is a graduate of an approved school of professional nursing. On January 1, 2005, Virginia joined the Nurse Licensure Compact. Under the Code of Virginia, the Nurse Licensure Compact authorized licensed practical nurses and registered nurses licensed and residing in a **compact** state to practice in other **compact** states without the necessity of obtaining an additional license. The Virginia Board of Nursing website (www.dhp.virginia.gov) provides detailed information as to which states are considered **compact** states and an explanation of "primary state of residence." It is the home health agency's responsibility to insure that the nurse is licensed by the Virginia Board of Nursing and meets all requirements as mandated by the Virginia Department of Health Professions.

There are three types of nursing visits:

Initial assessment is a visit by a registered nurse, to assess all of the participant's health care needs and to admit the participant into home health services.

- Routine follow-up are visits in which a specific treatment/procedure or participant/ caregiver education related to developed goals is performed. Some examples of routine follow-up visits are:

- Wound care where strict aseptic or sterile technique is required;

- Periodic Foley catheter changes;

- Post-hospital teaching sessions where the primary focus is to assist the participant and/or caregiver in the transition of receiving extensive patient teaching to meet the participant's medical needs in the home environment;

- Pre-filling of insulin syringes no more than once every two weeks, unless the participant's blood sugar instability warrants medically necessary changes in insulin dosages or the prescribed brand of insulin changes.

- A routine follow-up visit is not a visit that would be done periodically over extended periods of time for general or non-specific goals. Examples of these types of visits are, but not limited to: periodic assessment of diabetic hypertensive or otherwise chronically ill participants whose conditions have remained stable and well-baby growth and development assessments on infants and children without current acute deficits or routine infant care teaching to parents. Visits made because of on-going social welfare limitations (e.g., protective services) do not constitute a routine, follow-up skilled nursing visit. These types of visits are not Medicaid reimbursable visits.

- The comprehensive skilled nursing visit criteria establishes a set of conditions that must be met for a visit to be billed as a comprehensive skilled nursing visit, therefore, reimbursed at the higher reimbursement rate. This set of conditions includes, but are not limited to:

- High technology and extended lengths of time for the provision of the high tech task;

- Complex AND multidimensional situations requiring skills in teaching the provision of extensive hands-on skilled care by qualified personnel. It is the responsibility of the agency to send a qualified nurse into the home. The credentials of the nurse are not the determining factor of Medicaid reimbursing at the comprehensive rate.)

"High-technology" refers to the complexity of procedures often involving the use of instruments, equipment and machines. At a minimum, supporting documentation in the form of practitioner's orders, plans of treatment, nursing care plans, and/or visit progress notes must clearly describe the following:

- The number and type of skilled procedures to be performed by the nurse during the visit;

- The number and complexity of steps needed to complete each procedure; and

The extent to which the nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a practitioner, and/or adjust orders/plans of care.

NOTE: See Chapter VI for minimum documentation requirements for reimbursement at the comprehensive visit rate.

A registered nurse must make the start of care assessment visit to initiate home health services; regularly evaluate the participant's nursing needs; initiate the plan of care and necessary revisions; provide those services requiring substantial and specialized nursing skill; initiate appropriate preventive and rehabilitative nursing procedures; prepare clinical and progress notes; coordinate services; inform the practitioner and other personnel of changes in the participant's condition and needs; educate the participant and family in meeting nursing and related goals; and supervise and educate other personnel involved in the participant's care.

As a normal scope of practice, the licensed practical nurse furnishes services according to agency policies; prepares clinical and progress notes; assists the practitioner and registered nurse in performing specialized procedures; prepares equipment and materials for treatments involving aseptic techniques as required; and assists the participant in learning appropriate self-care techniques.

Home Health Aide Services

Home health aide services are intended to assist the participant/caregiver during a period of daily living or can appropriately be utilized to assist in carrying out nursing or rehabilitative care plans. Home health aide services must be incorporated into an outcome-specific nursing care plan.

Home health aides must meet the qualifications specified by 42 CFR § 484.36. The home health agency must maintain documentation which demonstrates that the home health aides employed or contracted by the agency meet these required qualifications. Home health aide services are not intended to be utilized for any services outside the specified qualifications. Examples of services which are not considered a part of the home health aide responsibilities are preparing or administering medications, administering nasogastric or gastrostomy tube feedings and teaching or instruction to the participant or caregiver.

Home health aide services may include assisting with personal hygiene, eating, walking, meal preparation and feeding, and taking and recording blood pressure, pulse, and respiration. Written instructions for participant care must be prepared by the registered nurse or licensed therapist as appropriate.

When it is identified that a participant has an ongoing need for services similar to those provided by the home health aide, the home health agency must provide information to the participant and/or caregiver about other services (e.g., personal care, companion aide, etc.) that may be more appropriate in meeting their needs. The home health agency is expected to make the necessary referrals for these services prior to utilization of the participant's 32 allowable home health aide visits. Once other services similar to those provided by the home health aide begin, the home health aide services are terminated.

Supervisory Visits for Home Health Aide Services

As stated in the VAC 30-50-160, home health aide services must be provided under the supervision of a registered nurse or licensed therapist. When only home health aide services are being furnished, a registered nurse must make a supervisory visit to the participant's residence at least once every 60 days when the aide is furnishing care. The supervisory visit is not reimbursable by the Medicaid program.

When skilled nursing care or physical therapy, occupational therapy, or speech-language pathology services are also being furnished to the patient, a registered nurse must make a supervisory visit to the patient's residence at least every two weeks (either when the aide is present or when the aide is absent). When only a rehabilitative therapy is furnished in addition to the home health aide services, a skilled therapist may make the supervisory visit in place of a registered nurse. The supervisory visit is not reimbursable by Medicaid.

When supervisory visits are not provided in accordance with DMAS policy, DMAS will not provide reimbursement for the home health aide visits.

Rehabilitation Services: Physical Therapy, Occupational Therapy, and Speech Language Pathology Services

Physical Therapy

Physical Therapy services are those services provided to a participant in his/her place of residence that meets all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a practitioner after any needed consultation with a physical therapist (PT) licensed by the Virginia Board of Physical Therapy. The *Code of Federal Regulations* (42 CFR § 440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;

- The services must be of a level of complexity and sophistication or the condition of the participant must be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy or a physical therapist assistant (LPTA), who is licensed by the Virginia Board of Physical Therapy, under the direct supervision of a qualified licensed physical therapist, as defined above;

- The services must be provided with the expectation, based on the assessment made by the practitioner of the participant's rehabilitation potential, that the condition of the participant will improve in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of services be reasonable.

Only a licensed PT has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a participant's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and where appropriate, recommend to the practitioner a plan of care/treatment plan. However, while the skills of a licensed physical therapist (PT) are required to evaluate the participant's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapist assistant. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed physical therapist. When services are provided by an LPTA, the PT must conduct a supervisory visit at least every 30 days while therapy is being conducted and documented accordingly. When supervisory visits are not conducted in accordance with DMAS policy, physical therapy visits will not be reimbursed by Medicaid.

If an adequate number of qualified personnel are not available to carry out the practitioner order, the therapist must inform the practitioner of this and record the response of the practitioner in the participant's medical record. The plan of care/treatment plan must be revised according to the practitioner's written approval. This revision may be obtained in the form of a practitioner signed and dated (verbal order is acceptable) to amend the home health certification plan of care/treatment or therapy plan of care.

Physical Therapy services may include the following:

Gait Training

Gait evaluation and training, provided to a participant whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality, require the skills of a licensed physical therapist and constitute physical therapy, provided that it can

reasonably be expected to significantly improve the participant's ability to walk.

Examples of services that do not constitute rehabilitation physical therapy are:

- Activities appropriately provided by supportive personnel (e.g., aides or nursing staff); and
- Activities that do not require the skills of a licensed physical therapist or licensed physical therapy assistant.

Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specific diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Range of motion exercises, whether because of their nature or the condition of the participant, which may be performed safely and effectively only by a licensed physical therapist or licensed physical therapy assistant under the direct supervision of a therapist, will be considered rehabilitation physical therapy that is reimbursed by Medicaid.

Range of motion exercises not related to the restoration of a specific loss of function can ordinarily be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.) and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. Passive exercises to maintain range of motion in paralyzed extremities can be carried out by physical therapy aides, home health aides, nursing staff or supportive caregivers and will not be considered rehabilitation therapy and, therefore, are not reimbursable visits by Medicaid.

Therapeutic Exercises

Therapeutic exercises (e.g., strengthening, stretching, tilt table activities, etc.), performed by or under the direct supervision of a licensed physical therapist, due to either the type of exercise employed or the condition of the participant, constitute covered physical therapy and can be reimbursed by Medicaid.

Occupational Therapy

Occupational Therapy services are those services provided to a participant in his/her place of residence that meets all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the practitioner after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The *Code of Federal Regulations* (42 CFR § 440.110) requires that the therapist meet licensure requirements within the scope of practice under state law;

- The services must be provided with the expectation, based on the assessment made by the practitioner of the participant's rehabilitation potential, that the condition of the participant will improve in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a registered and licensed occupational therapist has the knowledge, training and experience required to evaluate and, as necessary, reevaluate a participant's level of

function; determine whether an occupational therapy program could reasonably be expected to improve, restore or compensate for lost of function; and, where appropriate, recommend to the practitioner a plan of care/treatment plan. While the skills of a registered and licensed occupational therapist are required to evaluate the participant's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the registered and licensed occupational therapist (not the COTA). When services are provided by a COTA, the OTR must conduct a supervisory visit at least every 30 days and document accordingly. When supervisory visits are not conducted in accordance with DMAS policy, occupational therapy visits will not be reimbursed by Medicaid.

If an adequate number of qualified personnel are not available to carry out the practitioner order, the therapist must inform the practitioner of this fact and record the response of the practitioner in the medical record. The plan of care/treatment plan must be revised accordingly with the practitioner's written approval. This revision may be in the form of a practitioner signed and dated (verbal order is acceptable) to amend the home health certification plan of care or therapy plan of care.

Occupational therapy may involve some or all of the following:

- The evaluation and re-evaluation, as required to assess a participant's level of function by administering diagnostic and prognostic tests that can be completed in a participant's place of residence;

- The selection and teaching of task-oriented, therapeutic activities designed to restore physical function (e.g., use of woodworking activities to restore shoulder, elbow and wrist range of motion lost as a result of burns or other injury);

- The planning, implementing and supervising of an participantized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, assist with memory

loss and reality orientation in a neurologically impaired participant);

- The planning and implementing of therapeutic tasks and activities to restore sensory integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke participant with functional loss resulting in a distorted body image); and

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a participant who has lost the use of an arm dressing and cooking skills with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a spinal cord injured participant new techniques to enable him or her to perform feeding, toileting, and other activities as independently as possible). Rehabilitation services shall be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services must be reasonable.

Speech-Language Pathology

Speech-language pathology services are those services provided to a participant in his/her place of residence that meet the following conditions:

The services must be directly and specifically related to an active written plan of care/treatment plan designed by a practitioner after needed consultation with a speech language pathologist licensed by the Virginia Department of Health Professions and the Virginia Board of Audiology and Speech-Language Pathology. The *Code of Federal Regulations* (42 CFR § 440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law.

The services must be of a level of complexity and sophistication or the condition of the participant must be of a nature that the services can only be performed by any one of the following:

- A Master's level prepared speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions and the Virginia Board of Audiology and Speech-Language Pathology; or

- A participant licensed by the Virginia Board of Audiology and Speech-Language Pathology who meets one of the following:

  a. Has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); or

  b. Has completed the Master's level academic program and is acquiring supervised work experience to qualify for the ASHA certification.

  This participant is in the Clinical Fellowship Year (CFY). This participant must be under the direct supervision of a licensed CCC/SLP or SLP. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP, a licensed CCC/SLP or SLP must make a supervisory visit at least every 30 days while therapy is being conducted and document the visit in the participant's record accordingly.

  c. Effective January 1, 2001, DMAS will reimburse for the provision of speech language services when provided by a participant identified as a speech language assistant, e.g., Bachelor's level, a Master's level without licensure by the Board of Audiology and Speech Language Pathology, or a Master's level with licensure only by the Department of Education. The identity of the unlicensed assistant (and the fact he/she does not meet qualification requirements to bill Medicaid) shall be disclosed to the participant, parent, or legal guardian prior to treatment, and this disclosure shall be documented and made a part of the participant's record. These speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets provider licensure requirements.

Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP or a speech-language assistant, a licensed CCC/SLP or SLP must make a supervisory on-site visit at least every 30 days while therapy is being conducted. The supervisory therapist is not required to co-sign the speech-language assistant's progress visit notes; however, he or she is required to review the notes. If the supervisory therapist co-signs the assistant's progress visit notes, this does not constitute a 30-day supervisory visit note. Evidence of the supervisory therapist's on-site visit must be documented every 30 days in the participant's record.

- The services must be provided with the expectation, based on the assessment made by the practitioner of the participant's rehabilitation potential, that the condition of the participant will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a licensed speech-language pathologist has the knowledge, training and experience required to evaluate and, as necessary, reevaluate a participant's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore or compensate for lost function, and, where appropriate, recommend to the practitioner a plan of care/treatment plan. However, while the skills of a licensed speech language pathologist are required to evaluate the participant's level of function and develop a plan of care/treatment plan, the implementation of the plan of may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, and speech-language assistants as identified above. The plan of care/treatment care plan must be developed and signed only by the licensed speech language pathologist.

If an adequate number of qualified personnel are not available to carry out the practitioner's order, particularly related to the frequency of service, the therapist will inform the practitioner of this fact and record the response of the practitioner in the

medical record. The plan of care will be revised accordingly with the practitioner's written approval. This amendment to the home health plan of care may be obtained in the form of a written, verbal order including duration and frequency, as appropriate, that is signed and dated by the practitioner.

Speech-language pathology services include the following procedures:

- Assistance to the practitioner in evaluating participants to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech-language pathologist of a participant with aphasia following a recent stroke to determine the need for speech-language pathology services;

- Providing rehabilitative services for speech and language disorders;

- Providing rehabilitative services for swallowing disorders, cognitive problems, etc.

Guidelines for Initiating and Continuing Therapy

The following are guidelines designed to assist with the determination of appropriate services:

- DMAS will only reimburse for the specific therapy evaluation. A nursing evaluation is not required by DMAS and will not be reimbursed.

- **Maintenance Therapy** – Maintenance therapy is defined as the point where the participant demonstrates no further significant improvement or the skills of a qualified rehabilitative therapist are not required to carry out an activity or home program to maintain function at the level to which it has been restored. Services in this category are not covered.

- **Improvement of Function** - Rehabilitation services designed to improve function must be based on an expectation that the therapy will result in a significant, practical improvement in a participant's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the rehabilitative therapy program is instituted, the services would be recognized even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the participant is not going to improve or has reached his/her maximum rehabilitation potential. A home exercise program should be reviewed with the participant and/or caregiver to maintain skills taught by the qualified therapist. At this point, home health therapy services should be terminated.

Discharge/Termination from Services

Rehabilitation services must be considered for termination regardless of the preauthorized length of services when any one of the following conditions is met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered therapist are no longer required for safe and effective provision of such rehabilitation services. The participant has reached his or her maximum progress, and a safe and effective maintenance program has been developed;

- There is limited motivation on the part of the participant or caregiver;

- The participant has an unstable condition that affects his or her ability to participate in a rehabilitative plan of care/treatment plan;

- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;

- The established goals serve no purpose to increase functional or cognitive capabilities; and

The service can be provided by someone other than a licensed or registered/certified rehabilitation professional.

Definition of a Visit

A visit is defined as the duration of time that a home health nurse, home health aide or rehabilitation therapist is with a participant to provide covered practitioner-ordered services in the participant's place of residence. Visits are not defined in measurements or increments of time. The furnishing of any services by a particular qualified nurse, therapist or home health aide on a particular day or particular time of day constitutes a visit. For example, if both a physical therapist and/or an occupational therapist furnish services on the same day, this constitutes two visits. However, if a therapist, nurse of home health aide furnishes several services during a visit, this constitutes only one visit for each discipline that furnishes services. If a therapist, nurse or home health aide provides two distinctly separate therapy sessions/services in the same day (e.g. morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist, nurse or home health aide cannot be billed as separate visits if the goals are the same for that visit by a particular discipline (e.g. two therapists, nurses or home health aides are required to perform a single procedure or are working collaboratively toward the same goal). The overall goal(s) of the session determines how the visit can be billed.

Covered Maintenance Services

Home health services are services provided by a certified home health agency on a part time or intermittent basis to a participant in his/her place of residence. For Medicaid, the participant does not have to be home bound, but the services must be provided in the participant's home. Home health services are intended to provide skilled intervention with an emphasis on participant or caregiver teaching. For all maintenance services, the emphasis will be on keeping the participant at home rather than requiring the participant to go to the practitioner's office, unless practitioner visits are scheduled and would coincide with the needed home health visits. Below are some common maintenance issues and related procedures that the DMAS pre-authorization contractor, will follow when prior authorization is required.

The general questions that will be asked for these procedures are:

- Can the participant perform the procedure?
- If the participant cannot perform the procedure, is there a caregiver who is willing and able to perform the procedure? The "willing and able" reason cannot be based solely on the provider's policy.
- If the provider states that there is no one willing or able to perform the service, this will be further explored. If the caregiver is able to learn, but is not willing, the contractor will ask for the reason(s). For example, if the caregiver has a fear of administering injections, the contractor will authorize extra teaching visits and request documentation of the teaching efforts.

In addition to the questions above, the following specific procedures require additional information:

- **B-12 injections and insulin injections:** If the practitioner certifies that there is a need for this procedure to be performed as a home health visit AND no one else is willing and able to perform this procedure AND if appropriate documentation is provided supporting the medical necessity of these home health visits, it will be approved.

- **Central venous access devices (dressing changes, etc.):** The contractor will ask the provider if the participant is currently getting medication through the line, how frequently is it being accessed, and whether it is a PICC, Groshog, Hickman, Porta Cath, etc. If the practitioner certifies that there is a need for this procedure to be performed as a home health visit and no one else is willing and able to perform this procedure and appropriate documentation is provided supporting the medical necessity of these home health visits, it will be approved.

Other Services

- **Changing of indwelling catheters:** Authorization will be based on the merits of

each participant case. If the service is needed no more than once a month, no discharge plan is required. If the service is needed more than once a month, will request the provider to supply documentation supporting the medical necessity of these home health visits. Approval will be based on the documentation of medical necessity provided.

- **Blood draws:** Authorization will be based on the merits of each participant case. The contractor will ask if the home health visits are medically necessary to address a specific medical condition (i.e. participant is medically unstable or is morbidly obese and requires transportation by an ambulance). The contractor will ask if the medical condition is chronic and requires routine visits. If appropriate documentation is provided supporting the visits as medically necessary, contractor will approve the visits.

Services For Participants In Assisted Living Facilities (ALFs)

Limited home health coverage is available for participants in an assisted living facility (ALF). ALFs must provide for certain services as mandated by the Department of Social Services (DSS) licensing standards for ALFs. When the ALF must provide home health nursing or aide services as a component of these covered services, DMAS shall not reimburse a home health agency to provide such services to residents of ALFs. The ALF must provide the services as specified below, and the home health agency cannot bill DMAS for any of the specified non-reimbursable services. These services are:

- Home health aide services;
- Medication administration including, but not limited to:
- By-mouth (oral) administration
- Insulin injections
- Eye drops
- Rectal administration
- Topical application
- Inhalers, and
- Nasal administration;
- Medication monitoring; and
- Superficial wound care for pressure ulcers up to stages I to II or care to skin tears, minor cuts, or abrasions.

When injections other than insulin are necessary and ordered by the practitioner, the ALF must either administer the injection by appropriately licensed staff or assist the resident by securing the injection services through a home health agency, through an outpatient clinic visit, or through emergency services as most appropriate for the medical circumstance and reimbursement guidelines.

If a home health provider bills for or has billed for any of these services for a resident of an ALF, DMAS will deny or retract reimbursement for the inappropriate payments for such services.

Medicaid may cover skilled nursing services provided by a home health agency. These cases only include services the ALF is not required to provide. Personal care/ADL services provided by a home health agency will not be reimbursed. If skilled nursing services have been utilized for over 30 days, a change in the resident's cognitive or functional ability may have occurred. The ALF should notify DMAS within two weeks of the resident's receiving 30 days of skilled nursing services. The resident's change in cognitive or functional ability may warrant an assessment as to whether the resident is receiving the appropriate level of care. The *Virginia Administrative Code* (22 VAC 4071-150) prohibits ALFs from admitting or retaining participants with any of the following conditions:

1. Ventilator dependency;

2. Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent practitioner to be healing;

3. Intravenous therapy or injections directly into the vein except for intermittent therapy managed by a health care professional licensed in Virginia when it is on a time limited basis under a practitioner's treatment plan;*

4. Airborne infectious disease in a communicable state, including diseases such as

tuberculosis and excluding infections such as the common cold;

5. Psychotropic medications without appropriate diagnosis and treatment plans;

6. Nasogastric tubes;

7. Gastric tubes except when the participant is capable of independently feeding himself or herself and caring for the tube; *

8. Participants presenting an imminent physical threat or danger to self or others;

9. Participants requiring continuous, licensed nursing care;

10. Participants for whom his or her practitioner certifies that ALF placement is no longer appropriate;

11. Unless the participant's independent practitioner determines otherwise, participants who require maximum physical assistance as documented by the Uniform Assessment Instrument (UAI) and meet Medicaid nursing facility level of care criteria as defined by the *State Plan for Medical Assistance*. Maximum physical assistance means a participant has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI; and

12. Participants whose health care needs cannot be met in the specific ALF as determined by the residence.

For those participants who do not receive the auxiliary grant payment, at the request of the resident, and pursuant to regulations of the Department of Social Services, care for

the conditions or care needs defined in Sections 3 and 7 above may be provided to a resident in an ALF by a licensed practitioner, a licensed nurse under a practitioner's treatment plan, or by a home care organization licensed in Virginia when the resident's independent practitioner determines that such care is appropriate for the resident.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Supplies and equipment (e.g., gauze, cotton, adhesive bandage, sphygmomanometer, scales, etc.), which are used during the course of the home visit by personnel of the home health agency, are included in the visit fee paid to the agency. The only supplies for which the provider of supplies may receive separate reimbursement are those supplies that remain in the home beyond the time of the visit to allow the participant to continue treatment.

Intravenous Therapy Supplies

Nursing visits for Intravenous (I.V.) Therapy are reimbursed under home health services.

To receive reimbursement for I.V. Therapy Nursing Services, the provider must be a Medicaid home health provider with a valid home health Medicaid provider number. The home health visit reimbursement for all nursing services includes, but is not limited to; travel time, participant education, and I.V. administration. A home health nurse must be present delivering a service that is deemed medically necessary in order to receive reimbursement. Supplies used by the nurse during the course of the home health visit for I.V. therapy, such as I.V. start kits, angiocaths, midline catheters, etc., will be reimbursed under the durable medical equipment (DME) service day rate allowance to whichever DME provider furnishes the supplies.

TRANSPORTATION (Home Health)

Extraordinary transportation costs to and from the participant's home may be recovered by the home health agency if the participant resides outside of a 15-mile radius of the home health agency. An add-on fee will be paid for miles traveled per day per independent staff member in excess of a 15-mile radius from the home health agency. Mileage will be calculated from the radius to the farthest point of travel per day and return to the point of radius. Payment will be set at a rate per mile as established by the General Services Administration in the "Federal Travel Regulations," which is published in the *Federal Register*, times the excess mileage over the 15-mile radius.

If a visit is within the 15-mile radius, the transportation cost is included in the visit rate; therefore, no additional reimbursement for transportation will be made, regardless of the number of miles driven by the staff member. Mileage charges should be added to the invoice of the participant who lives the farthest point of travel for the day. The home health agency must keep daily mileage records of staff and have available a map that identifies a 15-mile radius. For a home health agency to receive reimbursement for transportation, the participant must be receiving Medicaid home health services.

NON-COVERED SERVICES (Home Health)

The following services are not covered:

- Medical social services;
- Services or items which would not be paid for if provided to an inpatient of a hospital or nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), such as private-duty nursing service, or items of comfort which have no medical necessity, such as a television;
- Meals on Wheels or similar food service arrangements;
- Domestic or housekeeping services which are unrelated to participant care and which materially increase the time spent on a visit;
- Custodial care which is participant care that primarily requires protective services rather than definitive medical and skilled nursing care;
- Skilled home health nursing and home health aide services when the participant is enrolled for comparable services available under one of the home and community-based waivers;
- Home health nursing or aide services for residents of ALFs if the residence is

responsible for providing the services as a component of the covered services governed by the Department of Social Services licensing standards for ALFs;

- Multiple visits when there is no break in services on a given day or multiple disciplines providing a single procedure or working collaboratively toward the same goal;

- Services which fall under the category of psychotherapy;

- Maintenance therapy;

- Services which fall under the category of private duty nursing; and

- Services related to cosmetic surgery.

Copayments For Home Health Participants

The copayment for home health participants is limited to one $3.00 charge per day. It is important that providers use care in billing for overlapping dates of service. A copayment is applicable for each date of service; however, as the invoice does not show the specific dates of service when a range of days is billed, claims processing applies certain assumptions in calculating copayments. The primary assumption is that a copayment is taken based on the lesser of the number of days indicated by the from/through days or the number of visits for a single procedure code on the claim. Providers should use care to accurately reflect the number of days (encounters) of direct patient care. Only one copayment is applicable for each day (encounter) per provider type for a participant regardless of the number of services being provided.

DMAS will calculate the copayment by multiplying the copayment amount ($3.00) by the number of days listed in Locator 7, which is a required field on the invoice. Home health claims will be rejected if (a) Locator 7 is blank; (b) the total days exceed the number of days between the from and through dates; or (c) the total days exceed the number of services. The amount of the copay will be deducted from the provider's reimbursement.

See Chapter V for detailed billing instructions.

Individuals enrolled in the Medallion 4 and CCC Plus managed care program do not have copayments for services.

Billing Procedures (Home Health)

Updated: 11/9/2015

INTRODUCTION

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Electronic Submission of Claims (Home Health)

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information contact our fiscal agent, Xerox State Healthcare, LLC:

Phone: (866)-352-0766

Fax number: (888)-335-8460

Website: https://www.virginiamedicaid.dmas.virginia.gov or by mail

Xerox State Healthcare, LLC

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

Timely Filing (Podiatry)

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met

within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or

more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Billing Invoices (Home Health)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

- Health Insurance Claim Form, CMS-1450 (UB-04)

The requirement to submit claims on an original CMS-1450 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid

Billing Instructions: Automated Crossover Claims Processing (DME)

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather than the Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier “1D” in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Virginia Medicaid will reduce the need for submitting follow-up paper claims.

DMAS has established a special email address for providers to submit questions and issues related to

the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

Requests for Billing Materials

Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402

(202)512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by: Mail Your Request To:

Commonwealth Mailing
1700 Venable St.,

Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin

804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

Remittance/Payment Voucher (Hospice)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

Billing Procedures (RD)

Physicians and other practitioners must use the appropriate

claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical
Assistance Services
Practitioner

P.O. Box 27444

Richmond, Virginia 23261-7444

Or

Department of Medical Assistance
Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

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

For providers that 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.

Billing Instructions: ClaimCheck

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:

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

- MUE Edits:

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

- Exempt Provider Types:

DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC),Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:

DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of “1”or “0” in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of “1”, a modifier is allowed and both codes will pay. If the modifier indicator is “0”, the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient’s medical record **must** contain documentation to support the use of the modifier by clearly

identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

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

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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

Vaccine Billing Information

Billing Codes for the Administration Fee

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

Billing Instructions Reference For Services Requiring Service Authorization

Please refer to the “service authorization” section in Appendix D.

Payment Methodology

DMAS has established a flat rate for each level of service for home health agencies (HHAs) by peer group. There are three peer groups: (i) the Department of Health's HHAs, (ii) non-Department of Health HHAs whose operating offices are located in the Virginia portion of the Washington DC-MD-VA metropolitan statistical area, and (iii) nonDepartment of Health HHAs whose operating offices are located in the rest of Virginia.

The use of the CMS designation of urban metropolitan statistical areas (MSAs) is used for Medicare home health rates, incorporated to determine the appropriate peer group for these classifications.

The Department of Health's agencies are placed in a separate peer group due to their unique cost characteristics (only one consolidated cost report is filed for all Department of Health agencies).

Rates were established based on 1989 costs and are inflated annually as described in regulations at 12 VAC 30-80-180. The rates are published on the DMAS web site at www.dmas.virginia.gov. They are located in the Provider Services section under "Rate Setting Information."

Transportation Costs

Extraordinary transportation costs to and from a Medicaid member's home that are not also covered by Medicare may be recovered by the home health agency if the member resides outside of a 15-mile radius of the home health agency. Payment will be set at a rate per mile as established by the General Services Administration in the Federal Travel Regulations. (Federal Travel Regulations are published in the *Federal Register*.)

If a visit is within the 15-mile radius, the transportation cost is included in the visit rate; therefore, no additional reimbursement for transportation will be made. For a home health agency to receive reimbursement for transportation, the member must be receiving Medicaid home health services.

Durable Medical Equipment and Supplies

Billable durable medical equipment and supplies, defined as equipment and supplies which

remain in the home beyond the time of the visit, will be reimbursed separately. **To bill for durable medical equipment (DME), the agency must also be enrolled as a DME vendor.** Expendable medical supplies left in the home by a nurse will be reimbursed separately only when billed on the CMS-1500 using a DME provider number. Refer to the Virginia Medicaid *DME and Supplies Manual* for complete billing instructions.

Third-Party Liability

Since Medicaid is always the payer of last resort, the provider must seek payment from any other source where the member may have coverage for the services provided before billing Medicaid. Information regarding other sources can be obtained from the member or from the Medicaid identification card. Information showing the payments collected from other sources must be included on the Medicaid invoices. It is the responsibility of the provider to ensure that an individual who receives Medicaid home health services is Medicaideligible on the date of service.

CLIA Certification (Home Health)

Any laboratory claims submitted by a Home Health agency will be denied if no CLIA certificate and identification number are on file with DMAS. This requirement implements the federal Clinical Laboratory Improvement Amendment of 1988. To obtain a CLIA certificate and number or to obtain information about CLIA, call or write the Virginia Department of Health (VDH) at:

VDH Office of Health Facility Regulation

3600 Centre, Suite 216

3600 W. Broad Street

Richmond, Virginia 23230

804-367-2104

DMAS will deny claims for services outside of the CLIA certificate type, reason 480 (provider not CLIA certified to perform procedure).

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

Billing Instructions: Invoice Processing (IFDD)

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
  - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
  - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been

received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

Billing Instructions: Group Practice Billing Functionality

Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-based organizations (NPI Type 2), sole practitioners, and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

See “Exhibits” for more information related to Group Billing.

Medicare Crossover: Sole Practitioners that submit claims to Medicare with a Type 2 Organization Billing Provider NPI, and a different Type 1 Individual Rendering Provider NPI should enroll in Virginia Medicaid with their Type 2 Billing Provider NPI. DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claims. You will not enroll as a Group Practice with Virginia Medicaid. Claims submitted directly to Virginia Medicaid should use the Type 2 Billing Provider NPI in both the Billing Provider and Rendering Provider Locators.

Utilization Review (Home Health)

Updated: 8/26/2020

INTRODUCTION

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

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from Medicaid. Under the Participation Agreement with DMAS, the provider also agrees to provide 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.

Individuals Enrolled in Managed Care (DME)

Most individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. Durable medical equipment (DME) providers serving individuals enrolled within an MCO shall reference their MCO provider agreement regarding Utilization Review and Control. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations. For those who are enrolled in Medicaid and continue to receive care under Medicaid fee-for-service, the provider is responsible for adhering to state and federal regulations, as well as this manual.

Financial Review and Verification (Podiatry)

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 (Home Health)

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid participants are medically necessary and appropriate and are provided by the appropriate provider. Providers and participants are identified for review by:

- Systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or participants. Exception reports developed for providers compare an participant provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.
- Referrals and complaints from agencies or participants. Referrals and complaints of inappropriate utilization of Medicaid services are investigated to determine if a Quality Management Review is necessary. The case may be referred to the DMAS' Provider Review Unit or the Attorney General's Office for further review. Reviews are conducted by:
- The reviewer, who is either a Health Care Compliance Specialist (HCCS), trained professional employed by DMAS or a Contractor of DMAS, reviews all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

On-site review process:

- Upon arrival at the facility, the reviewer will supply the provider with a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The reviewer will begin the review at the facility.
- At completion of the on-site portion of the review, the reviewer will conduct an Exit Conference. This conference is a brief summary of the onsite findings.
- Upon return to DMAS, the reviewer will complete the review. Completion of this review includes a summary letter to the provider. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division of DMAS. The provider will receive another letter outlining the repayment requirements from this Division. Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The records must be received by DMAS by the date instructed. Upon receipt of the documents, the reviewer will review the records received. The reviewer may contact the provider for clarification of any documents received.
- Upon completion of the review, the reviewer will send a summary letter to the provider via certified mail. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division at DMAS. A letter outlining the repayment requirements will be received from this Division.

Overpayments:

- Overpayments may 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 records or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision

of poor quality services or any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

Fraudulent Claims (Home Health)

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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 Program 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 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, 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*:*

Department of Medical Assistance Services

Division of Program Integrity

Supervisor, Provider Review Unit

600 East Broad Street

Richmond, Virginia 23219

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:

Office of the Attorney General

Director, Medicaid Fraud Control Unit

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Participant Fraud

Allegations concerning fraud or abuse by participants are investigated by the Division of Program Integrity of the Department of Medical Assistance Services. The Division focuses primarily on determining whether participants misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in eligibility. The Division also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the participant was not entitled were approved, corrective action is taken by referring participants 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 participant who is convicted of Medicaid fraud by a court. That participant will be eligible for Medicaid for a

period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Department of Medical Assistance Services

Division of Program Integrity

Cost Settlement and Audit

600 East Broad Street

Richmond, Virginia 23219

Referrals to the Client Medical Management Program (Hospice)

DMAS providers may refer individuals enrolled in Medicaid who are suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity (PI) of the Department of Medical Assistance Services. Referred individuals 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. If CMM enrollment is not indicated, Recipient Monitoring Unit (RMU) staff may educate these individuals 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. Voicemail receives after hours referrals. Written referrals should be mailed to:

Program Integrity Division

Department of Medical Assistance Services

600 East Broad Street

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 individual and a brief statement about the nature of the utilization problems. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Home Health Program

The home health agency and its staff must operate and furnish services in compliance with all applicable federal, State, and local laws and regulations and must comply with accepted professional standards and principles that apply to professionals furnishing services. All personnel furnishing services must maintain liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences must establish that effective interchange, reporting, and coordination of patient care has occurred. A written summary report for each participant must be sent to the attending physician at least every 60 days.

Retention of Medical Records (Home Health)

A medical record containing pertinent past and current findings in accordance with accepted professional standards must be maintained for every participant receiving home health services and must contain the plan of care, appropriate identifying information; the name of the physician; drug, dietary, treatment and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and once discharged, a discharge summary.

For participants currently receiving a home health service, a copy of the plan of care, all supporting verifiable medical documentation, and all associated billing documentation must be kept on file at the location serving the participant. For participants no longer receiving a home health service, completed plans of care, all supporting verifiable medical documentation, and all associated billing documentation must be retained by the provider as stipulated by the licensing agency for at least five years. If a participant transfers to another home health agency, medical documentation shall be forwarded to the new home health provider.

Medical record information must be safeguarded against loss and unauthorized use. The home health agency must have written procedures in place that govern the use and removal of records and the conditions for the release of information. The participant's written consent is required for the release of information not otherwise authorized or required by law.

Documentation Requirements For Home Health Services

Face-to-Face Encounters for Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for initiation of home health services (as defined in 12VAC30-50-160) unless a face-to-face encounter has been performed by an approved practitioner (see Chapter 4) within 90 days prior to when the individual enrolled in Medicaid begins the services or within 30 days after the individual begins the services. The Medicaid face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires home health services.

Providers **may** use the **sample form** (found below) to document these new requirements. If a provider does not use the DMAS sample form or the CMS-485 (with the F2F elements clearly included) to document the F2F encounter, any supporting documentation must be clearly titled and easily recognizable as documentation of the F2F encounter and include the required elements listed below.

Providers who opt to use their own forms or systems to document the F2F encounter must include the following required elements:

1. The date of the face-to-face encounter;
2. The practitioner, including full name and credentials, who conducted the face-toface encounter;
3. The primary reason the Medicaid individual requires home health services;
4. Any communication between the ordering physician and the practitioner who conducted the face-to-face encounter, if such individuals are different;

5. The date of the order and the ordering physician's full name and signature.

SAMPLE FORM: Home Health Face-To-Face Encounter Form

Individual Name:_____ Date of Birth:_____ Medicaid ID:_____

Check one of the following:

[ ] Same Practitioner: Face to Face Visit: I had a face-to-face encounter that meets the practitioner face-to-face encounter requirements with the individual. The individual is under my care. I have initiated the establishment of the plan of care.

OR

[ ] Different Practitioner: Face to Face Visit: A face-to-face encounter was performed on this patient by (check one):

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist working in collaboration and with a practice agreement with the physician who orders the individual's services;
- A certified nurse midwife ;
- A licensed physician assistant working under the supervision of the physician who orders the individual's services; or
- For individuals admitted to home health immediately after an acute or post-acute stay, the attending acute or postacute physician.

Date of Face-to-Face Encounter:_____

Based on the clinical finding of this encounter, the following services are medically necessary.

c Skilled Nursing c Therapy (type _____) c Home Health Aide

Based on clinical findings of this encounter, the services this individual needs are the following:

c Teaching/Training (Disease Management) c Observe/assess c Anticoagulation therapy

c Bladder Cath Care c Wound care care c Tracheostomy/Ventilator

c Medication/Education management c IV Care (Bowel/Bladder) c Ostomy Care

c Nutritional Status/Tube feedings c Decubitus Care c Chest Tube

c Equipment assessment/training c Oxygen therapy (new/changed)

c Other: _____

Ordering Practitioner Signature:_____**Date:**_____

Ordering Practitioner Printed Name:_____

Face-to-Face Practitioner Signature (if applicable):_____

Face-to-Face Practitioner Printed Name (if applicable):_____

Note to Ordering Practitioner: Please place a copy of this Face-to-Face form in the individual's medical record.

General Documentation Requirements

The documentation of home health services shall, at a minimum:

a. Describe the clinical signs and symptoms of the participant's illness;
b. Document an accurate and complete chronological picture of the participant's clinical course and treatments;
c. Document all treatment rendered to the participant in accordance with the plan with specific attention to the frequency, duration, modality, response, and identify who provided the care (include the full name, title and date);
d. Document the changes in the participant's condition;
e. Include all plans of care;
f. Document drugs and treatments as ordered by the physician;
g. Document that the home health agency staff is checking all medicines a participant is taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication and must promptly report any problems to the physician; and
h. Describe the efforts to discharge the participant from home health services
i. Documentation describing the efforts to provide the service and

contacts to the physician must be maintained in the medical record.

NOTE: Home health agencies must follow all Virginia Department of Health Professions' guidelines on qualifications and supervision of staff as specified in 12 VAC5-381.

When an individual is admitted to home health services, a start of care assessment must be completed no later than five (5) calendar days after the start of care. If services cannot be provided as ordered by the physician (e.g., in the case of the unavailability of a service, staff absences, etc.), the attending physician must be notified and the medical record must reflect the attempts made by the home health agency to provide the service and reasons why the service could not be provided as ordered. Documentation describing the efforts to provide the service and contacts to the physician must be maintained in the medical record.

If corrections are required, the error shall be crossed out, corrected, initialed and dated by the person who made the corrections.

Physician Documentation Requirements

The individual must be under the care of a physician who is legally authorized to practice and who is acting within the scope of physician's license. The physician may be the participant's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the assisted living facility (ALF) which is the participant's residence or, if the agency is hospital-based, a physician on the hospital staff.

Participants are accepted for treatment on the basis of a reasonable expectation that the participant's medical and nursing needs can be met adequately by the home health agency in the participant's place of residence. Care follows a written plan of care established and reviewed by a physician as often as the participant's condition requires, but at least every 60 days. Services must be necessary to carry out the plan of care and must be related to the participant's medical condition.

The plan of care, developed in consultation with the appropriate qualified agency staff, must include the following applicable documentation:

- Diagnosis and prognosis;
- Functional limitations;
- Activities permitted;
- Mental status;
- Safety measures to protect against injury;
- Orders for medications and treatments;
- Orders for dietary or nutritional needs;
- Orders for nursing and therapeutic services;
- Orders for home health aide services;
- Orders for medical tests, including laboratory tests and x-rays;
- Measurable goals for treatment for all disciplines within established time frames;
- Frequency and duration of all services;
- Rehabilitation potential; and
- Instructions for a timely discharge or referral.

A written physician's statement, which may be in the form of the physician's orders on the home health certification plan of care, located in the medical record must certify that:

- The participant needs nursing care on an intermittent basis; the participant needs physical or occupational therapy or speech-language pathology services; and

- A plan for furnishing such services to the participant has been established and is periodically reviewed by a physician.

The physician is responsible for signing (name and title) and dating (month, day, and year) this required documentation. Any dictated typed reports must be signed and dated by the physician. A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other

signature requirements that are not for Medicaid purposes. If the physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the home health agency administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The physician must initial and completely date all rubber-stamped signatures.

The initial plan of care (certification) must be reviewed by the attending physician or physician designee. The physician must sign the initial certification before the home health provider may bill DMAS. A physician shall review and recertify the plan of care every 60 days. DMAS will not reimburse the home health agency for services provided prior to the date of the physician's signature.

A physician recertification shall be performed within the last five days of each current 60-day certification period, i.e. between and including days 56-60. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. The physician must sign the recertification before the home health provider may bill DMAS. DMAS will not reimburse the home health agency for services provided prior to the date of the physician's signature.

The recertification plan of care must include any orders obtained as a result of modifications to the previous plan of care, which remain in effect, and include updated goals and time frames for goal achievement for all services ordered. The physician must approve, in writing, modifications to the plan of care. DMAS will not reimburse the home health agency for services prior to the date of the physician's signature.

A verbal order that necessitates a change in the current plan of care must be signed and dated by the physician. The verbal order must be received by a registered nurse or qualified therapist. If rehabilitative therapies are the only services ordered by the physician, a qualified licensed therapist may receive the verbal order.

Nursing Documentation Requirements

The following components are required for nursing documentation:

Nursing Assessment - A start of care assessment must be made by a registered nurse at the time of admission to home health nursing services. This initial evaluation must be maintained in the participant record throughout the duration of treatment and must contain a history of the medical conditions; a review of the physical systems and the identification of the physical problems and disabilities; and a psycho-social assessment which must include the identification of support persons, environmental issues, needs and the reason for admission to home health services.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all participants and must indicate the actual or potential participant/family needs, measurable goals and objectives, specifically state the method by which they are to be accomplished, and include time frames for goal achievement. Nursing care plans must be updated as the participant's nursing care needs change. If home health aides are needed to provide services, the nursing care plan should reflect their duties and frequency. If the nursing care plan is a part of the home health certification plan of care, all of the above documentation must be identified.

Nursing Visit Notes - Visit notes are required at the time of each visit and must describe the treatment and/or instruction provided. In addition, the notes must address the medical status, treatment and/or instructions given for any special nursing procedures and identification and resolution of acute episodes. Treatment and care must be in accordance with the provisions of the plan of care.

Comprehensive Nursing Visit Documentation Requirements

Reimbursement at the comprehensive rate is based on the complexity of the skilled nursing procedures ordered and performed during each visit and not on the complexity of the overall case. A visit to determine if the patient and/or caregiver performed a procedure as previously taught would not be considered reimbursable at the comprehensive visit rate. An example of this type of visit would be the assessment by the nurse that the patient or caregiver had already performed a procedure correctly, prior to the nurse's visit, and no further complex teaching/treatment was required or medically necessary by the nurse.

The following examples identify some situations and describe the minimum documentation requirements necessary to support the appropriateness of billing at the comprehensive visit rate. These examples and participant cases must be within the context of the definition of comprehensive visits. Many participants and caregivers learn from short, focused teaching sessions. These short, focused sessions do not qualify for reimbursement at the comprehensive rate.

Diabetic Instruction

- Documentation must show that the assessment, direct care, or teaching requires an extensive length of time and that the participant and/or caregiver are able to comprehend in-depth instruction. Arrival and departure times must support the extended duration of the visit for the purpose of teaching the participant or caregiver and the complexity of the skilled procedures performed.

- The teaching plan must be clearly outlined.

- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

Wound Care

- The participant must have multiple or extensive wounds.

- Treatment orders must include multi-step procedures requiring longer periods of time than routine wound care.

- All documentation as to the size, depth, appearance, color, odor, drainage, and treatment provided must be included in each visit note.

- Arrival and departure times must support the extended duration of the visit for the purpose of teaching the participant or caregiver and the complexity of the skilled procedures performed.

- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

Intravenous (I.V.) Infusion

- Documentation must include arrival and departure times, supporting an extended duration of the visit for the purpose of teaching a participant or caregiver to administer I.V. fluids or medications and the complexity of the procedures performed.

- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

- If the nurse is required to stay with the participant throughout the administration of an I.V. medication, the physician orders and visit notes must identify the participant-specific risk factors requiring the continuous monitoring by the nurse. Additionally, the specific requirements for monitoring, reporting, and skilled interventions must be detailed in the physician's orders and documented in each visit note.

NOTE: Routine I.V. administration of fluids for hydration or medication which have no identified significant risk factors requiring nurse monitoring are not considered high-tech even if the task takes eight hours. DMAS does not consider a charge for a second skilled visit the same day as reasonable and necessary when the visit is for the sole purpose of discontinuing an I.V. when there is no other skilled intervention required.

Instruction to Non-English Speaking Participants or Caregivers

- Circumstances must be documented regarding the fact that the only acceptable communication is in the participant's birth language (no interpreter, no staff member who speaks the language of the participant or caregiver, no English speaking family members, friend, or other support); and

- Documentation must include to the duration of the visit (arrival and departure times) and the type of service rendered to support the complexity of the procedures performed and/or the instructions given to the participant and/or caregiver.

NOTE: These situations should be very rare. Once a means of communication has been established, reimbursement at the comprehensive visit rate will no longer be considered necessary.

Extended Time Due to the Age/Condition of the Participant

- Documentation must describe the condition, the skilled procedure performed, and the difficulty resulting from the particular set of problems in situations (i.e. attempting to start peripheral I.V.s on a child with spasticity or an adult with fragile veins.

- Visit notes must identify arrival and departure times and include a clear description of the efforts to complete the physician ordered skilled procedure and why these efforts were unsuccessful.

- Visit notes must also document what steps the nurse took to either obtain additional orders or have another skilled professional attempt the procedure.

NOTE: If another nurse were successful in the performance of the skilled procedure, this visit would not be considered reimbursable at the comprehensive visit rate by Medicaid.

Visits that require additional nursing time because of social issues do not constitute reimbursement at the comprehensive nursing visit rate. Examples may include, but are not limited to:

- The participant has no community support for meals, transportation, etc.;
- The participant lives alone and has no family support; or
- The housing conditions are inappropriate or unsafe.

All nursing documentation must be fully signed with full name, title and dated completely with month, day and year.

Rehabilitative Therapies Documentation Requirements

If physical therapy, occupational therapy, or speech-language pathology services are ordered by the physician and rendered to a home health participant, there must be an initial assessment conducted by a qualified therapist. The initial assessment must include current functional deficits, clinical status, symptoms of the participant's condition, including the diagnosis, and identification of needs indicating rationale for therapeutic interventions, prior to the delivery of home health therapy services. The initial assessment must also document an accurate and complete chronological picture of any clinical course of other therapy treatments, including any prior home health or rehabilitation treatments. A plan of care specifically designed for the participant must be established and must include measurable short and long-term goals which describe the anticipated level of functional improvement and include time frames for improvement and/or goal achievement. This plan must be reviewed and updated as needed, but at least every 60 days. This includes updating goals and achievement dates that

are identified on the care plan. When all the established long-term goals have been met based on the achievement dates and there are no other established long-term goals identified on the plan of care, the therapist must reevaluate the plan of care to determine if it is appropriate for services to continue. If there are no other long-term goals to be established, the participant should be discharged from services.

Progress notes must be written in the participant's medical record at the time of each visit to a home health participant and must include the type and duration of the treatment given, the participant's response to the treatment, and progress or lack of progress toward established goals. All entries to the medical record must be signed and fully dated by the provider of treatment, including full name and title. Treatment and care must be provided in accordance with the plan of care. The progress note must also indicate any education conducted, the participant/caregiver's ability to carry out the instructions given and any home program established. None of the above services are reimbursed by DMAS without a current physician's order which specifies the service treatment plan, the frequency and duration of the provision of the service.

If the participant is receiving therapy services from more than one provider (e.g., home health and outpatient or school rehabilitation), the participant's medical record must show documentation of coordination of these services, including goals, time frames for goal accomplishment and progress or lack of progress towards the established goals coordination efforts.

Home Health Aide Documentation Requirements

Written instructions for home health aide services must be documented in the medical record prior to the provision of services. These instructions must clearly identify all the services the aide is expected to perform for the participant in the place of residence. These instructions must be completely signed and dated by the registered nurse or licensed qualified therapist.

Home health aide visits must be documented in the participant's medical record for each visit to the participant in his/her place of residence must include identification of the services provided by the home health aide and must be signed and fully dated with the month, day and year, by the aide who performs the services. Documentation must also reflect that the services are being provided in accordance with the home health plan of care. Home health aide documentation should also include any information that identifies why the participant or home health aide is unable to participate in meeting the goals of home health aide services.

Supervision of Home Health Aide Services

Based on the Virginia Administrative Code, home health aide services must be provided under the general supervision of a registered nurse.. This documentation may be in the form of a visit note, by the registered nurse for the purpose of the supervisory visit of the home health aide only and must be signed and fully dated with the month, day and year. The results of the supervisory visit must be documented (e.g., if the home health aide is performing services in accordance with the plan of care and the response of the participant and/or caregiver). If the supervisory visit is conducted in conjunction with the skilled visit, the documentation must reflect that the supervisory task was performed and the results (i.e., if the home health aide is performing services in accordance with the plan of care and the response of the participant and/or caregiver.)

When only home health aide services are provided, a registered nurse must make a supervisory visit to the participant's residence at least once every 60 days. Supervisory visits should occur while the aide is providing care.. The supervisory visit is not reimbursable Medicaid.

When skilled nursing services, in addition to home health aide services, a registered nurse must make a supervisory visit to the participant's place of residence at least every two weeks (either when the aide is present or absent). Supervisory visits should not be made when the aid is absent. This supervisory only visit is not reimbursable Medicaid. When rehabilitative therapy (physical, occupational and/or speech-language pathology therapies, in addition to the home health aide) are the only services provided, a licensed qualified therapist may make the supervisory visit instead of the registered nurse.

Discharge Planning

Discharge planning must be an integral part of the overall treatment plan which is developed at the time of admission to home health services. Discharge planning documentation for all disciplines providing services to the participant must include any or all of the following:

- Anticipated improvements in limitations or health care needs;

- Time frames necessary to meet the goals;
- Feasibility of alternative care, including options for other Medicaid covered services;
- Documentation that the participant and/or caregiver participated in the discharge planning process; and
- Discharge planning activities were explored at least every 60 days, or as often as changes occur.

When goals have been accomplished and/or the participant no longer requires skilled services, each discipline must promptly prepare a discharge summary to be sent to the physician within 30 days. The summary should document the participant's progress or lack of progress and identify the treatment goals that were met or not met. Recommendations for follow-up care should be included.

Utilization Review Responsibilities of The Home Health Agency

The agency must maintain records on each participant in accordance with accepted professional standards and practices. Participant records must be complete, accurately documented, readily accessible, and systematically organized. All entries in the participant records must be signed with the first initial, last name, and professional title of the author and completely dated with the month, day, and year. Home health agencies must have current physician orders for services rendered, including orders to discontinue services if participants are discharged prior to the end of the current certification period.

Services must be provided within the requested time frames.

The home health agency must have written policies requiring an overall evaluation of the agency's total program at least once a year by a group of professional personnel (or a committee of this group), home health agency staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation must consist of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

As a part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote participant care that is appropriate, adequate, effective, and efficient. Mechanisms must be established in writing for the collection of pertinent data to assist in the evaluation.

At least quarterly, the appropriate health professionals, representing at least the scope of the program, must review a sample of both active and closed medical records to determine whether established policies are followed in furnishing services directly or under contract. There must be a continuing review of the medical records for each 60day period that a participant receives home health services to determine the adequacy of the plan of care and the appropriateness of the continuation of care.

Utilization Review Responsibilities Of DMAS

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes a review of the utilization of the services rendered by providers to participants. Desk and on-site reviews of each Medicaid participating home health provider will be made periodically, and may be unannounced. The utilization review will include a professional review of the services provided by the home health provider with respect to:

- The care being provided to the participants;
- The adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each participant;
- The necessity and desirability of the continued participation in home health services by the participant;
- The feasibility of meeting the participant's health needs in alternate care arrangements; and
- The verification of the existence of all documentation required by Medicaid to indicate that reimbursement coincides with services provided.

Other visits may be made to follow-up on deficiencies or problems, to investigate complaints, and to provide technical assistance. A plan of correction may be requested based on the findings of the visit. All utilization reviews will be followed-up with a written report to the home health agency outlining any areas out of compliance with DMAS regulations and policies. Services not found to be appropriate or not specifically documented in the participant's medical record as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided. In addition, no reimbursement will be allowed if documentation does not reflect that services provided met program criteria.

Use of Electronic Signatures (Home Health)

Use of electronic signatures for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Failure to properly maintain or authenticate medical records(sign and date the entry) may result in the retraction of Medicaid payments. An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the participant signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Providers must have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use computer keys or electronic signatures, must sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal

policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records. For guidance on billing, please refer to Chapter V of this manual.

Participant Rights (Home Health)

The participant has the right to confidentiality of the clinical records maintained by the home health agency. The agency must advise the participant of the agency's policies and procedures regarding the disclosure of clinical records.

Before the care is initiated, the home health agency must inform the participant, orally and in writing, of the extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the home health agency; the charges for services that will not be covered by Medicare; and the charges that the participant may have to pay.

The participant has the right to be advised orally and in writing of any changes in the information regarding participant's rights as they occur. The home health agency must advise the participant of these changes as soon as possible, but no later than 30 working days from the date that the agency becomes aware of a change. The participant has the right to be advised of the availability of the toll-free complaint line established by the Department of Health, Division of Licensure and Certification. The telephone number is 1-800-955-1819. When the agency accepts the participant for treatment or care, the agency must advise the participant in writing of the telephone number and that the purpose of the hotline is to receive complaints or questions about local home health agencies.

Appendix A: Definition of Terms

Updated: 12/5/2008

Term	Definition
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid/FAMIS Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally-recognized standards for health care. Abuse also means the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation of an individual.
Accommodation	A type of room; e.g., private,semi-private, ward, etc. Adjudicate To determine whether a claim should be paid or disallowed.
Adjustments	Changes made to correct an error in the billing or processing of a claim.
Atypical Provider Identifier (API)	A unique 10-digit identification Number issued to providers by DMAS. An API Number is issued for non-health care (atypical) providers and for providers in an MCO network who do not participate with Medicaid/FAMIS.
Adverse Action	Any action taken by DMAS or its designee to deny, reduce, terminate, delay or suspend a covered service. Any action taken to deny payment in whole or part to a provider of Medicaid services.
Aid Category	A designation within federal or State regulations under which an individual may be eligible for public assistance. Also, a numerical identifier for VAMMIS of the covered group in which the person is enrolled.
Allowed Charge	That part of the reported charge that qualified as a covered benefit, and is eligible for payment under the Virginia Medicaid/FAMIS Program.
Ancillary Services	Services available to individuals other than room and board for which charges are customarily made in addition to a routine service charge; e.g., pharmacy, x-ray, lab, and medical supplies.
Appeal	A request for review of an adverse action to determine whether the action complied with Medicaid laws, regulations, and/or policy, or a challenge to any DMAS adverse action affecting a provider's reimbursement.
Appeal Procedure	The process of reviewing, at the member's request, any adverse action taken by DMAS or its designee to deny, reduce, terminate, delay, or suspend eligibility or a covered service in accordance with 42 CFR §431 et seq., and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, or the process for challenging an action taken by DMAS adversely affecting a provider's reimbursement, in accordance with the Virginia Administrative Process Act §2.2 - 4000 et seq and DMAS appeal regulations at 12VAC30-20-500 et seq. The appeal procedure shall be governed by the Department's regulations and any and all applicable laws and court orders.
Attending Physician	The physician who has the overall responsibility for the patient’s medical care and treatment.
Automated Response System (ARS)	Web-based Internet Eligibility Verification system that provides twentyfour-hour-a- day, seven-day-a-week Internet access to eligibility information, service limits, claim status, prior authorizations, provider check status,pharmacy prescriber identification lookup, as well as MCO enrollment information.

Term	Definition
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.
Barrier Crime	Barrier crime laws, as defined in Code of Virginia § 63.2-1719, prohibit persons convicted of certain statutorily defined crimes from obtaining employment with certain employers, mostly those employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities.
Benefits	Services covered under the Virginia Medicaid/FAMIS Program.
CAP	Corrective Action Plan.
Capitation Payment	A payment the Department makes periodically to a Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular member receives services during the period covered by the fee.
Capitation Rate	The monthly amount, payable to the Contractor, per member, for all expenses incurred by the Contractor in the provision of contract services as defined herein.
Categorically Needy	Under Medicaid, categorically needy cases are aged, blind, or individuals with disabilities or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for Aid to Dependent Children (ADC), Supplemental Security Income (SSI), or an optional state supplement.
CFR (Code of Federal Regulation)	Medicaid federal regulations are located at 42 CFR 430 through 42 CFR 505.
CHIP	Virginia's Child Health Insurance program (CHIP) for low-income children. The program is funded under Title XXI of the Social Security Act, and is known as FAMIS.
Claim	An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB04.
ClaimCheck	McKesson ClaimCheck is an automated procedure coding review software. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. All Claim Checked its are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or postoperative time frame. The process involves all Physician and Laboratory Service claims. ClaimCheck edits are based on guidelines as specified in the CPT Manual as well as guidelines from the American Medical Association (AMA), the Centers for Medicare and Medicaid (CMS) to include the Correct Coding Initiative (CCI) edits and specialty society guidelines.
Client Medical Management Program (CMM)	An utilization-control program designed to promote proper medical management of essential health care and enhance service efficiency.
Clinic	A facility for the diagnosis and treatment of outpatients.

Term	Definition
Centers for Medicare and Medicaid Services (CMS)	The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.
CMS-1500	The CMS-1500 is the uniform professional hardcopy claim form. It is the only hardcopy claim form that CMS accepts from professional pr o v i d e r s (e.g., physicians, DME providers, Independent Laboratories, etc.)
Coinsurance	The portion of Medicare- or other insurance- allowed charges for which the patient would be responsible if no other insurance is responsible.
Community Services Board	A citizens' board, which provides mental health, intellectual disability, and substance abuse programs and services within the political subdivision or political subdivisions participating on the board.
Comprehensive Services Act (CSA)	The legislation that created a collaborative system of services and funding that is child centered, family focused, and community based to address the strengths and needs of troubled and at-risk youth and their families.
Concurrent Review	Encompasses aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
Copayment	The portion of Medicaid/FAMIS-allowed charges which an individual is required to pay directly to the provider for certain services or procedures rendered.
Cosmetic Surgery	Cosmetic surgery includes any surgical procedure solely directed at improving appearance.
Covered Group	Federal and state laws describe the groups of people who may be eligible for Medicaid/FAMIS. These groups of people are called Medicaid/FAMIS covered groups. The eligibility rules and medical services available are different for certain covered groups. People who meet one o f the covered groups criteria may be eligible for Medicaid/FAMIS coverage if their income and resources are within the required limits of the covered group.
Covered Services	Services and supplies for which Medicaid/FAMIS will reimburse.
Crossover Claims	Claims for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for services rendered to a member entitled to benefits under both programs.
Cultural Competency	The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.
Current Procedural Terminology (CPT)	A HCPCS component developed by the American Medical Association.
Customary Charge	The amount providers usually bill Medicaid individuals for furnishing particular services or supplies.
Date of Service (DOS)	The date or span of days that services were received by an individual.
Direct Data Entry (DDE)	An alternative way to submit claims via the web. Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer. Virginia Medicaid is currently working with the fiscal agent on a DDE solution.

Term	Definition
Deductible (Medicare)	The dollar amount that the Medicare/Medicaid member must pay toward the cost of covered benefits before Medicare payment can be made for additional services. Medicaid pays the Medicare Part B deductible for eligible members. Medicare Part A deductible is paid by Medicaid within the Program limits.
Dental Benefits	The covered dental services available to Medicaid/FAMIS eligible children as well as the limited, emergency services available to Medicaid eligible adults.
Dental Benefits Administrator	The DMAS-contracted entity through which Medicaid dental benefits are offered. Also known as a DBA.
Department	The Virginia Department of Medical Assistance Services (DMAS).
Dependent	A spouse or child who is entitled to benefits under the Virginia Medicaid/FAMIS Program.
DESI Drugs	Drug products identified by the Federal Food and Drug Administration, in the Drug Efficacy Study Implementation Program, as lacking substantial evidence of effectiveness.
Diagnosis	The identity to recognize the nature of a condition, cause, or disease.
Direct Personal Supervision	Supervision rendered at the site of treatment by the responsible participating provider.
Diagnostic Related Groupings (DRGs)	A classification system for inpatient hospital claims for reimbursement purposes. DMAS currently uses it to reimburse inpatient hospital medical-surgical services.
DMAS	The Department of Medical Assistance Services. The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
Department of Social Services (DSS)	The agency responsible for determining eligibility for medical assistance programs and the provision of related social services. This includes the local and the state DSS.
Dual Eligibles	Medicare beneficiaries who are also enrolled in the Medicaid program
Duplicate Claim	A claim which is the same as one previously paid. Also, a claim deemed by DMAS to be an identical claim as one previously submitted.
Enhanced Ambulatory Patient Grouping	Enhanced Ambulatory Patient Grouping (EAPG) is the new payment methodology developed and licensed by 3M for Virginia Medicaid's Ambulatory Surgical Centers (ASCs) with dates of service on or after April 5, 2010. The methodology defines EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by ASCs. DMAS currently uses it to reimburse ambulatory surgery centers.

Term	Definition
Early Intervention (EI)	Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. §440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
–OR– Early Intervention (EI)	Developmental supports and services that are performed in natural environments to meet the developmental needs of Medicaid or FAMIS eligible children, ages zero to three years of age, who have a 2% or greater delay in one or more developmental areas, atypical development, or diagnosed condition with a high probability of delay.
Elective Surgery	Surgery which is not medically necessary to restore or materially improve a body function.
Eligible Person	An individual satisfying the requirement for Virginia Medicaid/FAMIS in accordance with the State Plan of the Virginia Medical Assistance Program under Title XIX or FAMIS under Title XXI, who has been certified and enrolled as such by a local social services department or FAMIS CPU.
Emergency Custody Order (ECO)	An emergency custody order by local law enforcement to take custody of a person believed to be mentally ill and in need of an psychiatric evaluation ECO limited to maximum 4 hours.
Encounter	Any covered or enhanced service received by a member through a DMAS contractor.
Encryption	A security measure process involving the conversion of data into a format that cannot be interpreted by outside parties.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Medicaid's comprehensive and preventive child health program for individuals under the age of 21.
Estimated Acquisition Cost (EAC)	Cost for drugs determined by the Virginia Medicaid Program for reimbursement.
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected individuals to allow them to confirm the services which they received.
Family Access to Medical Insurance Security (FAMIS)	Virginia's CHIP program that operates under Title XXI of the Social Security Act and provides comprehensive health benefits to children through the age of 18, in families with incomes at or below 200 percent of the federal poverty level who do not have any health insurance coverage and are not eligible for Medicaid.
Family Planning Services	Any medically-approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling, which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.

Term	Definition
FAMIS Member	Persons enrolled in DMAS' FAMIS program who are eligible to receive services under the State Child Health Plan under Title XXI of the Social Security Act.
FAMIS Plus Member	Child under the age of 19 who meets "medically indigent" criteria under Medicaid program rules, and who receives the full Medicaid benefit package and have no cost- sharing responsibilities.
FAMIS Moms	Virginia's Health Insurance program for low-income pregnant women whose family income is above Medicaid limits and at or below 200% FPL. It is a TitleXXI of the Social Security Act program, known as FAMIS MOMS. FAMIS Select Virginia's Child Health Insurance Premium Assistance program for FAMIS eligible children. It is a Title XXI of the Social Security Act program, known as FAMIS Select. Benefits are provided through the private or employer sponsored plan. There is no wrap around coverage in FAMIS Select, with the exception of immunizations.
Federal Information Processing Standards Codes (FIPS codes)	A standardized set of numeric or a lphabetic (also known as city/county code) codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies.
Federally Qualified Health Centers (FQHCs)	Community-based facilities that provide comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services.
Fee-for-Service (FFS)	The Department's traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide.
Fiscal Year (State)	Fiscal Year is from July 1 through June 30. Fraud An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
Freedom of Choice	The patient's freedom to choose between institutional placement or community based services, and/or an available program, service, or a participating provider of service.
FTE	Full-time equivalent position.
Health Insurance Portability & Accountability Act of 1996 (HIPAA)	Title II of HIPAA protects the confidentiality and integrity of individually identifiable health information past, present, or future.
Home and Community–Based Services Waiver	The range of community services approved (HCBS) by the Centers for Medicare and M edicaid Services (CMS) pursuant to C1915c of the Social Security Act 420.SC. § 1396 (c) to be offered to individuals as an alternative to i nstitutionalization.

Term	Definition
HCPCS	The Centers for Medicare and Medicaid Services Common Procedure Coding System (HCPCS) contains services not included in CPT, such as ambulance, audiology, physical therapy, speech pathology, and vision care and such supplies as drugs, durable medical equipment, orthotics, prosthetics, and other medical and surgical supplies.
Health Insurance Premium Payment Program (HIPP)	Premium assistance program for individuals enrolled in full coverage Medicaid that provides premium assistance subsidy for the employee share of employer sponsored group health insurance when it is determined to be cost effective.
HIPP For Kids	Premium assistance program for children under the age of 19 enrolled in full coverage Medicaid that reimburses the employee share of qualified employer sponsored coverage. The employer must contribute at least 40% to cost of the premium.
International Classification of Diseases, Clinical Modification (ICD-CM)	A standardized listing of descriptive terms and identifying codes for reporting diagnoses and medical services performed in the inpatient or outpatient facility.
Inpatient	An individual admitted to a hospital, nursing facility, an intermediate care facility, or a residential treatment center.
Intermediate Care Facility (ICF/MR)	A facility or distinct part of another facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an intermediate care facility for persons with mental retardation/intellectual disability or related conditions. These facilities must address the total needs of the resident which include physical, intellectual, social, emotional, and habilitation and must provide “active treatment”.
Institution for Mental Disease (IMD)	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 institution for mental diseases 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 mental retardation/intellectual disability is not an institution for mental diseases.
Intensive Care	Constant observation care to critically ill or injured patients in a critical care unit.
Length of Stay (LOS)	The total number of days a patient stays in a facility such as a hospital. Length of stay would only apply to acute general psychiatric and intensive rehab hospital admissions.
Legend Drugs	Drugs which bear the federal caution: "Federal Law Prohibits Dispensing a Drug Without a Prescription."
Level of Care (LOC)	The level of service that an individual needs based on their assessment which includes functional activities of daily living, medical and/or nursing, or behavioral needs.

Term	Definition
Long-Stay Hospital (LSH)	A Virginia Medicaid designation for hospital care that is a slightly higher level of care than Nursing Facilities.
Long-Term Acute Care Hospitals (LTAC)	A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in heating patients with serious and often complex medical conditions, DMAS recognizes these facilities as Acute Care Facilities.
Maintenance Drug	A drug that is prescribed to treat a medical condition that requires continuous administration for an indefinite period of time.
Managed Care Organization (MCO)	An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion 3.0 and FAMIS programs. Virginia Medicaid Managed Care is a state program that helps people who have Medicaid get the health care services they need.
Maximum Allowable Cost (MAC) (Upper Limits)	The upper limit allowed by the Virginia Medicaid Program for certain drugs.
Medallion 3.0	A fully capitated, risk-based, mandatory Medicaid/FAMIS Plus managed care program.
Medicaid Member	Any person identified by the Department who is enrolled in Medicaid.
Medicaid Fraud Control Unit (MFCU)	The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for the Code of Virginia § 32.1- 320, as amended.
Medicaid Works (Medicaid Buy-In Program)	Medicaid Works allows working people with disabilities whose income is no greater than 80% FPL to pay a premium to participate in the Medicaid program.
MediCall	A toll-free telephone number providing 24- hour-per-day, seven-day-a-week access to current member data necessary to verify eligibility for Medicaid/FAMIS services.
Medical Necessity	Those services which are reasonable and necessary for the diagnosis or treatment of an illness, condition, injury, or to improve the function of a disability, consistent with community standards of medical practice and in accordance with Medicaid/FAMIS policy.
Medically Complex	Those who have a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability. Also includes individuals who receive long-term services and supports.
Medically Indigent	Pregnant women, children, and other individuals who meet certain income and/or age requirements and who are eligible for some or all of the covered Medicaid services.
Medically Needy	Individuals whose income and resources exceed those levels for assistance established under a State or federal plan but are insufficient to meet their costs of health and medical services.
Medicare Part A (Hospital Insurance)	Covers inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care.

Term	Definition
Medicare Part B (Supplementary Medical Insurance)	Covers doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part B helps pay for these covered services and supplies when they are medically necessary.
Member	An individual who meets the Virginia Medicaid/FAMIS eligibility requirements and is receiving or has received medical services. Member Enrollment The determination by a local department of social services or central processing unit of an individual's eligibility for Medicaid, FAMIS Plus or FAMIS and subsequent entry into VAMMIS.
National Drug Code (NDC)	A drug code used in pharmacy and other healthcare practitioner claims to identify a drug dispensed.
National Provider Identifier (NPI)	A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).
Non-Legend Drugs Over-the-Counter Drugs. Nursing Facility (NF)	A nursing facility or a distinct part of another facility which provides, on a regular basis, services to individuals who do not require the degree of care and treatment which a hospital or specialized care unit is designed to provide, but who require care and services which meet the established written criteria.
Nutritional Supplement	A nutritional supplement refers to enteral or parenteral nutrients given to an individual to make up for deficient nutritional intake.
Open Enrollment	The timeframe in which Members are allowed to change from one MCO to another, without cause, which occurs at least once every 12 months per 42 CFR 438.56 (c)(1) and (f)(1). Open enrollment will occur from October 1st – December 18th for a January 1 effective date. Individuals eligible through Medicaid expansion will have an open enrollment period from November 1st – December 18th for a January 1st effective date. Within sixty (60) calendar days prior to the open enrollment begin date, the Department will inform Members of the opportunity to remain with the current plan or change to another plan without cause. Those Members who do not choose a new health plan during the open enrollment period shall remain in his or her current health plan selection until their next open enrollment period.
Outliers	Statistical term. An observation that lies an abnormal distance from other values in a random sample from a population. Also used in hospital reimbursement for a hospital discharge with charges higher than a threshold which entitles the facility to additional reimbursement.
Outpatient	A beneficiary who receives medical services but is not admitted to a hospital, hospital, or other institutional settings.
Over-Utilization	Medically unnecessary use of the Virginia Medicaid/FAMIS Program by any provider and/or Medicaid individual.
PACE (Program of All-inclusive Care for the Elderly)	PACE provides the entire spectrum of health and long-term care services (preventive, primary, acute and long-term care services) to their members on a per member, per month basis.

Term	Definition
Participating Provider	A person, organization, or institution with a current valid participation agreement with DMAS who or which will (1) provide the service, (2) submit the claim, and (3) accept as payment in full the amount paid by the Virginia Medicaid/FAMIS Program.
Payer of Last Resort	The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
Personal Comfort	Items Items which do not contribute directly to the treatment of a condition, illness, or injury or to the functioning of a malformed body part and are not covered by Medicaid/FAMIS.
Plan of Care	Plan of care is comprised of individual service plans as dictated by the persons' health care and support needs.
Plan First	The limited benefit Medicaid fee-for-service family planning program. Men and women who have income less than or equal to 200 percent of the federal poverty level may be eligible for Plan First if they are not eligible for a full benefit medical assistance program.
Pre-admission Screening Team (PAS)	The team comprised of a nurse and social worker from the local departments of health and local departments of social services OR the hospital discharge planners charged to perform the assessment to determine the appropriate level of care needs for longterm care services for an individual. The entity contracted with DMAS that is responsible for performing preadmission screening pursuant to 32.1-330 of the Code of Virginia.
Primary Care Physician	A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
Primary Care Provider (PCP)	A primary care physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
Procedure Code	A code used to identify a medical service or procedure performed by a provider.
Protected Health Information (PHI)	Individually identifiable patient information, including demographics, which relates to a person's health, health care, or payment for health care.
Provider	An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Department.
Provider Number	A ten-digit number assigned to identify each provider of services.
Qualified Medicare Beneficiary (QMB)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit less any applicable copayments on allowed charges for Medicare-covered services.

Term	Definition
Qualified Medicare Beneficiary-- Extended (QMB--Extended)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the 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.
Qualified Disabled and Working Individuals (QDWI)	Persons with disabilities who are working and who meet certain income limits and are eligible for Medicaid payment of the Medicare Part A premiums only.
Quality Monitoring (QM)	The ongoing process of assuring that the provision of health care service is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards.
Referral	A request by a provider for a participant to be evaluated and/or treated by a different physician, usually a specialist, or to receive specific services.
Remittance Voucher	A notice sent to providers that advises on the status of claims received. Paid, denied, pended, voided, and adjusted claims are reported on remittance vouchers.
Reported Charge	The total amount submitted on the claim form by a provider of services for reimbursement.
Resident	An individual admitted to a nursing facility, assisted living facility, or other institutional placement.
Residential Treatment Facility	A 24-hour-per-day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders of individuals 21 years old or younger. All services must be provided at the facility as part of the therapeutic milieu.
Retroactive Eligibility	Eligibility in which a person was determined to be eligible for a period of time prior to the month in which the application was initiated. The retroactive period is the three months prior to the application month. Once retroactive eligibility is established, Medicaid/FAMIS coverage begins the first day of the earliest retroactive month in which eligibility exists. Retroactive coverage in FAMIS is only available for newborns.
Retrospective Review	Warranted when a patient's eligibility for Medicaid/FAMIS coverage has been determined after the service has been rendered and retroactive eligibility has been granted or as otherwise allowed by the appropriate manuals/regulations.
Routine Services	Inpatient routine services in a facility are those services included by the provider in a daily service charge - sometimes referred to as the "room and board" charge. Included in routine services are certain services, supplies, and use of equipment and facilities for which a separate charge is not customarily made.
Rural Health Clinic	Is a clinic located in a rural, medically under-served area; facility as defined in 42C.F.R. § 491.2.
School Health Services	Any service rendered on property of a local education agency or public school. Services must be included in an individualized education program (IEP).
Secure Email	Applies to sensitive email being passed over the Internet in some form of encrypted format.

Term	Definition
Service Authorization (Srv Auth)	Formerly referred to as prior authorization, the approval necessary for specified services for a specified member by a specified provider before the requested services may be performed and payment made.
Service Authorization Request	Where not otherwise defined in this manual, a service authorization request shall consist of a written request from the provider (prior to providing the service), identifying the requested service (including the CPT/HCPCS or ADA codes), the patient's name and Medicaid number, and the condition being (to be) treated with documentation supporting the medical necessity, a description of the requested service, the anticipated length of treatment, the prognosis, and the estimated cost of the service.
Services Facilitator (CDSF)	A provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer-directed care. Shall Indicates a mandatory requirement or a condition to be met.
Spend-Down	A Medicaid individual eligible for Medicaid for a limited period of time because his or her income exceeds the limits and all other eligibility factors are met. The applicant's incurred medical expenses must equal or exceed the difference between his or her income and the Medicaid income limit.
Supplemental Security Income (SSI)	The federal program administered by the Social Security Administration (SSA) that pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits. In Virginia, SSI members must apply for Medicaid separately; Medicaid is not automatic. State Commonwealth of Virginia.
State Agency	The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
State Fair Hearing	The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the member to the DMAS Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R. §.§ 431.200 through 431.250 and 12 VAC 30-110- 10 through 12 VAC 30-1 10-380.
State Plan for Medical Assistance (State Plan)	The comprehensive written statement submitted by the Department to the Centers for Medicare and Medicaid Services (CMS) for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation.
Temporary Detention Order (TDO)	A temporary custody order by sworn petition to any magistrate to take into custody a person believed to be mentally ill and in need of hospitalization and transported to a location to be evaluated pursuant to 42 D.F.R. 441.150 and Code of Virginia, 16.1-335 et seq. and 37.1-67.1 et seq. Centers for Medicare and Medicaid Services.

Term	Definition
Third Party Liability (TPL)	Any individual, entity or program (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for which benefits were paid by the medical assistance programs under the State Plan.
Title XVIII	That portion of the Social Security Act which authorizes the Medicare Program.
Title XIX	That portion of the Social Security Act which authorizes the Medicaid Program.
Title XXI	That portion of the Social Security Act that authorizes the Children's Health Insurance Program, known as FAMIS.
Treatment Foster Care	Case Management Is a component of treatment foster care through which a case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board... UB-04 The UB-04, also known as the Form CMS1450, is the uniform institutional provider hardcopy claim form. It is the only hardcopy claim form that CMS accepts from institutional providers (e.g., hospitals, Skilled Nursing Facilities, Home Health Agencies, etc.)
UMCF (Uninsured Medical Catastrophe UMCF was established by the 1999 General Fund)	Assembly to provide funds for uninsured persons who need treatment for a life threatening illness or injury. An uninsured medical catastrophe includes a life- threatening illness or injury requiring specializedmedical treatment, hospitalization or both that if left untreated would more than likely result in death. There is a three page application form that must be completed and mailed to DMAS. Eligibility for funds are determined on a first come, first served basis based on the date the original application is received.
Uniform Assessment Instrument (UAI)	The multidimensional, standardized Assessment tool, which assists the assessor to determine a member's social, physical health, mental health, and functional abilities, and provides a comprehensive assessment of the individual.
Utilization Management	The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.
Virginia's Acute and Long Term Care Program (VALTC)	Delivery system that integrates acute and long-term care. Effective September 1 , 2007, individuals already M C O-enrolled who then become eligible for Home and Community-Based Waiver programs except for the Technology Assisted Waiver will remain in their MCO for acute care services.
Virginia Administrative Code (VAC)	Contains administrative regulations for State Agencies. Available as a searchable database at http://leg1.state.va.us/lis.htm
Virginia Medicaid Management Information System (VAMMIS)	The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services.

Term	Definition
Web Portal	A secure web site offering a broad array of resources and services to registered providers.

Appendix D Prior Authorization Information (Home Health)

Updated: 2/22/2019

INTRODUCTION

Service authorization (Srv Auth) 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 Srv Auth and some may begin prior to requesting authorization.

Purpose of Service Authorization

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.

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 Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the recipient was eligible under fee-for-service (not MCO enrolled) for dates where the recipient has subsequently become enrolled with a DMAS contracted MCO.

Srv Auth decisions by the DMAS Srv Auth contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify recipient eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled recipients, the provider must follow the MCO's Srv Auth policy and billing guidelines.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM (Home Health)

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor’s authorization for a period of not less than 90 calendar days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and back to Medicaid Fee-For Service (FFS) Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the Srv Auth contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 60day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
C. For CCC Plus Waiver Services, Cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the Srv Auth Contractor's service authorization but the member's CCC Plus eligibility has been retrovoided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The Srv Auth contractor will re-open the original service authorization for the same

provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link:

http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Communication

Provider manuals are located on the DMAS web portal and KEPRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.comand clicking on the *Forms* tab for fax forms to request services. A service specific checklist may be found under Service Authorization Checklists on KEPRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Outpatient* tab.

The Srv Auth entity provides 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 Srv Auth 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.

Submitting Requests For Services (Home Health)

The contracted entity that provides service authorization services to DMAS is Keystone Peer Review Organization (KEPRO). Contact information for KEPRO is as follows:

KEPRO

2810 N. Parham Road, Suite 305

Henrico, VA 23294

Phone: (804) 662-8900 (Richmond)

1-888-827-2884 (Toll Free)

1-888-VAPAUTH

Fax: 1-877-652-9329

1-877-OKBYFAX

The purpose of service authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not automatically guarantee payment for the service; payment is contingent upon

passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Service authorizations are specific to a recipient, a provider, a service code, an established quantity of units, and for specific dates of service. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer.

Service Authorization for Home Health Services

Face-to-Face Encounters for Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for initiation of home health services (as defined in 12VAC30-50-160) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) within 90 days prior to when the individual enrolled in Medicaid begins the services or within 30 days after the individual begins the services. The Medicaid face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires home health services.

The face-to-face encounter must be conducted by one of the following five (5) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist acting within the scope of their practice as defined by state law;A certified nurse midwife;
- A licensed physician assistant working under the supervision of the physician who orders the individual's services; or
- For individuals admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician. For the home health services that exceed five (5) visits and require service authorization, home health providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met.

Additional details may be found in Chapters IV and VI of the Home Health Provider Manual.

Service Limitations

Skilled nursing, physical therapy, occupational therapy, and speech-language pathology services shall be limited to five (5) visits per participant and per discipline annually without service authorization. Initial skilled nursing and therapy evaluations are included in the five (5) visits. Visits include those services provided by home health agencies and/or rehabilitation agencies. Limits are specific per discipline and participant, regardless of the number of providers rendering services. "Annually" is defined as July 1st through June

30th.

The provider must maintain documentation to justify the need for services. Srv Auth is required before payment will be made for any visits over 5 annually.

Evaluations must be related to the admission or readmission to service or to a significant change in the condition of the participant. For continued authorization beyond the initial period providers must submit a request prior to the Srv Auth end date. Reimbursement shall not be made for additional services without Srv Auth. Care rendered beyond the 5th visit allowed annually which has not been authorized shall not be approved for reimbursement.

Srv Auth must be obtained whether or not Medicaid is the primary payer, except for Medicare-crossover claims. Srv Auth is required when more than 5 visits are medically necessary per fiscal year as noted above. When a participant has Medicare Part B coverage, Srv Auth is not required. If Medicare denies the claim and/or if Medicare benefits are exhausted, the provider may request authorization as a retrospective review. Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid, the health care provider must request a retrospective service authorization.

Providers may obtain information regarding service limit utilization by contacting any of the following:

DMAS Provider HelpLine 1-800-552-8627 (in-state long distance)

1-804-786-6273 (local and out-of-state customers)

MediCall System 1-800-772-9996

1-800-884-9730

1-804-965-9732 (Richmond area)

Automated Response System (ARS): www.virginiamedicaid.dmas.virginia.gov

Service Authorization Processing

Srv Auth for skilled nursing and rehabilitation services must be obtained through KEPRO. All Srv Auth requests, as well as any information submitted in response to pend letters, must be directed to KEPRO. If the provider fails to submit information prior to the completion of the 5th visit, retroactive authorization will not be granted. Authorization will begin with the date the request is received at KEPRO. Any service provided without Srv Auth in excess of the 5th visit limitation will not be reimbursed.

To request service authorization, contact KEPRO, the DMAS Srv Auth contractor. For information regarding the service authorization submission process, refer to the

“Submitting Requests for Service Authorizations” section in this Appendix D.

The following information is required in order to determine if the individual meets criteria: (1) a physician order and nursing plan of treatment or therapy evaluation; (2) verification of medical necessity for the service; and (3) evidence of discharge planning.

Service authorizations are specific to the recipient, provider, service code, and specific dates of service. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer. If a claim for a service requiring service authorization does not match the authorization, the claim will be pended for review or denied.

DMAS requires the following for Home Health Services:

- The participant meets InterQual criteria upon initial and/or recertification review. These criteria may be obtained through:

McKesson Health Solutions LLC

275 Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: mckesson.com or InterQual.com

Recertification Review

Prior to the last Srv Auth end date, or the next visit, the provider must submit a request for continued Srv Auth. This request will be reviewed to determine if DMAS criteria and documentation requirements are met. A decision will be made to approve, pend, deny, or reject the request. Approvals will include a specific number of units and dates of service.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION (Home Health)

DMAS' Service Authorization Contractor, KEPRO, is moving to their own Provider Portal

"Atrezzo Connect" effective October 31, 2011 at 6:00 a.m. The previous system (iEXCHANGE™) will not be available to providers, effective 5:00 p.m., October 28, 2011. For direct data entry requests, providers must begin using the new Atrezzo Connect Provider Portal. The new Atrezzo Connect Provider Portal advantages include easier system changes when DMAS program changes occur and specific prompts and edits related to certain programs in the new system. DMAS-related information from the previous system will be transferred into KEPRO's new Atrezzo Connect Provider Portal prior to October 31, 2011.

The registration process for providers is much simpler and quicker than with

iEXCHANGE™ and happens immediately on-line. Existing iEXCHANGE™ users can log onto Atrezzo Connect without re-registering, using a special username consisting of their iExchange group ID, a hyphen, and their iExchange username. The initial password is also the iExchange group ID. They will then be given a one-time opportunity to change their username and password. Users from providers not currently registered with iExchange will select a username and password and then establish their legitimate connection to the selected NPI# by providing information taken from the most recent remittance advice. After logging in, Group administrators and Administrators within Atrezzo can specify other users within their organization and establish preferences for servicing providers, diagnoses and procedure codes. The Atrezzo Connect User Guide is available at dmas.kepro.com: Click on the Training tab, then the General tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact

KEPRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KEPRO will also accept requests by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the service authorization requirements and methods of submission may be found on the contractor's website at https://dmas.kepro.com.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's file, and are subject to review during Quality Management Review (QMR).

Direct all telephone inquiries regarding Service Authorization to the DMAS Provider Helpline at the telephone numbers listed in Chapter I of this manual.

KEPRO does not review requests when participants have Medicare Part B.

Except when Medicare is the primary payer, when more than five visits are medically necessary, the provider must request service authorization. When a recipient has Medicare Part B coverage, service authorization is not required. If Medicare denies the claim, the provider may request authorization as a retrospective review. This is the only time that a retrospective review is allowed, and it must be done within 30 days of the notification of the Medicare denial.

Prior to billing Medicaid the provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 days of the notice of Medicaid eligibility.

OUT-OF-STATE PROVIDER INFORMATION

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled *"Notification of a Procedural*

Change for Out-of-state Providers Submitting Requests for Service Authorization Through KEPRO".

KEPRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Specific Information for Out-of-State Providers

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 KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within the 12 business days,

KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. 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 which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

"Effective September 12, 2016, KEPRO added additional questions to the out-of-state provider questionnaire (found on the Provider Portal):

a. Question #2 - If the medical services are needed, will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel."
b. Question #5 - "In what state is the provider rendering the service and/or delivering the item physically located?"
c. Question #6 - "In what state will this service be performed?"
d. Question #7 - "Can this service be provided by a provider in the state of

   Virginia? If a provider answers "No", then additional question #7.2.1 asks: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10120 and 42 CFR 431.52.

Early Periodic Screening Diagnosis and Treatment Service Authorization

EPSDT is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

1. EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no

cost to the member.

2. EPSDT also compels state Medicaid agencies to cover other services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" [make better] a defect, physical or mental illness, or condition [health problem] identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. For more information, visit: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

Example of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

The review process as described is to be applied across all non waiver Medicaid programs for children. 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.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: residential substance abuse treatment, behavioral therapy, specialized residential treatment not covered by the psychiatric services program. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

NOTE: Effective November 1, 2012, EPSDT specialized services that are service authorized by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor include:

Hearing Aids and Related Devices
Assistive Technology

Private Duty Nursing

Personal Care and Attendant Care Services

Requests for EPSDT services **not contracted to be reviewed and authorized by KEPRO**

may be sent to:

DMAS Medical Support Unit

Fax: 804-452-5450 Phone: 804-786-8056

Medicaid Expansion

On January 1, 2019 Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace. The new expansion aid categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL
AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following services:

Covered Service
Doctor, hospital and emergency room services
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services including addiction and recovery treatment
Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
Family planning
Transportation to appointments
Home Health
DME and supplies
Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and
Community Based Service

Preventive and wellness
Chronic disease management
Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.

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

Service(s)	Telemedicine-specific Service Limitations	Code(s)
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
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

Service(s)	Telemedicine-specific Service Limitations	Code(s)
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
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

Service(s)	Telemedicine-specific Service Limitations	Code(s)
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.