



Hospice

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Hospice

General Information

Updated: 2/22/2019

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

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

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

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

Program Background

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

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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

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

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

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

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

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

General Scope of the Program

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

Covered Services

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

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
- Blood glucose monitors and test strips for pregnant women
- Case management services for high-risk pregnant women and children up to age 1

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

- Christian Science sanatoria services

- Clinical psychology services

- Clinic services

- Community developmental disability services

- Contraceptive supplies, drugs and devices

- Dental services

- Diabetic test strips

- Durable medical equipment and supplies

- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) - For individuals under age 21, EPSDT must include the services listed below:

- Screening services, which encompass all of the following services:
 - Comprehensive health and developmental history
 - Comprehensive, unclothed physical exam
 - Appropriate immunizations according to age and health history
 - Laboratory tests (including blood lead screening)

- Health education

- Home health services

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

- Hearing services

- Inpatient psychiatric services for members under age 21

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

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

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section “transplant services”

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

criteria for non-State Plan services under EPSDT.

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

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

- Emergency hospital services
- Emergency services for aliens
- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.
- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)
- Eye refractions
- Plan First (family planning services) - Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to

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

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

- Laboratory and radiograph services

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

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:
 - Mental Health:
 - Crisis stabilization
 - Mental health support
 - Assertive community treatment
 - Intensive in-home services for children and adolescents
 - Therapeutic day treatment for children and adolescents
 - Partial hospitalization Program
 - Intensive Outpatient Program
 - Psychosocial rehabilitation
 - Crisis intervention
 - Case management

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

- Outpatient Treatment
- Community Living Waiver:
 - Nurse-midwife services
 - Nursing facility services
- Occupational therapy
- “Organ and disease” panel test procedures for blood chemistry tests
- Optometry services
- Outpatient hospital services
- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor’s prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.
- Papanicolaou smear (Pap) test
- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services
- Prostate specific antigen (PSA) test (1998)
- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.
- Psychiatric Hospitals for the Aged (65 Years and Older)
- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)
- Reconstructive surgery - post-mastectomy (1998)
- Rehabilitation services (physical therapy - effective 1969; other rehabilitation services - effective 1986)
- Renal dialysis clinic services
- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21
- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI

Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services
- School-based services
- Services for individuals age 65 and older in institutions for mental diseases
- Specialized nursing facility services
- Speech-language therapy services
- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.
- Telemedicine for selected services.
- Tobacco Cessation screening, counseling and pharmacotherapies.
- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is

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

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

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

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping

services which are unrelated to patient care

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

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

MEMBER COPAYS

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

Managed Care Programs

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

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

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

Individuals awaiting managed care enrollment will receive coverage through the DMAS fee-for-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 1 through 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 fee-for-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 pending 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-four-hour-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 Lunenburg
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 (Hospice)

Updated: 1/19/2022

Managed Care Enrolled Members (Hospice)

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, CCC, CCC Plus, and 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:

- Medallion 3.0:

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

- Commonwealth Coordinated Care (CCC):

http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx

- 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/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 (Hospice)

A participating hospice provider is a hospice which has been certified by the Virginia Department of Health (VDH) and by Title XVIII (Medicare) as a provider of hospice services and which has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

Provider Enrollment (Hospice)

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 completion of the enrollment process, the ten-digit National Provider Identifier (NPI)

number that was provided with the enrollment application will be assigned as the provider identification number. 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.

Requests For Enrollment (Hospice)

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 Xerox 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.

Conditions of Participation

Providers of hospice services must comply with all of the following conditions of participation:

Services

Employees who provide hospice services must be licensed, certified, or registered in accordance with applicable federal or state laws;

The hospice must designate an interdisciplinary team composed of a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor who are employees of the hospice and who provide or supervise the care and services offered by the hospice.

The interdisciplinary team is responsible for participation in the establishment of the plan of care, provision or supervision of hospice care and services, periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services.

The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

A written plan of care must be established and maintained for each individual admitted to the hospice program, and the care provided to an individual must be in accordance with the plan.

The hospice must make nursing services, physician services, drugs, and biologicals routinely available on a 24-hour basis. The hospice must make all other covered services available on a 24-hour basis to the extent necessary to

meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions.

All services must be provided in a manner consistent with accepted standards of practice.

Professional Management

A hospice must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the hospice's total operation. The governing body must designate an individual who is responsible for the day-to-day management of the hospice program.

The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

- A hospice may arrange for another individual or entity to furnish services to the hospice's patients. If services are provided under contractual arrangement, the hospice must:
 - 1) assure the continuity of patient/family care in home, outpatient, and inpatient settings, and
 - 2) have a legally binding written agreement for the provision of arranged services which includes the identification of the services to be provided; a stipulation that services may be provided only with the express authorization of the hospice; the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice; the delineation of the roles of the hospice and the contractor in the admission process, patient/family assessment, and the interdisciplinary group care conferences; requirements for documenting that services are furnished in accordance with the agreement; and the qualifications of the personnel providing the services.

The hospice must retain professional management responsibility for contracted services and ensure that they are furnished in a safe and effective manner by qualified persons and in accordance with the patient's plan of care.

The hospice must ensure that inpatient care is furnished only in a facility that has a legally binding written agreement with the hospice. The hospice must furnish the contractor with a copy of the patient's plan of care and specify the inpatient services to be furnished. The inpatient provider must have established policies that are consistent with those of the hospice and must agree to abide by the patient care protocols established by the hospice for its patients. The medical record must include documentation of all inpatient services and events, and a discharge summary must be provided to the hospice. The agreement must specify the party responsible for the implementation of the provisions of the agreement. The hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.

Quality Assurance

A hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care, and care provided under contractual arrangements. These findings are used by the hospice to correct identified problems and to revise hospice policies, if necessary.

Those responsible for quality assurance must implement and report on activities and mechanisms for monitoring the quality of patient care, identify and resolve problems, and make suggestions for improving patient care.

Documentation Requirements (Hospice)

Medical records must substantiate the services billed to DMAS by the hospice. The medical records must be accurate and appropriate and must include the following:

the initial and subsequent certifications

the plan of care

identification data

authorization forms

pertinent medical history, diagnoses, and prognosis

complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

physician certification statements of the terminal illness of each recipient

election statements from each recipient

The record must identify the patient on each page. Entries must be signed and dated (month, day, and year) by the author, followed by professional title. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider. All services provided, as well as the plan of care, must be entered in the record.

Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided.

Participation Requirements

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

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to eligible individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial

assistance. The Rehabilitation Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals 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 an eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.
- Accept assignment of Medicare benefits for eligible individuals.
- Use DMAS-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 six 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 eligible individuals.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. 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.

Requirements of Section 504 of the Rehabilitation Act (ARTS)

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability 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, each Medicaid provider has the responsibility for

making provision for individuals with disabilities in the provider's programs or activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964 (Hospice)

All providers of care and suppliers of services under the contract with DMAS must 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.

Fraud (Hospice)

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

Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel in this unit for investigative purposes.

Review and Evaluation (VS)

Under the provisions of federal regulations, the Medical Assistance Program must provide for the continuing review and evaluation of the care and services paid through Medicaid, including the review of the utilization of the services of providers and by recipients. This function is handled by the Division of Program Compliance of the Department of Medical Assistance Services.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. Computerized exception reports for providers are developed by comparing an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with that of the recipient peer group. For recipients and providers who exceed the peer group averages by at least two standard deviations, an exception report for this activity is generated.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. The Department utilizes a scientific random sample of paid claims for a 15-month audit period to calculate any excess payment. The number and amount of invalid dollars paid in the audit sample is compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample.

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

Providers selected for review will be contacted directly by DMAS personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician and/or pharmacy of his or her choice because of misutilization of Medicaid services.

Termination of Provider Participation (Transport)

The participation agreement will be time-limited to your licensing expiration date with revalidation every five (years. DMAS will request a renewal of the Participation Agreement 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.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), 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.

Termination of a Provider Contract Upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

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 and 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



Hospice

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:
 - o Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - o Email to appeals@dmas.virginia.gov; or
 - o 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.

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. At the 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 patient 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
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):
<http://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 (Hospice)

Updated: 1/26/2021

Under the Medicaid program, hospice care must not be of any less or greater duration, scope, or quality than that provided to individuals not receiving state and/or federal assistance.

Hospice is a coordinated program of home and inpatient care as defined in 12 VAC5-391 (Virginia Department of Health). The hospice provider employs an interdisciplinary team to assist in providing palliative care to meet the special needs of enrolled individuals. The hospice model of care utilizes volunteers and family members, training them to provide much of an individual's care. This unique combination of professional staff, volunteers, and family members ensures a greater magnitude of services can be provided to an individual within his or her home, allowing for the highest quality of life and avoiding unnecessary institutionalization.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness, if the terminal illness runs its normal course. The individual must be certified as being terminally ill and must elect hospice coverage. A plan

of care must be established and services must be consistent with the plan of care.

Freedom of Choice (Hospice)

Individuals eligible for Medicaid must be offered a choice of service provider(s) and this freedom of choice must be documented in the individual's file.

Individuals Enrolled IN CCC Plus Managed Care (Hospice)

Many individuals enrolled in the Medicaid program 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 in which health plan the individual is enrolled. The MCO may require a referral or prior authorization in order for the individual to receive services. All MCO network hospice providers are responsible for adhering to their MCO provider contract, as well as state and federal regulations. Some providers may choose not to enroll in the MCO network; the individual's choice of provider is limited to those in the MCO network.

For those individuals enrolled in Medicaid receiving care under Medicaid fee-for-service, the provider is responsible for adhering to this manual, as well as state and federal regulations.

Admission Criteria for Covered Hospice Services

The following applies to Fee-for-Service (FFS) and MCO determinations. In order to be eligible for hospice care under Medicaid, an individual must be certified as terminally ill. An individual is considered terminally ill if his or her life expectancy is six months or less, if the terminal illness runs its normal course. In addition, the individual or, in cases where a representative has signed the election statement, his or her representative, must have knowledge of the illness and life expectancy and must elect to receive hospice services, rather than active treatment for the illness. Both the attending physician and the hospice medical director, or physician member of the interdisciplinary team, must certify life expectancy. The hospice benefit period begins with the date of the individual/representative signature on the hospice election statement. A representative is defined as a person who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care, or to terminate medical care on behalf of the individual who is enrolling hospice.

Hospice must obtain certification an individual is terminally ill in accordance with the following procedures:

For the initial 90-day benefit period of hospice coverage, a written certification documented on page 2 of the *Request for Hospice Benefits* form (DMAS 420) must be signed and dated by the attending physician and hospice medical director. (NOTE: For directions on how to access the current version of this form, please refer to the last section of this chapter, titled “How to Access DMAS Hospice Forms.”) This initial certification must be obtained prior to the request for authorization of enrollment. For individuals who are dually eligible (Medicare/Medicaid), Medicaid will accept the Medicare certification period(s) signed by both physicians (the attending physician and the hospice medical director) within the required Medicare time frames. This will apply even when the individual becomes Medicare eligible after a period when Medicaid was the primary payer for hospice services. Hospice services cannot begin prior to the individual’s election of the hospice benefit. This certification must be maintained in the individual’s medical record.

DMAS will accept the Medicare definition and regulations regarding the “Certification of Terminal Illness” as cited in the *Code of Federal Regulations* at 418.22(a)(2) and (3), which read as follows:

“a) *Timing of certification* -- (1) *General rule*. The Hospice must obtain written certification of terminal illness for each of the periods listed in §418.21, even if a single election continues in effect for an unlimited number of periods, as provided in §418.24(c).

(2) *Basic requirement*. Except as provided in paragraph (a)(3) of this section, the Hospice must obtain the written certification before it submits a claim for payment.

(3) *Exceptions*. (i) If the Hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.”

For any subsequent 90-day or 60-day hospice period, *Section IV: Notice of Re-Election of Hospice Benefit* of the *Request for Hospice Benefits* form (DMAS 420) or a *Physician Recertification* form (DMAS 420A), must be signed and dated by the medical director of the hospice, or the physician member of the hospice interdisciplinary team, on or before the beginning day of the 90-day or 60-day period. (NOTE: For directions on how to access the current version of this form, please refer to the last section of this chapter, titled “How to Access DMAS Hospice Forms.”) This certification must include a statement that the individual’s medical prognosis (his or her life expectancy) is six months or less, if the illness runs its normal course.

If hospice cannot obtain the written recertification within two (2) calendar days after the recertification period begins, it must obtain an oral recertification within two (2) calendar days and the written recertification prior to submission of a claim for payment. Documentation must be in the chart that the provider received oral recertification and the date that recertification was received. This recertification must be maintained in the individual's medical record.

In cases of Medicaid retroactive eligibility, the requirements listed above still apply.

Election of Hospice Care

The election of the hospice benefit is an individual, or his or her representative's choice. The hospice benefit is not designed to meet the needs of every individual with a terminal illness. The individual and his or her family representative must be fully informed of the services available and any limitation(s) on those services prior to electing the benefit. Some individuals' needs can be more effectively met by utilizing other state and/or local programs and services.

In addition to the provision of core services (physician, nursing, medical social services, and counseling), all other covered services must be available and provided to meet the needs of the individual. When an individual elects Medicaid hospice care, he or she waives rights to those services covered by Medicaid which are also covered by Medicare and relate to the treatment of his or her terminal illness. Hospice providers are responsible for the provision of all covered services through one of four per diem rates. Therefore, any covered services provided after the election of the hospice benefit becomes the financial responsibility of the hospice provider.

Note that, on April 1, 2011, Virginia's Medicaid State Plan Amendment incorporated the federal requirement that children under the age of 21 must be permitted to continue to receive curative medical services, even if they also elect to receive hospice services. This change was implemented in order to enforce Section 2302 of the Patient Protection and Affordable Care Act, termed the "Concurrent Care for Children" requirement. Concurrent curative care means receiving curative care to eradicate disease or normalize the underlying health condition, while simultaneously receiving hospice care for physical symptoms and psychosocial needs at end of life. See end of chapter for additional information.

The hospice benefit consists of two 90-day periods, followed by an unlimited number of 60-day periods (referred to as election periods). An individual must elect to receive hospice care in order to receive hospice services. A *Request for Hospice Benefits form* (DMAS 420) must be completed by the individual, or the individual's representative, who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care. (NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.") When an individual elects Medicaid hospice care, he or she waives rights to services covered by Medicaid which are also covered by Medicare. Therefore, after the hospice benefit is elected, Medicaid payment will continue for services covered under the Virginia State Plan for Medical Assistance if those services are not covered by Medicare and the individual meets the program criteria.

This does not mean a hospice provider may provide fewer services than specified in the *Code of Federal Regulations*, Title 42, Part 418, because the services could also be covered under another Medicaid benefit. For example, since payment to the hospice provider includes home health aide services, the provider cannot refuse to provide these services because similar services are available under another benefit. DMAS will reimburse the hospice provider only for services that are medically necessary. Services which are duplicative are considered unnecessary. An individual receiving hospice services may be considered appropriate for personal care services if the services cannot be provided under the law by home health aide or homemaker services.

Admission and Disenrollment Process for Individuals Enrolled in FFS, Effective January 1, 2020:

- When an individual enrolled in Medicaid fee-for-service elects the hospice benefit, the hospice provider must enter the hospice admission directly into the Automated Admission and Disenrollment (AE&D) portal;
- Hospice providers must enter all hospice disenrollments for FFS individuals directly into the AE&D portal;
- The hospice provider will no longer fax the DMAS 421A form to DMAS; and
- The hospice provider will maintain the DMAS 420, 420A, and 421A forms in the individual's record. (Note: For directions on how to access the most current version of these forms, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")

Hospice Enrollment Process for Individuals Enrolled in a CCC Plus Managed Care

Organization:

- For hospice enrollment of an individual enrolled in a CCC Plus Managed Care Organization, please refer to and follow the MCO's enrollment process.

Hospice care may not be provided by a hospice provider other than that designated by the individual, unless services are provided under arrangements made by the designated hospice provider. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected are waived, except for services provided by the individual's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

An election period to receive hospice care will continue through the initial election period, as well as through the subsequent election periods, without a break in care, as long as the individual remains under the care of hospice and does not revoke the election in writing.

The election statement must include the following:

Identification of the particular hospice provider that will provide care to the individual;

The individual's (or representative's) acknowledgment that he or she has been given a full understanding of the palliative, rather than curative, nature of hospice care as it relates to his or her terminal illness;

Acknowledgment that certain Medicaid services are waived by the election of hospice care;

The effective date of the election; and

The signature and date of the individual or representative.

If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs. The hospice provider is responsible for completion of the DMAS required *Request for Hospice Benefits form*, pages 1 and 2 (DMAS 420). (NOTE: For directions on how to access the most current version of

this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.") If the provider bills Medicare for hospice services, Medicaid will accept the Medicare election of benefits forms with the Medicaid required physician signatures and dates.

Authorization to bill for Medicaid hospice services does not guarantee Medicaid payment for these services. The following conditions must be met for payment to be made:

The individual must be eligible for Medicaid during the dates of service delivery;

The individual must not have revoked the hospice election;

The hospice provider must be enrolled with Medicaid during the dates of service delivery; and

The hospice provider must pursue all other payment sources (e.g., Medicare and other insurance) prior to submitting a claim to DMAS.

DMAS reimbursement is subject to all DMAS and MCO quality management/utilization review activities.

Advance Directives (Hospice)

The hospice provider must provide written information to adult individuals at the time of the initial receipt of hospice care services regarding the individual's right to make medical care decisions. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will and/or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. 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. Further, the law does not require individuals to execute an advance directive.

Under the law, the hospice provider must:

Provide all adult individuals 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 residents about the hospice provider's policy on implementing advance directives;

Document in the individual's medical record whether he or she has signed an advance directive;

Not discriminate against an individual based on whether he or she has executed an advance directive; and

Provide staff and community education on advance directives.

Authorization For Services (Hospice)

Enrollment must be authorized by DMAS for reimbursement to be made for simultaneous provision of services under the hospice Medicare or Medicaid benefit. Hospice Providers must enter all hospice admissions and disenrollments directly into the AE&D portal for FFS individuals enrolled in Hospice. Hospice providers will no longer FAX the DMAS 421A to DMAS. The Hospice provider must maintain the DMAS 420, 420A and 421A forms in the individual's record. Hospice enrollment cannot be completed without an active Medicaid number.



For individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for service authorizations.

The *Request for Hospice Benefits form* (DMAS 420), pages 1 and 2, must have all physician signatures and dates before the DMAS 421A can be submitted to DMAS. If there is no date for either physician's signature, it is the hospice provider's responsibility to obtain current dated signatures certifying the individual is eligible. Please note backdated signatures are not acceptable. Quality management/utilization reviews will be conducted to ensure services are appropriate and all documentation requirements are met.

A delay in enrollment shall place the hospice provider at risk of financial liability for covered services provided after the election statement is signed. Prompt enrollment limits the risk to the provider. The hospice provider cannot bill the individual for failure on the provider's part to obtain the required physician signatures and or failure to submit an enrollment to DMAS. Verification of documentation will be conducted upon post payment review.

In addition, the hospice provider must demonstrate respect for an individual's rights by ensuring an informed consent form, specifying the type of care and services that may be provided as hospice care during the course of the illness, has been obtained for every enrollee, either from the individual, or his or her representative. A representative is defined as a person who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or to terminate medical care on behalf of the individual.

A determination of the appropriateness of Medicaid payment will be made for the initial certification period, as well as each subsequent recertification period. With the exception of instances where the individual or representative revokes during a previous benefit period, subsequent periods of care do not have to be authorized, but shall be certified by the physician, and the documentation of the physician's certification must be maintained by the hospice provider. The initial date of authorization of services will not be made retroactive prior to the date of the individual's election of hospice.

Hospice is responsible for providing or arranging for all services pertaining to the terminal

illness. DMAS will perform quality management/utilization reviews to determine if the services were provided by the appropriate provider and to ensure services provided to individuals enrolled in Medicaid are medically necessary, appropriate, and that all certification and recertification requirements are met.

Revocation/Termination Of Hospice Services

An individual, or his or her representative, may revoke the election of hospice care at any time during an election period using the *Hospice Benefits Change/Revocation/Termination Statement*, (DMAS 421). (NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled “How to Access DMAS Hospice Forms.”) Upon revocation of the hospice benefit, the individual is no longer covered by Medicaid for hospice care; however, if eligible, he or she may resume Medicaid coverage under the regular scope of benefits. The individual may, at any time, elect to receive hospice coverage for any other benefit period(s) that he or she is still eligible to receive. For individuals enrolled under Medicaid fee-for-service, the hospice provider must enter the discharge date into the AE&D portal within 5 calendar days of the revocation, using the *Hospice Enrollment/Disenrollment Authorization Request* form (DMAS 421A). For those enrolled in a managed care organization, please refer to and follow that particular MCO’s hospice revocation/termination notification procedures. The DMAS 421 must be maintained in the individual’s medical record.

Change of Hospice Provider

An individual (or representative) may change the designation of the particular hospice provider, from which hospice care will be received, once in each election period by signing the *Hospice Benefits Change/Revocation/Termination Statement*, (DMAS 421) prior to provision of hospice services.

The change of the designated hospice provider is not a revocation of the election period for which it is made. The new provider must maintain the signed DMAS 421 in the individual’s medical record. The new hospice provider must have a new *Request for Hospice Benefits* form (DMAS 420) signed by the individual or representative. The new provider must enter the admission in the AE&D portal for FFS individuals. For individuals enrolled in a managed care organization, please refer to and follow that particular MCO’s hospice procedures for a new provider.

Re-Election of Hospice Benefits

If an individual revokes the hospice benefit and subsequently re-elects the hospice benefit, the individual, or his or her representative, must sign and date a new *Request for Hospice Services* form (DMAS 420). The hospice medical director must sign and date the certification of the appropriate benefit period. This form must be maintained in the individual's medical record. Hospice must obtain written certification within two (2) calendar days of the beginning of the re-election benefit period and the provider must enter the admission in the AE&D portal for FFS hospice individuals. For individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for admission.

Notification of Death

The hospice provider must notify DMAS of the death of an individual no later than five (5) days following the death. The hospice provider should use the Hospice Enrollment/Disenrollment Authorization Request (DMAS 421A) as notification of death. (*NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms."*) The hospice provider must enter the discharge date in the AE&D portal for FFS hospice individuals. For individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for discharge. The local Department of Social Services that has case responsibility for the individual must also be notified by the hospice provider, using the DMAS 225 process, if applicable. DMAS will reimburse the provider for the last day of service, which includes either discharge or death.

Categories of Care

As described for Medicare and applicable to Medicaid, hospice services entail the following four categories of daily care:

- a. Routine home care is at-home daily care that is not continuous.
- b. Continuous home care consists of a minimum of 8 hours of care a day. The care is predominantly nursing and is provided as short-term crisis care. A registered nurse or licensed practical nurse, with current licensure in the Commonwealth of Virginia, must provide care for more than half of the period of care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be

- provided to qualify as continuous home care.
- c. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the individual. The hospice provider is responsible for all services related to the individual's terminal illness. These services may be provided under contract with the hospital or nursing facility, or by hospice direct staff. Medicaid reimbursement will be allowed for no more than five (5) consecutive days of hospice respite care.
 - d. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control, or acute/chronic symptom management, which cannot be successfully treated in another setting. The hospice provider is responsible for all services related to the individual's terminal illness. These services may be provided under contract with the hospital or nursing facility, or by hospice direct staff.

General Hospice Services

Hospice is responsible for the provision of all covered services through one of the above categories of care. Any covered services provided after the individual's election of the hospice benefit becomes the financial responsibility of hospice provider. Hospice must ensure that substantially all of the core services (physician, nursing care, social work, and counseling) are routinely provided directly by hospice employees to the individual. An individual or designated representative may refuse home health aides or homemaker services, social work, or counseling services, but the reason must be clearly documented in the medical record and identified in the plan of care. If appropriate, when due to a change in the individual's needs, the service should be re-introduced to the individual, or his or her responsible party, and the results of this discussion documented in the medical record.

Hospice may use contracted home health aides or homemaker services, if necessary, to supplement hospice employees to meet the needs of individuals during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice provider must maintain professional, financial, and administrative responsibility for the services and ensure the qualifications of staff and services provided meet all requirements. Documentation must be maintained by the provider to ensure the contracted aide has been fully trained in hospice philosophy and the provision of palliative care prior to any individual contact. Hospice maintains responsibility of nursing supervisory visits of any contracted

aide.

Hospice is required to have a legally binding, written agreement for the provision of arranged services such as x-rays, laboratory, and pharmaceutical services for individuals enrolled under their Medicaid hospice benefit. Hospice retains financial responsibility for these services. Although the services are provided to an individual enrolled in Medicaid, since the hospice provider retains financial responsibility, there is no obligation on the part of the service provider to accept the Medicaid-allowable payment on the basis of the individual's eligibility status. Provision of and payment for these services should be included in the contractual agreement between the hospice provider and the service provider.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

- ***Nursing Care*** - Nursing care must be provided by a licensed registered nurse, or licensed 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 authorizes 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 (<http://www.dhp.virginia.gov/nursing/>) provides detailed information as to which states are considered compact states and an explanation of "primary state of residence." Nursing services must be directed and staffed to ensure the nursing needs of individuals are met. Patient care responsibilities of nursing personnel must be specified. Services must be provided in accordance with recognized standards of practice.
- ***Homemaker/Home Health Aide Services*** - Home health aides must meet the federal and state qualifications specified for home health aides. Home health aide and homemaker services must be available and adequate to meet the needs of the individuals. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the individual, such as changing the bed or light cleaning and

laundrying essential to the comfort and cleanliness of the individual. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse. A registered nurse must visit the home site at least every two weeks when aide services are being provided and the visit must include an assessment of the aide services. Written instructions for the individual's care must be prepared by a registered nurse. Documentation of all services provided by the home health aide under the hospice benefit must be maintained in the individual's medical chart.

An individual in the CCC Plus Waiver can receive personal care, respite care, adult day health care, and Personal Emergency Response System (PERS) services in conjunction with hospice services. This is applicable regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Waiver services are authorized and coordinated under CCC Plus managed care organizations. For members enrolled in the CCC Plus Managed Care Program, please refer to the CCC Plus Waiver Manual for specific requirements and enrollment information.

If an individual is currently receiving services under the CCC Plus waiver and elects the hospice benefit, both the personal care provider and hospice provider must communicate to determine the most appropriate plan for aide services. The individual and/or caregiver must be included in the formation of the plan and informed of the hours permitted for personal and hospice care. Although each provider maintains their separate record documentation, it is required that this documentation reveal a collaboration of services provided by both providers.

Once an individual elects the hospice benefit, the hospice provider becomes responsible for establishing an interdisciplinary plan of care designed to meet individual's needs. If, at the time of the hospice assessment, the individual's needs indicate waiver services might be appropriate to supplement those services provided by hospice and these hours cannot be met by hospice staff, volunteers, the family support system, or other community resources, the individual should be referred to a preadmission screening team (PAS) to evaluate whether the individual meets the criteria for the CCC Plus waiver.

When waiver services are requested in addition to the services being provided under the hospice benefit, PAS teams must:

- q. Authorize the waiver, based on existing preadmission screening criteria, as long as the individual will be safe in the home setting with the total amount of care available through waiver services, hospice, and informal supports. Preadmission screening teams do not authorize services, but determine if criteria is met for LTSS waiver programs, which is a pre-determination of a need for the waiver service. The waiver provider determines the amount, duration, and scope of each waiver service and requests authorization from the appropriate entity.

Hospice must coordinate with the waiver provider to establish and agree upon one plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation. The individual and service providers must be involved in any and all decisions that affect the individual's care.

Hospice and the waiver provider must agree upon any collection of the patient pay from the individual each month. This is an agreement which should be established at the onset of care to determine which provider (whether it be the hospice or waiver provider) will be responsible for collection of the monthly patient pay. If the person is choosing to use consumer directed services through one of the waiver programs, the hospice provider will need to coordinate the collection of the patient pay with the individual directly.

After admission to hospice services, the individual may continue to receive community-based respite. The hospice benefit only provides coverage for facility-based respite and is limited to five (5) consecutive days. The decision to choose this option is the individual's. If the individual wants community-based respite services it must be coordinated in accordance with CCC Plus waiver policies.

- ***Medical Social Services*** - Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and who is working under the direction of a

physician. The social worker must meet all qualifications as outlined by the Virginia Department of Licensure and Certification.

- **Physician Services** - Physician services must be performed by a professional who is legally authorized to practice, is acting within the scope of his or her license, and is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director, or the physician member of the interdisciplinary team, must be a licensed doctor of medicine or osteopathy.

Attending physician means a physician who is a doctor of medicine or osteopathy and is identified by the individual or representative, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

- **Counseling Services** - Counseling services are required to be provided as part of the “core services” of a hospice program. Medicaid will not provide direct reimbursement to the hospice, or any other provider, for counseling services. Counseling services must be provided to individuals enrolled in hospice and their family member(s), or other persons caring them. Counseling may be provided for the purpose of training the family or other caregivers to provide care and/or for the purpose of helping the individual and his or her caregivers adjust to the approaching death. Hospice must give notice to the individual as to the availability of clergy to provide spiritual counseling.
- **Dietary Counseling**- Dietary counseling, when required, must be provided by a qualified professional and described in the plan of care. Other counseling services may be provided by members of the interdisciplinary team, or other qualified professionals, as determined by the hospice provider.
- **Bereavement Counseling** - Bereavement counseling consists of services provided to the individual’s family up to one year after the individual’s death. “Family” means the individual’s immediate kin, including spouse, brother, sister, child, parent, or any other relation or individual with significant personal ties to the individual who, by mutual agreement with the individual, family, and hospice, participated in care. The

plan of care must reflect the following: family needs, services to be provided, frequency of service delivery, and a clear delineation of who is to provide the bereavement counseling.

- ***Short-Term Inpatient Care*** - Short-term inpatient care, which is also referred to as inpatient respite care, may be provided in a participating Medicaid hospice facility, in-patient unit, or a participating Medicaid hospital or nursing facility, to relieve the primary caregiver(s) providing at-home care for the individual enrolled in hospice. No more than five (5) consecutive days of respite care will be covered.
- ***General In-Patient Care*** - General in-patient care may be required for procedures necessary for pain control or acute/chronic symptom management which cannot be provided in other settings. It may be provided in an approved facility (freestanding hospice facility, hospital, or nursing facility).

NOTE: Individuals enrolled in hospice care are exempt from the preadmission screening process for nursing facility requirements. For example: If an individual enrolled in hospice enters a nursing facility and remains under the hospice benefit, a preadmission screening is not required for the individual to enter the nursing facility. However, if the individual revokes the hospice benefit prior to entering the nursing facility, all of the preadmission screening requirements will apply. All preadmission screening requirements apply if the individual wants to enroll in the CCC Plus waiver. If the individual was not screened prior to entering the nursing facility, the preadmission screening team (PAS) may go into the nursing facility to complete the screening for CCC Plus waiver enrollment.

- ***Durable Medical Equipment (DME) and Supplies*** - Durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the individual's terminal illness, are covered. The written plan of care must include any supplies and equipment that are necessary to provide hospice care to the individual. Medical supplies and appliances must be provided as needed for the palliation and management of the terminal illness and related conditions. For additional information, refer to the Virginia Medicaid DME Manual.
- ***Drugs and Biologicals*** - Only drugs used primarily for the relief of pain and

symptom control related to the individual's terminal illness are covered. All drugs and biologicals must be administered in accordance with accepted standards of practice. Hospice must have a policy for the disposal of controlled drugs maintained in the individual's home when those drugs are no longer needed by the individual. Drugs and biologicals must be provided as needed.

- ***Rehabilitation Services*** - Rehabilitation services include physical and occupational therapies and speech-language pathology services used for purposes of symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Rehabilitative services must be available and, when provided, offered in a manner consistent with accepted standards of practice.

Rehabilitative services shall be specific and provide symptom management related to the individual's terminal diagnosis in accordance with accepted standards of medical practice. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

Physical therapy services can only be performed by a physical therapist licensed by the Board of Medicine in the state in which the hospice provider is located, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine.

Occupational therapy services are covered only when performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Board, under the direct supervision of an occupational therapist as defined above.

Speech-language therapy services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology in the state in which the hospice provider is located.

For additional information on rehabilitation services, refer to the *Rehabilitation* provider manual issued by DMAS.

INDIVIDUALS WHO RECEIVE HOSPICE CARE AND RESIDE IN NURSING FACILITIES (NFS) OR INTERMEDIATE CARE FACILITIES/INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICFS/IDD)

If an individual receiving hospice services is admitted to a nursing facility under the hospice benefit and remains, the preadmission screening evaluation is not required.

Responsibilities of the Hospice Provider for Individuals in NFs or ICFs/IDD:

Once an individual, or his or her representative, has elected the hospice benefit, the hospice provider becomes responsible for providing:

Skilled services, including but not limited to, the administration and monitoring of narcotics therapy, wound care, total parenteral nutrition, physical therapy, occupational therapy, and speech/language pathology services for treatment and related conditions;

Care coordination, including, but not limited to, arranging routine appointments and transportation to those appointments, ordering and ensuring receipt of specialized equipment and supplies necessary to carry out the established care of the individual, and ensuring timely physician visits and pharmacy reviews;

Assessments and care planning by individual disciplines and timely updates;

Interdisciplinary team care planning and timely updates;

Quality management/utilization review and maintenance of medical records;
and

Submitting claims to DMAS for routine home care for fee-for-service,

Medicaid-only individuals. Revenue code 0658 must be billed by the hospice provider in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), for FFS members.

Effective July 1, 2015, hospice providers furnishing services to nursing facility residents must submit Resource Utilization Group (RUG) codes on the revenue code 0022 line. Revenue code 0022 must be billed with revenue code 0658.

For Medicaid members enrolled in the CCC Plus program, nursing facilities shall directly bill hospice related nursing facility services to the CCC Plus health plans. Providers should bill using the existing revenue code structure for Medicaid nursing facility services, ie., using revenue code 190. These claims will not differ from other Medicaid NF Resource Utilization Groups IV (RUG-IV) Group 48 claims billed to CCC Plus health plans; NFs should not bill managed care plans using hospice revenue codes.

Effective with dates of service 07/01/2019 and after, DMAS and CCC Plus plans will reimburse Hospice 100% of the Medicaid per diem rate for the nursing facility, in addition to reimbursement for either routine or continuous home care. The calculation of the per diem rate will be determined based on the nursing facility rate associated with the dates of service.

Responsibilities of the Nursing Facility and the ICF/IDD:

"Room and board" furnished to the individual enrolled in hospice by a nursing facility or intermediate care facility for those with intellectual disabilities (ICF/IDD) is defined as follows:

Performance of personal care services, including assistance in activities of daily living and in socializing activities;

Administration of medications;

Maintaining the cleanliness of a resident's room; and

Supervising and assisting in the use of durable medical equipment and prescribed therapies.

The nursing facility or ICF/IDD must bill the hospice provider, not DMAS, for reimbursement that would normally be paid to the facility by DMAS. Individuals receiving hospice services in nursing facilities or ICFs/IDD have the same responsibility to apply their income to their cost of care as other nursing facility residents. Local Departments of Social Services will send the facility the DMAS-225 form as with any other resident, for FFS members. The facility bills the hospice provider instead of DMAS, but the facility must deduct the patient-pay amount from the bill it submits to the hospice provider. The nursing facility and ICF/IDD must account for the patient pay for these individuals and provide the hospice with a copy of the current DMAS-225. Hospice must adjust its total charges for revenue code 658 (percentage of nursing facility per diem). Any patient pay amount cannot be included in the nursing facility charges. Hospice must submit a copy of the current DMAS-225 identifying the patient-pay amount with its invoice when billing for revenue code 658.

For individuals eligible for hospice benefits under Medicare and Medicaid, the hospice provider must bill Medicare. Unless specifically prohibited by statute, Medicaid is the payer of last resort. In these instances (for example, because Medicare only reimburses for nursing facility care when it is provided in a skilled nursing bed), the routine or continuous home care charges would be billed to Medicare and the hospice provider would bill Medicaid for nursing facility charges for FFS members. For dates of service July 1, 2019 and after, Hospice providers do not bill CCC Plus MCOs for nursing facility room and board charges. The nursing facility must bill the MCO directly for these charges and not the hospice provider.

In addition, Medicaid does not make bed-hold payments to any nursing facility when an individual is in an acute care setting. Any arrangement to hold a bed for an individual enrolled in hospice would be made between the hospice provider and the nursing facility. The individual and/or his or her family may elect to pay to reserve the bed while the individual is hospitalized, but they cannot be required to do so. All residents and their families must be informed the resident has the right to be admitted at the time of the next available vacancy following discharge from the hospital.

Individuals who are dual eligible and qualify for and are admitted to a Medicare skilled bed must dually elect their Medicare/Medicaid hospice benefit. Therefore, Medicaid cannot become the primary payer for dually eligible individuals who elect skilled nursing facility placement.

When an individual residing in a nursing facility elects the hospice benefit, the nursing facility is not required to submit a patient intensity rating system (DMAS 80) form to DMAS on admission, or any subsequent nursing facility stays, as long as the individual remains in hospice care. The hospice provider must submit the current version of the DMAS 421A to the DMAS Division of Aging and Disability Services to request authorization of enrollment for individuals under Medicaid fee-for-service. Nursing facilities must continue to complete a Minimum Data Set (MDS) on individuals receiving hospice care, as required for all nursing facility residents.

If a resident is in a nursing facility under the DMAS specialized care program, no payment for hospice services will be made to the hospice provider by DMAS. The nursing facility specialized care provider is responsible for providing and billing for all services needed by the resident.

Individuals Receiving Hospice Services While In Dedicated Hospice Facilities

If an individual is admitted to a dedicated hospice facility under the hospice benefit, preadmission screening is not required. The facility shall provide 24-hour nursing services sufficient to meet the total nursing needs of those its care. This includes treatment, medication, and diet, as prescribed, as well as keeping individuals comfortable, well-groomed, and protected from accident, injury, and infection.

Individuals residing in dedicated hospice facilities are not eligible to receive CCC Plus waiver services, as facility staff are required to meet the needs of persons residing in the facility.

PEDIATRIC CONCURRENT CARE

Under Federal requirements DMAS must cover concurrent care for children under the age of 21. Concurrent curative care is covered outside of the hospice benefit when the child is enrolled in Medicaid FFS, a CCC Plus plan or Medallion 4 (FAMIS only). Those children who are enrolled in a Medallion 4 plan (that is a non-FAMIS plan) and elect hospice will be

moved out of the Medallion plan and moved into Medicaid FFS the day before the hospice benefit is elected.

Those receiving pediatric concurrent care do not have to be discharged from hospice to receive concurrent curative care. Concurrent care would be covered under the regular Medicaid benefit or waiver services. Coordination of care is an important piece in the management of these cases. The hospice provider, care coordinator (for MCO plans) and the treating providers should work together as much as possible to make sure everyone one involved in the child's care has accurate information.

Normal procedures for curative care should be followed even though the child is enrolled in hospice. Providers will need to seek service authorization for concurrent care if it is required. For Medicaid FFS members see the published manuals on our website for guidelines and service authorization requirements. Provider should refer to the individual CCC plus or Medallion 4 plan guidelines for members enrolled in one of the MCO plans. It is important for those enrolled in an MCO plan to work with the care coordinator for the Medicaid member to coordinate care.

Some examples of pediatric concurrent care include (but are not limited) to the following:

- A child who has elected hospice care at home and needs 24 hour mechanical ventilation and also needs a specialty wheelchair to accommodate the ventilator and their functional limitations in order for the child to be mobile for doctor's visits, movement around the home and community.
- A child with a diagnosis of cancer whose family has elected hospice but is actively still seeking treatment for cancer. The cancer treatment may include specialty doctor's visits and inpatient or outpatient treatments.
- A child who is on the waiting list for a lung transplant, whose family elected the hospice benefit. The child is actively seeking curative treatment and is seeing several specialists for care.

How To Access DMAS Hospice Forms

There are four hospice DMAS forms, including: (1) the *Request for Hospice Benefits* (DMAS 420); (2) the *Physician Recertification* (DMAS 420A); (3) the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421); and (4) the *Hospice Enrollment/Disenrollment Authorization Request* (DMAS 421A). The current versions of these forms are available on the Virginia Medicaid Portal located online at: www.virginiamedicaid.dmas.virginia.gov. To access the forms, visit the portal and click on the "Provider Services" tab highlighted in blue on the right side of the page. Once on the Provider Services page, click on "Provider Forms Search" in the center of the page. On the page that generates, select "Long Term Care Facility and Home Based Services" in the "Type" dropdown box, while selecting "Hospice" in the "Category" dropdown box. Finally, click the "Search" button at the bottom. The current versions of all DMAS hospice forms

will populate on the next page.

The provider must not alter any DMAS forms, though the forms may be duplicated. Forms may also be obtained through Commonwealth Martin at 804-780-0076.

NOTE: These forms and processes may be different for providers who participate in the CCC Plus network. Refer to your provider contract or guidance from the MCO for compliance audit specifications.

Billing Instructions (Hospice)

Updated: 3/31/2020

The purpose of this chapter is to explain the 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

Electronic billing using Electronic Data Interchange (EDI) is an efficient way to submit Medicaid claims. Providers use EDI software that enables the automated transfer of data in a specific format following specific data content rules directly to DMAS. For more information, go to <https://vamedicaid.dmas.virginia.gov/edi>.

The mailing address, phone number and fax number for the EDI program are:

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Phone: (866) 352-0766



Fax number: (888) 335-8460

The email to use for technical/web support for EDI is MESEDISupport@dmas.virginia.gov.

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 through 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 (Hospice)

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.

Nursing Facility Residents

For dates of service on or after July 1, 2015, hospice providers furnishing services to nursing facility residents must submit Resource Utilization Group (RUG) codes on the claim. The hospice provider must obtain the RUG billing information from the nursing facility.

The RUG code must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment (reason for assessment) or modifier should be reported in the last two digits of the HIPPS rate code. The total charges reported for revenue code 0022 should be zero.

The occurrence code and assessment reference date should be reported in the occurrence code and the occurrence span and date locators.



Claims will continue to be billed on the UB-04 claim form, the 8371 electronic format, or entered through Direct Data Entry by the provider as currently billed.

Hospice providers bill DMAS for room and board for fee for service (FFS) members. For dates of service 7/1/2019 and after, the Hospice provider does not bill CCC Plus MCOs for nursing facility room and board charges. The nursing facility must bill the MCO directly for these charges and not the hospice provider.

Service Intensity Add-On Payment

For dates of service on or after January 1, 2016, A Service Intensity Add-On (SIA) payment equal to the Continuous Home Care Hourly rate has been established for services provided by a Registered Nurse or Social Worker within the last 7 days of the member's life.

Claims must be submitted with a separate single line item entry for each eligible date of service along with a combination of revenue code 0551- "Skilled Nursing Visit" and procedure code G0299 which is defined as "direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting" and/or revenue code 0561 - Medical Social Service Visit and procedure code "G0155" which is defined as "Services of clinical social worker in home health or hospice settings, each 15 minutes." The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment. Visits made after the member's death should be reported with the "PM" - post mortem modifier, to be considered for the SIA payment. Providers must also utilize a discharge status of 20 (expired) or 40 (expired at home) to be reimbursed for the SIA payment.

Claims will continue to be billed on the UB-04 claim form, the 8371 electronic format, or entered through Direct Data Entry by the provider as currently billed.

Automated Crossover Claims Processing (Hospice)

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 to providers to their Virginia Medicaid provider record, providers are to begin including their NPI Provider Number as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a NPI Provider Number, the claim will be processed by DMAS using the NPI Provider 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 "ID" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the NPI Provider Number on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

Effective March 26, 2007 (NPI dual use) DMAS will no longer attempt to match a Medicare provider number to a Medicaid provider number. If an NPI is submitted, DMAS will "only" use this number. DMAS has established a special email address for providers to submit questions and issues related to the 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.
Governme
nt Print
Office
Superinte
ndent of
Document
s
Washingto



Hospice

n, 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:

Com
monw
ealth
Maili
ng
1700
Venab
le 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, pending, 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 (CMH)

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 members. Each member'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



Hospice

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>.

UB-04 (CMS-1450) BILLING INSTRUCTIONS

Instructions for completing the UB-04 cms-1450 claim form

DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007.

Locator	Instructions
1	<p>Provider Name, Address, Telephone Required</p> <p>Provider Name, Address, Telephone - Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent.</p> <p>Line 1. Provider Name Line 2. Street Address Line 3. City, State, Line 4. Zip Code- NOTE: DMAS will need to have the 9 digit zip code on line four, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service. Note: DMAS does not require telephone/fax numbers.</p>
2	<p>Pay to Name & Address Required if Applicable</p> <p>Pay to Name & Address - Enter the address of the provider where payment is to be sent, if different than Locator 1.</p>
3a	<p>Patient Control Number Required</p> <p>Patient Control Number - Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.</p>
3b	<p>Medical/Health Record Required</p> <p>Medical/Health Record - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.</p>
4	<p>Type of Bill Required</p> <p>Type of Bill - Enter the code as appropriate. Valid codes for Virginia Medicaid are:</p> <p>0811 Original Inpatient Nursing Home Hospice Invoice 0812 Interim Inpatient Nursing Home Hospice Claim Form* 0813 Continuing Inpatient Nursing Home Hospice Claim Invoice* 0814 Last Inpatient Nursing Home Hospice Claim Invoice* 0817 Adjustment Inpatient Nursing Home Hospice Invoice 0818 Void Inpatient Nursing Home Hospice Invoice</p>

Locator

Instructions

Note: For the above bill types, the revenue code that is billed for Nursing Facility services which are provided by Hospice is 0658- Nursing Facility Resident

- 0821 Original Inpatient Hospital Hospice Invoice
- 0822 Interim Inpatient Hospital Hospice Claim Form*
- 0823 Continuing Inpatient Hospital Hospice Claim Invoice*
- 0824 Last Inpatient Hospital Hospice Claim Invoice*
- 0827 Original Inpatient Hospital Hospice Invoice Adjustment
- 0828 Original Inpatient Hospital Hospice Invoice- Void

Note: For the above bill types, the revenue code that is billed for Inpatient Hospital Hospice Services which are provided by Hospice is 0655 - Inpatient Respite Care.

- 0831 Original Outpatient Invoice
- 0837 Adjustment Outpatient Invoice
- 0838 Void Outpatient Invoice

These below are for Medicare Crossover Claims Only

Note: For the above bill types, the revenue code that is billed for Nursing Home Outpatient Services which are provided by Hospice are 0651- Routine Home Care **OR** 0652 - Continuous Home Care.

- 5 Federal Tax Number Not Required Federal Tax Number - The number assigned by the federal government for tax reporting purposes
- 6 **Statement Covered Period Required** **Statement Covered Period** - Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day.
- 7 Reserved for assignment by the NUBC Reserved for assignment by the NUBC
NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.
- 8 **Patient Name/Identifier Required** **Patient Name/Identifier** - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
- 9 Patient Address Patient Address - Enter the mailing address of the patient.
 1. Street address
 2. City
 3. State
 4. Zip Code (9 digits)
 5. Country Code if other than USA
- 10 **Patient Birthdate Required** **Patient Birthdate** - Enter the date of birth of the patient.
 Note: The format for birthdate is MMDDYYYY. This is the only locator that the 4-digit year is to be used.

Locator		Instructions														
11	Patient Sex Required	Patient Sex - Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown														
12	Admission/Start of Care Required	Admission/Start of Care - The start date for this episode of care. For general Hospice this date is the date hospice began. For patients already in a nursing home facility, but elect hospice services the date hospice care began is to be entered. NOT the admission date to the nursing home.														
13	Admission Hour Required	Admission Hour - Enter the hour during which the patient was admitted for inpatient or outpatient care. Note: Military time is used as defined by NUBC.														
14	Priority (Type) of Visit Required	<p>Priority (Type) of Visit - Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for hospice are:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>3</td> <td>Elective - patient's condition permits adequate time to schedule the services</td> </tr> <tr> <td>9</td> <td>Information not available</td> </tr> </tbody> </table>	Code	Description	3	Elective - patient's condition permits adequate time to schedule the services	9	Information not available								
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3	Elective - patient's condition permits adequate time to schedule the services															
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15	Source of Referral for Admission or Visit Required	<p>Source of Referral for Admission or Visit - Enter the code indicating the source of the referral for this admission or visit. Note: Appropriate codes accepted by DMAS are:</p> <table border="1"> <thead> <tr> <th>Code:</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Physician Referral</td> </tr> <tr> <td>2</td> <td>Clinic Referral</td> </tr> <tr> <td>4</td> <td>Transfer from Another Acute Care Facility</td> </tr> <tr> <td>5</td> <td>Transfer from a Skilled Nursing Facility</td> </tr> <tr> <td>6</td> <td>Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)</td> </tr> <tr> <td>9</td> <td>Information not available</td> </tr> </tbody> </table>	Code:	Description	1	Physician Referral	2	Clinic Referral	4	Transfer from Another Acute Care Facility	5	Transfer from a Skilled Nursing Facility	6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)	9	Information not available
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16	Discharge Hour Required	Discharge Hour - Enter the code indicating the discharge hour of the patient from inpatient care. Note: Military time is used as defined by NUBC														

Locator	Instructions																								
17 Patient Discharge Status Required	<p>Patient Discharge Status - Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:</p> <table border="1"> <thead> <tr> <th style="text-align: left;">Code</th> <th style="text-align: left;">Description</th> </tr> </thead> <tbody> <tr><td>01</td><td>Discharged to Home</td></tr> <tr><td>02</td><td>Discharged/transferred to Short term General Hospital for Inpatient Care</td></tr> <tr><td>03</td><td>Discharged/transferred to Skilled Nursing Facility</td></tr> <tr><td>04</td><td>Discharged/transferred to Intermediate Care Facility</td></tr> <tr><td>05</td><td>Discharged/transferred to Another Facility not Defined Elsewhere</td></tr> <tr><td>07</td><td>Left Against Medical Advice or Discontinued Care</td></tr> <tr><td>20</td><td>Expired</td></tr> <tr><td>30</td><td>Still a Patient</td></tr> <tr><td>50</td><td>Hospice - Home</td></tr> <tr><td>51</td><td>Hospice - Medical Care Facility</td></tr> <tr><td>61</td><td>Discharged/transferred to Hospital Based Medicare Approved Swing Bed</td></tr> </tbody> </table>	Code	Description	01	Discharged to Home	02	Discharged/transferred to Short term General Hospital for Inpatient Care	03	Discharged/transferred to Skilled Nursing Facility	04	Discharged/transferred to Intermediate Care Facility	05	Discharged/transferred to Another Facility not Defined Elsewhere	07	Left Against Medical Advice or Discontinued Care	20	Expired	30	Still a Patient	50	Hospice - Home	51	Hospice - Medical Care Facility	61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed
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18 thru 28 Condition Codes Required if applicable	<p>Condition Codes - Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. Note: DMAS limits the number of condition codes to maximum of 8 on one claim.</p> <p>These codes are used by DMAS in the adjudication of claims:</p> <table border="1"> <thead> <tr> <th style="text-align: left;">Code</th> <th style="text-align: left;">Description</th> </tr> </thead> <tbody> <tr><td>39</td><td>Private Room Medically Necessary</td></tr> <tr><td>40</td><td>Same Day Transfer</td></tr> <tr><td>A1</td><td>EPSDT</td></tr> <tr><td>A4</td><td>Family Planning</td></tr> </tbody> </table>	Code	Description	39	Private Room Medically Necessary	40	Same Day Transfer	A1	EPSDT	A4	Family Planning														
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A4	Family Planning																								
29 Accident State	<p>Accident State - Enter if known the state (two digit state abbreviation) where the accident occurred.</p>																								
30 Crossover Part A Indicator	<p>Note: DMAS is requiring for Medicare Part A crossover claims that the word "CROSSOVER" be in this locator</p>																								
31 thru 34 Occurrence Code and Dates Required if applicable	<p>Occurrence Code and Dates - Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence. An example of how providers should identify Medicare coverage exhausted on a Medicaid claim is A3= MDCR Exhaust</p>																								

Locator		Instructions
35 thru 36	Occurrence Span Code and Dates Required if applicable	<p>Occurrence Span Code and Dates - Enter the code and related dates that identify an event relating to the payment of the claim. Enter codes in alphanumeric sequence.</p> <p>For nursing facility residents, report occurrence span code (50) and the Medicaid Assessment Reference Date (ARD) date in the occurrence span dates for each RUG code. Multiple occurrence code 50 entries and occurrence span dates may be entered.</p>
37	Reserved	Reserved For NUBC Assignment
38	Responsible Party Name and Address	Responsible Party Name and Address - Enter the name and address of the party responsible for the bill.
39 thru 41	Value codes and Amount Required	<p>Value Codes and Amount - Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim.</p> <p>Note: DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes:</p> <p>80. Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims.</p> <p>81. Enter the number of non-covered days for inpatient hospitalization</p> <p>AND One of the following codes must be used to indicate the coordination of third party insurance carrier benefits:</p> <p>82. No Other Coverage</p> <p>83. Billed and Paid (enter amount paid by primary carrier)</p> <p>85. Billed Not Covered/No Payment</p> <p>For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above:</p> <p>A1 Deductible from Part A</p> <p>A2 Coinsurance from Part A</p> <p>Other codes may also be used if applicable.</p> <p>The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid) in Locator 50 A, B, C.</p> <p>Revenue Codes - Enter the appropriate revenue code(s) for the service provided. Note:</p> <ul style="list-style-type: none"> • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim.
42	Revenue Code Required	

Locator

Instructions

0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day) Note: As of January 1, 2016, a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days 61 and thereafter

0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430).

0656 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day)

0658 Nursing facility resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Effective with dates of service 07/01/2019 and after, Hospice providers will be reimbursed 100% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.

0551 Skilled Nursing Visit - to be used when submitting charges representative of a visit by a Registered Nurse within the member's last 7 days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.

0561 Medical Social Service Visit - to be used to be used when submitting charges representative of a visit by a Clinical Social Worker within the member's last 7 days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.

Locator		Instructions
43	Revenue Description Required	Revenue Description - Enter the standard abbreviated description of the related revenue code categories included on this bill.
44	HCPCS/Rates/HIPPS Rate Codes Required (if applicable)	<p>HCPCS/Rates/HIPPS Rate Codes - Inpatient: Enter the accommodation rate. For nursing facility residents, report the RUG code in the first three digits HIPPS rate code locator and the assessment code (reason for assessment) or modifier in the last two digits of the HIPPS rate code.</p> <p>Outpatient: The following codes are to be used only when submitting charges applicable to and for consideration of the SIA Payment. G0299 - direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting. G0155 - Services of clinical social worker in home health or hospice settings, each 15 minutes.</p>
45	Service Date Required if applicable	Service Date - Enter one line item entry per revenue code for each date the outpatient service was provided.
46	Service Units Required	<p>Service Units - <u>Inpatient</u>: Enter the total number of covered accommodation days or ancillary units of service where appropriate.</p> <p><u>Outpatient</u>: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). For nursing facility residents, the total accommodation days for revenue code 0658 should equal total units for each revenue code 0022 line.</p>
47	Total Charges Required	<p>Total Charges - Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. Note: Use code "0001" for TOTAL. For nursing facility residents, the total charges for revenue code 0022 should be zero.</p>
48	Non-Covered Charges Required if applicable	Non-Covered Charges - To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	Payer Name A-C. Required	<p>Payer Name - Enter the payer from which the provider may expect some payment for the bill.</p> <p>A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable.</p>

Locator	Instructions
	When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.
51 Health Plan Identification Number A-C	Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. NOTE: DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57.
52 Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53 Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54 Prior Payments - Payer A,B,C Required (if applicable)	Prior Payments Payer - Enter the amount the provider has received (to date) by the health plan toward payment of this bill.
55 Estimated Amount Due A,B,C,	Estimated Amount Due - Payer - Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56 NPI Required	National Provider Identification - Enter your NPI. Once DMAS is in the dual use period (March 26, 2007), providers will submit their NPI in this locator on the UB 04. Until March 26, 2007, providers should enter their legacy Medicaid number in locator 57.
57A thru C Other Provider Identifier Required (if applicable)	Other Provider Identifier - Enter your legacy Medicaid provider number in this locator until DMAS is accepting NPI for claims processing which are claims submitted prior to March 26, 2007. After NPI Compliance, DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.
58 Insured's Name A-C Required	INSURED'S NAME - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. Enter the insured's name used by the primary payer identified on Line A, Locator 50.

Locator

Instructions

Enter the insured's name used by the secondary payer identified on Line B, Locator 50.

Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

59	Patient's Relationship to Insured A-C Required	<p>Patient's Relationship to Insured - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:</p> <table border="0"> <thead> <tr> <th style="text-align: left; padding-right: 20px;">Code:</th> <th>Description:</th> </tr> </thead> <tbody> <tr><td>01</td><td>Spouse</td></tr> <tr><td>18</td><td>Self</td></tr> <tr><td>19</td><td>Child</td></tr> <tr><td>21</td><td>Unknown</td></tr> <tr><td>39</td><td>Organ Donor</td></tr> <tr><td>40</td><td>Cadaver Donor</td></tr> <tr><td>53</td><td>Life Partner</td></tr> <tr><td>G8</td><td>Other Relationship</td></tr> </tbody> </table>	Code:	Description:	01	Spouse	18	Self	19	Child	21	Unknown	39	Organ Donor	40	Cadaver Donor	53	Life Partner	G8	Other Relationship
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19	Child																			
21	Unknown																			
39	Organ Donor																			
40	Cadaver Donor																			
53	Life Partner																			
G8	Other Relationship																			
60	Insured's Unique Identification A-C Required	<p>Insured's Unique Identification - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. NOTE: The Medicaid recipient identification number is 12 numeric digits.</p>																		
61	(Insured) Group Name A-C	<p>(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.</p>																		
62	Insurance Group Number A-C	<p>Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.</p>																		
63	Treatment Authorization Code Required (if applicable)	<p>Treatment Authorization Code - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.</p>																		
64	Document Control Number (DCN) Required for adjustment and void claims	<p>Document Control Number - The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. Note: This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.</p>																		
65	Employer Name (of the Insured) A-C	<p>Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.</p>																		

Locator		Instructions
66	Diagnosis and Procedure Code Qualifier Required	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) - The qualifier that denotes the version of the International Classification of Diseases.
67	Principal Diagnosis Code Required	Principal Diagnosis Code - Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care).
67 & 67A-Q	Present on Admission (POA) Indicator Required	Present on Admission (POA) Indicator - The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: <ul style="list-style-type: none"> • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient encounter. <p>Note: Not Required for Hospice Services</p>
67 A thru Q	Other Diagnosis Codes Required if applicable	Other Diagnosis Codes Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. DO NOT USE DECIMALS.
68	Special Note	Note: Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 - miscellaneous void or 1053 - miscellaneous adjustment.
69	Admitting Diagnosis Required	Admitting Diagnosis - Enter the diagnosis code describing the patient's diagnosis at the time of admission. DO NOT USE DECIMALS.
70 a-c	Patient's Reason for Visit	Patient's Reason for Visit - Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration.
71	Prospective Payment System (PPS) Code	Prospective Payment System - Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	External Cause of Injury Required if applicable	External Cause of Injury - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. DO NOT USE DECIMALS.
73	Reserved	Reserved for Assignment by the NUBC
74	Principal Procedure Code and Date Required if applicable	Principal Procedure Code and Date - Enter the ICD procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date.

Locator

Instructions

Note: For outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected.

74a-e Other Procedure Codes and Date Required if applicable

Other Procedure Codes and Date - Enter the ICD procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **DO NOT USE DECIMALS.**

75 Reserved

Reserved for assignment by the NUBC

76 Attending Provider Name and Identifiers Required

Attending Provider Name and Identifiers - Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after until April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the attending physicians' NPI will be accepted in the "NPI" space.

Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space.

Note: The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered.

Note: If the NPI is in locator 56, then this locator must also have the attending providers NPI.

Locator	Instructions
<p>77 Operating Physician Name and Identifiers Required if applicable</p>	<p>Operating Physician Name and Identifiers - Enter the name and the 9-digit number assigned by Medicaid of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim.</p> <p><u>Inpatient:</u> Enter the 9-digit number assigned by Medicaid for the operating physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the operating physicians' NPI will be accepted in the "NPI" space.</p> <p><u>Outpatient:</u> Enter the 9-digit number assigned by Medicaid for the operating physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space.</p> <p>Note: The qualifier for this locator is either '82' (Rendering Provider), 'DN' (Referring Provider) or 'ZZ' (Other Operating Physician) whenever the legacy Medicaid number is entered.</p>
<p>78 - Other Provider Name and Identifiers Required if applicable</p> <p>79</p>	<p>Other Physician ID. - Enter the 9 digit provider number assigned by Medicaid.</p> <p>For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider number in this locator. Please refer below to the time frame for entrance of either the legacy Medicaid provider number or the NPI.</p> <p>Note: Until DMAS has implemented the dual use period on March 26, 2007 the legacy Medicaid number or the providers NPI can be entered. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physician's NPI will be accepted in the "NPI" space.</p> <p>Note: The qualifier for this locator is 'DN' (Referring Provider) whenever the legacy Medicaid number is entered.</p>
<p>80 Remarks Field</p>	<p>Remarks Field - Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.</p>

Locator

Instructions

81 Code-Code Field Required if applicable

Code-Code Field - Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations).

Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.

Note: Hospice providers with **one** NPI must use a taxonomy code when submitting claims for different business types. (one NPI for 2 or more Medicaid PIN)

Service Type Description	Taxonomy Code(s)
Community Based Hospice	251G00000X
Inpatient Hospice	351D00000X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) Adjustment Invoice and Void Invoice Instructions

To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.

Type of Bill (Locator 4) - Enter code 0817, 0827 for inpatient Nursing Home Hospice Services or enter code 0837 for outpatient Hospice services.

Locator 64 - Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

- Locator 68 - Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
- Remarks (Locator 80) - Enter an explanation for the adjustment.

NOTE: Inpatient Hospice claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code

1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

Type of Bill (Locator 4) - Enter code 0818, 0828 for inpatient Hospice services or enter code 0838 for outpatient Hospice services.

Locator 64 - Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.

- Locator 68 - Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS).

Remarks (Locator 80) - Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge

1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Billing Instructions: Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. 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) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS1500 (02-12), please refer to the appropriate practitioner Provider Manual found at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Billing Instructions: 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: EDI Billing (Electronic Claims)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

Billing Instructions: Invoice Processing

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Upon receipt, a claim is scanned or directly keyed, assigned a claim reference number, and entered into the MMIS system. The claim is then placed in one of the following categories:

- **Remittance Voucher (Payment Voucher)** - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pending, denied, adjusted, or voided claims and should be kept in the provider's permanent files. The first page of the voucher contains a space for special messages from DMAS. The sections of the Remittance Voucher are:
 - **Approved** - These are claims which have been approved and for which the provider is being reimbursed;
 - **Pending** - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;
 - **Denied** - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously submitted claim);
 - **Debit** - This section lists any formerly paid claims which have been adjusted, thereby creating a positive balance;
 - **Credit** - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and
 - **Provider Number** - The nine-digit API or NPI identification number assigned to the individual provider. Include this number in all correspondence with DMAS.
- **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.

Denial Messages For Nursing Facility Residents

A denied claim is unacceptable for payment for the stated reason. Proper interpretation of the denial message will allow proper resubmission of an acceptable claim.

RUG Code Invalid - Check the RUG code to confirm the RUG grouper and version and revenue code 0022 for the dates of service.

Action to Take: Resubmit claim with correct RUG code with revenue code 0022 with zero (0) charges.

Invalid RUG Units - Check if the sum of the RUG units match the covered days submitted on the claim.

Action to Take: Resubmit the claim with the RUG units that match the covered days for the billing period.

Calculated RUG Amount is Zero - Confirm all claim information submitted is correct.

Action to Take: Resubmit the claim with corrected claim information.

DMAS has removed the previous rate tables from the exhibit section in this manual. Hospice rates can be found on our website: www.dmas.virginia.gov. Click on Provider Services and then click on Hospice Rate.

UB-04 (CMS-1450) BILLING INSTRUCTIONS

Instructions for completing the UB-04 cms-1450 claim form

DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007.

Locator	Instructions
1 Provider Name, Address, Telephone Required	<p>Provider Name, Address, Telephone - Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent.</p> <p>Line 1. Provider Name Line 2. Street Address Line 3. City. State, Line 4. Zip Code- NOTE: DMAS will need to have the 9 digit zip code on line four, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service. Note: DMAS does not require telephone/fax numbers.</p>
2 Pay to Name & Address Required if Applicable	<p>Pay to Name & Address - Enter the address of the provider where payment is to be sent, if different than Locator 1.</p>
3a Patient Control Number Required	<p>Patient Control Number - Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.</p>
3b Medical/Health Record Required	<p>Medical/Health Record - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.</p>
4 Type of Bill Required	<p>Type of Bill - Enter the code as appropriate. Valid codes for Virginia Medicaid are:</p> <p>0811 Original Inpatient Nursing Home Hospice Invoice 0812 Interim Inpatient Nursing Home Hospice Claim Form* 0813 Continuing Inpatient Nursing Home Hospice Claim Invoice* 0814 Last Inpatient Nursing Home Hospice Claim Invoice* 0817 Adjustment Inpatient Nursing Home Hospice Invoice 0818 Void Inpatient Nursing Home Hospice Invoice</p> <p>Note: For the above bill types, the revenue code that is billed for Nursing Facility services which are provided by Hospice is 0658- Nursing Facility Resident</p> <p>0821 Original Inpatient Hospital Hospice Invoice 0822 Interim Inpatient Hospital Hospice Claim Form* 0823 Continuing Inpatient Hospital Hospice Claim Invoice* 0824 Last Inpatient Hospital Hospice Claim Invoice* 0827 Original Inpatient Hospital Hospice Invoice Adjustment 0828 Original Inpatient Hospital Hospice Invoice- Void</p> <p>Note: For the above bill types, the revenue code that is billed for Inpatient Hospital Hospice Services which are provided by Hospice is 0655 - Inpatient Respite Care.</p> <p>0831 Original Outpatient Invoice 0837 Adjustment Outpatient Invoice 0838 Void Outpatient Invoice</p>

Locator	Instructions
<p>Note:</p>	<p>These below are for Medicare Crossover Claims Only</p> <p>For the above bill types, the revenue code that is billed for Nursing Home Outpatient Services which are provided by Hospice are 0651- Routine Home Care OR 0652 - Continuous Home Care.</p>
<p>5 Federal Tax Number Not Required</p>	<p>Federal Tax Number - The number assigned by the federal government for tax reporting purposes</p>
<p>6 Statement Covered Period Required</p>	<p>Statement Covered Period - Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day.</p>
<p>7 Reserved for assignment by the NUBC</p>	<p>Reserved for assignment by the NUBC NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.</p>
<p>8 Patient Name/Identifier Required</p>	<p>Patient Name/Identifier - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.</p>
<p>9 Patient Address</p>	<p>Patient Address - Enter the mailing address of the patient. 1. Street address 2. City 3. State 4. Zip Code (9 digits) 5. Country Code if other than USA</p>
<p>10 Patient Birthdate Required</p>	<p>Patient Birthdate - Enter the date of birth of the patient. Note: The format for birthdate is MMDDYYYY. This is the only locator that the 4-digit year is to be used.</p>
<p>11 Patient Sex Required</p>	<p>Patient Sex - Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown</p>
<p>12 Admission/Start of Care Required</p>	<p>Admission/Start of Care - The start date for this episode of care. For general Hospice this date is the date hospice began. For patients already in a nursing home facility, but elect hospice services the date hospice care began is to be entered. NOT the admission date to the nursing home.</p>
<p>13 Admission Hour Required</p>	<p>Admission Hour - Enter the hour during which the patient was admitted for inpatient or outpatient care. Note: Military time is used as defined by NUBC.</p>

Locator	Instructions																								
14 Priority (Type) of Visit Required	<p>Priority (Type) of Visit - Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for hospice are:</p> <table border="1"> <thead> <tr> <th data-bbox="491 472 564 501">Code</th> <th data-bbox="683 472 847 501">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="491 506 507 535">3</td> <td data-bbox="683 506 1294 568">Elective - patient's condition permits adequate time to schedule the services</td> </tr> <tr> <td data-bbox="491 573 507 602">9</td> <td data-bbox="683 573 1011 602">Information not available</td> </tr> </tbody> </table>	Code	Description	3	Elective - patient's condition permits adequate time to schedule the services	9	Information not available																		
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3	Elective - patient's condition permits adequate time to schedule the services																								
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15 Source of Referral for Admission or Visit Required	<p>Source of Referral for Admission or Visit - Enter the code indicating the source of the referral for this admission or visit. Note: Appropriate codes accepted by DMAS are:</p> <table border="1"> <thead> <tr> <th data-bbox="491 808 576 837">Code:</th> <th data-bbox="683 808 847 837">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="491 842 507 871">1</td> <td data-bbox="683 842 922 871">Physician Referral</td> </tr> <tr> <td data-bbox="491 875 507 904">2</td> <td data-bbox="683 875 874 904">Clinic Referral</td> </tr> <tr> <td data-bbox="491 909 507 938">4</td> <td data-bbox="683 909 1235 938">Transfer from Another Acute Care Facility</td> </tr> <tr> <td data-bbox="491 943 507 972">5</td> <td data-bbox="683 943 1203 972">Transfer from a Skilled Nursing Facility</td> </tr> <tr> <td data-bbox="491 976 507 1005">6</td> <td data-bbox="683 976 1326 1077">Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)</td> </tr> <tr> <td data-bbox="491 1081 507 1111">9</td> <td data-bbox="683 1081 1011 1111">Information not available</td> </tr> </tbody> </table>	Code:	Description	1	Physician Referral	2	Clinic Referral	4	Transfer from Another Acute Care Facility	5	Transfer from a Skilled Nursing Facility	6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)	9	Information not available										
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16 Discharge Hour Required	<p>Discharge Hour - Enter the code indicating the discharge hour of the patient from inpatient care. Note: Military time is used as defined by NUBC</p>																								
17 Patient Discharge Status Required	<p>Patient Discharge Status - Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:</p> <table border="1"> <thead> <tr> <th data-bbox="491 1480 564 1509">Code</th> <th data-bbox="660 1480 825 1509">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="491 1514 523 1543">01</td> <td data-bbox="660 1514 927 1543">Discharged to Home</td> </tr> <tr> <td data-bbox="491 1547 523 1576">02</td> <td data-bbox="660 1547 1262 1610">Discharged/transferred to Short term General Hospital for Inpatient Care</td> </tr> <tr> <td data-bbox="491 1615 523 1644">03</td> <td data-bbox="660 1615 1315 1644">Discharged/transferred to Skilled Nursing Facility</td> </tr> <tr> <td data-bbox="491 1648 523 1677">04</td> <td data-bbox="660 1648 1353 1677">Discharged/transferred to Intermediate Care Facility</td> </tr> <tr> <td data-bbox="491 1682 523 1711">05</td> <td data-bbox="660 1682 1267 1744">Discharged/transferred to Another Facility not Defined Elsewhere</td> </tr> <tr> <td data-bbox="491 1749 523 1778">07</td> <td data-bbox="660 1749 1315 1778">Left Against Medical Advice or Discontinued Care</td> </tr> <tr> <td data-bbox="491 1783 523 1812">20</td> <td data-bbox="660 1783 762 1812">Expired</td> </tr> <tr> <td data-bbox="491 1816 523 1845">30</td> <td data-bbox="660 1816 836 1845">Still a Patient</td> </tr> <tr> <td data-bbox="491 1850 523 1879">50</td> <td data-bbox="660 1850 868 1879">Hospice - Home</td> </tr> <tr> <td data-bbox="491 1883 523 1912">51</td> <td data-bbox="660 1883 1075 1912">Hospice - Medical Care Facility</td> </tr> <tr> <td data-bbox="491 1917 523 1946">61</td> <td data-bbox="660 1917 1337 1980">Discharged/transferred to Hospital Based Medicare Approved Swing Bed</td> </tr> </tbody> </table>	Code	Description	01	Discharged to Home	02	Discharged/transferred to Short term General Hospital for Inpatient Care	03	Discharged/transferred to Skilled Nursing Facility	04	Discharged/transferred to Intermediate Care Facility	05	Discharged/transferred to Another Facility not Defined Elsewhere	07	Left Against Medical Advice or Discontinued Care	20	Expired	30	Still a Patient	50	Hospice - Home	51	Hospice - Medical Care Facility	61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed
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Locator		Instructions										
18 thru 28	Condition Codes Required if applicable	<p>Condition Codes - Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. Note: DMAS limits the number of condition codes to maximum of 8 on one claim.</p> <p>These codes are used by DMAS in the adjudication of claims:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>39</td> <td>Private Room Medically Necessary</td> </tr> <tr> <td>40</td> <td>Same Day Transfer</td> </tr> <tr> <td>A1</td> <td>EPSDT</td> </tr> <tr> <td>A4</td> <td>Family Planning</td> </tr> </tbody> </table>	Code	Description	39	Private Room Medically Necessary	40	Same Day Transfer	A1	EPSDT	A4	Family Planning
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39	Private Room Medically Necessary											
40	Same Day Transfer											
A1	EPSDT											
A4	Family Planning											
29	Accident State	Accident State - Enter if known the state (two digit state abbreviation) where the accident occurred.										
30	Crossover Part A Indicator	Note: DMAS is requiring for Medicare Part A crossover claims that the word " CROSSOVER " be in this locator										
31 thru 34	Occurrence Code and Dates Required if applicable	Occurrence Code and Dates - Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence. An example of how providers should identify Medicare coverage exhausted on a Medicaid claim is A3= MDCR Exhaust										
35 thru 36	Occurrence Span Code and Dates Required if applicable	<p>Occurrence Span Code and Dates - Enter the code and related dates that identify an event relating to the payment of the claim. Enter codes in alphanumeric sequence.</p> <p>For nursing facility residents, report occurrence span code (50) and the Medicaid Assessment Reference Date (ARD) date in the occurrence span dates for each RUG code. Multiple occurrence code 50 entries and occurrence span dates may be entered.</p>										
37	Reserved	Reserved For NUBC Assignment										
38	Responsible Party Name and Address	Responsible Party Name and Address - Enter the name and address of the party responsible for the bill.										

Locator

Instructions

39 thru 41 Value codes and Amount Required

Value Codes and Amount - Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim.

Note: DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes:

80. Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims.

81. Enter the number of non-covered days for inpatient hospitalization

AND One of the following codes **must** be used to indicate the coordination of third party insurance carrier benefits:

82. No Other Coverage

83. Billed and Paid (enter amount paid by primary carrier)

85. Billed Not Covered/No Payment

For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above:

A1 Deductible from Part A

A2 Coinsurance from Part A

Other codes may also be used if applicable.

The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid) in Locator 50 A, B, C.

42 Revenue Code Required

Revenue Codes - Enter the appropriate revenue code(s) for the service provided. Note:

- Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order,
- Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services,
- DMAS has a limit of five pages for one claim,
- The Total Charge revenue code (0001) should be the last line of the last page of the claim.

0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day) Note: As of January 1, 2016, a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days 61 and thereafter

0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

Locator

Instructions

0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430).

0656 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day)

0658 Nursing facility resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Effective with dates of service 07/01/2019 and after, Hospice providers will be reimbursed 100% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.

0551 Skilled Nursing Visit - to be used when submitting charges representative of a visit by a Registered Nurse within the member's last 7 days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.

0561 Medical Social Service Visit - to be used to be used when submitting charges representative of a visit by a Clinical Social Worker within the member's last 7 days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.

43 Revenue Description Required

Revenue Description - Enter the standard abbreviated description of the related revenue code categories included on this bill.

Locator	Instructions
44 HCPCS/Rates/HIPPS Rate Codes Required (if applicable)	<p>HCPCS/Rates/HIPPS Rate Codes - Inpatient: Enter the accommodation rate. For nursing facility residents, report the RUG code in the first three digits HIPPS rate code locator and the assessment code (reason for assessment) or modifier in the last two digits of the HIPPS rate code.</p> <p>Outpatient: The following codes are to be used only when submitting charges applicable to and for consideration of the SIA Payment. G0299 - direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting. G0155 - Services of clinical social worker in home health or hospice settings, each 15 minutes.</p>
45 Service Date Required if applicable	<p>Service Date - Enter one line item entry per revenue code for each date the outpatient service was provided.</p>
46 Service Units Required	<p>Service Units - <u>Inpatient</u>: Enter the total number of covered accommodation days or ancillary units of service where appropriate. <u>Outpatient</u>: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). For nursing facility residents, the total accommodation days for revenue code 0658 should equal total units for each revenue code 0022 line.</p>
47 Total Charges Required	<p>Total Charges - Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. Note: Use code "0001" for TOTAL. For nursing facility residents, the total charges for revenue code 0022 should be zero.</p>
48 Non-Covered Charges Required if applicable	<p>Non-Covered Charges - To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.</p>
49 Reserved	<p>Reserved for Assignment by the NUBC.</p>
50 Payer Name A-C. Required	<p>Payer Name - Enter the payer from which the provider may expect some payment for the bill.</p> <p>A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable.</p> <p>When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.</p>

Locator	Instructions
51 Health Plan Identification Number A-C	<p>Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill.</p> <p>NOTE: DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57.</p>
52 Release of Information Certification Indicator A-C	<p>Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.</p>
53 Assignment of Benefits Certification Indicator A-C	<p>Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.</p>
54 Prior Payments - Payer A,B,C Required (if applicable)	<p>Prior Payments Payer - Enter the amount the provider has received (to date) by the health plan toward payment of this bill.</p>
55 Estimated Amount Due A,B,C,	<p>Estimated Amount Due - Payer - Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).</p>
56 NPI Required	<p>National Provider Identification - Enter your NPI. Once DMAS is in the dual use period (March 26, 2007), providers will submit their NPI in this locator on the UB 04. Until March 26, 2007, providers should enter their legacy Medicaid number in locator 57.</p>
57A Other Provider Identifier Required (if applicable) thru C	<p>Other Provider Identifier - Enter your legacy Medicaid provider number in this locator until DMAS is accepting NPI for claims processing which are claims submitted prior to March 26, 2007. After NPI Compliance, DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.</p>
58 Insured's Name A-C Required	<p>INSURED'S NAME - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card.</p> <p style="padding-left: 40px;">Enter the insured's name used by the primary payer identified on Line A, Locator 50.</p> <p style="padding-left: 40px;">Enter the insured's name used by the secondary payer identified on Line B, Locator 50.</p>

Locator

Instructions

Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

- | 59 | Patient's Relationship to Insured A-C Required | <p>Patient's Relationship to Insured - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Code:</th> <th style="text-align: left;">Description:</th> </tr> </thead> <tbody> <tr><td>01</td><td>Spouse</td></tr> <tr><td>18</td><td>Self</td></tr> <tr><td>19</td><td>Child</td></tr> <tr><td>21</td><td>Unknown</td></tr> <tr><td>39</td><td>Organ Donor</td></tr> <tr><td>40</td><td>Cadaver Donor</td></tr> <tr><td>53</td><td>Life Partner</td></tr> <tr><td>G8</td><td>Other Relationship</td></tr> </tbody> </table> | Code: | Description: | 01 | Spouse | 18 | Self | 19 | Child | 21 | Unknown | 39 | Organ Donor | 40 | Cadaver Donor | 53 | Life Partner | G8 | Other Relationship |
|--------------|--|---|--------------|---------------------|----|--------|----|------|----|-------|----|---------|----|-------------|----|---------------|----|--------------|----|--------------------|
| Code: | Description: | | | | | | | | | | | | | | | | | | | |
| 01 | Spouse | | | | | | | | | | | | | | | | | | | |
| 18 | Self | | | | | | | | | | | | | | | | | | | |
| 19 | Child | | | | | | | | | | | | | | | | | | | |
| 21 | Unknown | | | | | | | | | | | | | | | | | | | |
| 39 | Organ Donor | | | | | | | | | | | | | | | | | | | |
| 40 | Cadaver Donor | | | | | | | | | | | | | | | | | | | |
| 53 | Life Partner | | | | | | | | | | | | | | | | | | | |
| G8 | Other Relationship | | | | | | | | | | | | | | | | | | | |
| 60 | Insured's Unique Identification A-C Required | <p>Insured's Unique Identification - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. NOTE: The Medicaid recipient identification number is 12 numeric digits.</p> | | | | | | | | | | | | | | | | | | |
| 61 | (Insured) Group Name A-C | <p>(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.</p> | | | | | | | | | | | | | | | | | | |
| 62 | Insurance Group Number A-C | <p>Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.</p> | | | | | | | | | | | | | | | | | | |
| 63 | Treatment Authorization Code Required (if applicable) | <p>Treatment Authorization Code - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.</p> | | | | | | | | | | | | | | | | | | |
| 64 | Document Control Number (DCN) Required for adjustment and void claims | <p>Document Control Number - The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. Note: This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.</p> | | | | | | | | | | | | | | | | | | |
| 65 | Employer Name (of the Insured) A-C | <p>Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.</p> | | | | | | | | | | | | | | | | | | |
| 66 | Diagnosis and Procedure Code Qualifier Required | <p>Diagnosis and Procedure Code Qualifier (ICD Version Indicator) - The qualifier that denotes the version of the International Classification of Diseases.</p> | | | | | | | | | | | | | | | | | | |

Locator		Instructions
67	Principal Diagnosis Code Required	Principal Diagnosis Code - Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care).
67 & 67A-Q	Present on Admission (POA) Indicator Required	Present on Admission (POA) Indicator - The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: <ul style="list-style-type: none"> • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient encounter. <p>Note: Not Required for Hospice Services</p>
67 A thru Q	Other Diagnosis Codes Required if applicable	Other Diagnosis Codes Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. DO NOT USE DECIMALS.
68	Special Note	Note: Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 - miscellaneous void or 1053 - miscellaneous adjustment.
69	Admitting Diagnosis Required	Admitting Diagnosis - Enter the diagnosis code describing the patient's diagnosis at the time of admission. DO NOT USE DECIMALS.
70 a-c	Patient's Reason for Visit	Patient's Reason for Visit - Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration.
71	Prospective Payment System (PPS) Code	Prospective Payment System - Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	External Cause of Injury Required if applicable	External Cause of Injury - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. DO NOT USE DECIMALS.
73	Reserved	Reserved for Assignment by the NUBC
74	Principal Procedure Code and Date Required if applicable	Principal Procedure Code and Date - Enter the ICD procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. <p>Note: For outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected.</p>

Locator	Instructions
74a-e Other Procedure Codes and Date Required if applicable	Other Procedure Codes and Date - Enter the ICD procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. DO NOT USE DECIMALS.
75 Reserved	Reserved for assignment by the NUBC
76 Attending Provider Name and Identifiers Required	<p>Attending Provider Name and Identifiers - Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.</p> <p><u>Inpatient:</u> Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after until April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the attending physicians' NPI will be accepted in the "NPI" space.</p> <p><u>Outpatient:</u> Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space.</p> <p>Note: The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered.</p> <p>Note: If the NPI is in locator 56, then this locator must also have the attending providers NPI.</p>

Locator	Instructions
<p>77 Operating Physician Name and Identifiers Required if applicable</p>	<p>Operating Physician Name and Identifiers - Enter the name and the 9-digit number assigned by Medicaid of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim.</p> <p><u>Inpatient:</u> Enter the 9-digit number assigned by Medicaid for the operating physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the operating physicians' NPI will be accepted in the "NPI" space.</p> <p><u>Outpatient:</u> Enter the 9-digit number assigned by Medicaid for the operating physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space.</p> <p>Note: The qualifier for this locator is either '82' (Rendering Provider), 'DN' (Referring Provider) or 'ZZ' (Other Operating Physician) whenever the legacy Medicaid number is entered.</p>
<p>78 - Other Provider Name and Identifiers Required if applicable</p> <p>79</p>	<p>Other Physician ID. - Enter the 9 digit provider number assigned by Medicaid.</p> <p>For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider number in this locator. Please refer below to the time frame for entrance of either the legacy Medicaid provider number or the NPI.</p> <p>Note: Until DMAS has implemented the dual use period on March 26, 2007 the legacy Medicaid number or the providers NPI can be entered. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physician's NPI will be accepted in the "NPI" space.</p> <p>Note: The qualifier for this locator is 'DN' (Referring Provider) whenever the legacy Medicaid number is entered.</p>
<p>80 Remarks Field</p>	<p>Remarks Field - Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.</p>

Locator

Instructions

81 Code-Code Field Required if applicable

Code-Code Field - Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations).

Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.

Note: Hospice providers with **one** NPI must use a taxonomy code when submitting claims for different business types. (one NPI for 2 or more Medicaid PIN)

Service Type Description	Taxonomy Code(s)
Community Based Hospice	251G00000X
Inpatient Hospice	351D00000X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) Adjustment Invoice and Void Invoice Instructions

To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.

Type of Bill (Locator 4) - Enter code 0817, 0827 for inpatient Nursing Home Hospice Services or enter code 0837 for outpatient Hospice services.

Locator 64 - Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

- Locator 68 - Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
- Remarks (Locator 80) - Enter an explanation for the adjustment.

NOTE: Inpatient Hospice claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code

1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

Type of Bill (Locator 4) - Enter code 0818, 0828 for inpatient Hospice services or enter code 0838 for outpatient Hospice services.

Locator 64 - Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.

- Locator 68 - Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS).

Remarks (Locator 80) - Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge

1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Utilization Review and Control (Hospice)

Updated: 3/31/2020

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

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

Individuals Enrolled IN CCC Plus Managed Care (Hospice)

Many individuals enrolled in the Medicaid program 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 in which health plan the individual is enrolled. The MCO may require a referral or prior authorization in order for the individual to receive services. All MCO network hospice providers are responsible for adhering to their MCO provider contract, as well as state and federal regulations. Some providers may choose not to enroll in the MCO network; the individual's choice of provider is limited to those in the MCO network.

For those individuals enrolled in Medicaid receiving care under Medicaid fee-for-service, the provider is responsible for adhering to this manual, as well as state and federal regulations.

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 (Hospice)

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure services provided to individuals enrolled in Medicaid are medically necessary, appropriate, and are provided by the appropriate provider. These reviews are mandated by Title 42 of the *Code of Federal Regulations*, Part 455. Providers and enrollees are identified for review by:

- Systems-generated exception reporting using various sampling methodologies, or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider exceeding peer group averages.
- Referrals and complaints from agencies or individuals. 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), a trained professional employed by DMAS, or a contractor of DMAS, reviews all cases using available resources, including appropriate consultants, and makes 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 records to be reviewed. The provider must supply the reviewer with the requested records. The reviewer will begin the review at the facility.
- Upon 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 and appeals process from this Division.

Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of records to be reviewed. The provider must supply the reviewer with the requested records. The records must be received by DMAS by the date instructed. Upon receipt of the documents, the reviewer will review the records. The reviewer may contact the provider for clarification of any documents received, if needed.
- 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 DMAS Fiscal Division. A letter outlining the repayment requirements will be received from this Division.

NOTE: These processes may be different for providers who participate in the CCC Plus network. Refer to your provider contract or guidance from the MCO for compliance audit specifications.

Overpayments:

- Overpayments may also be calculated based on a review of all claims submitted during a specified time period.
- Providers will be required to refund payments made by Medicaid, or its contractor, 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 (Hospice)

Fraud means an intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to him or herself, 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, documents, or 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 all employees are informed of these regulations. 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, or its contractor, is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will 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:

Program Integrity Division

Department of Medical Assistance Services

600 East Broad Street



Hospice

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:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

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

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

Program Integrity Division



Hospice

Department of Medical Assistance Services

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.

Hospice Admission Process

Admission Package

Hospice will be responsible for completing the *Request for Hospice Benefits* form (DMAS 420, pages 1 and 2). (NOTE: For information on how to access DMAS hospice forms, please reference the “Accessing DMAS Forms” section of this chapter.) A copy of this completed form must be kept in the individual’s medical record. The written certification statement must be signed and dated by the hospice medical director, or the physician member of the hospice interdisciplinary team, and the individual’s attending physician (if he or she has an attending physician), at the beginning of the first 90-day period of hospice coverage.

If the hospice provider cannot obtain written certification within two (2) calendar days after a period begins, it must obtain an oral certification within two (2) calendar days and written certification prior to submission of a claim for payment. Documentation must be in the chart that the provider received oral certification and the date the certification was received.

Hospice must ensure the individual choosing hospice services is eligible for the Medicaid hospice benefit. The first page (Section I) of the *Request for Hospice Benefits* form (DMAS 420) is the election statement for hospice services and must be signed and dated by the individual, or his or her representative, prior to the initiation of hospice services. Section II, located on page 2 of the DMAS 420, contains hospice provider information, which also must be completed.

Section III is the required physician member certification and must be completed by the hospice medical director, or physician member of the hospice interdisciplinary team, and the individual’s attending physician (if he or she has an attending physician).

If the individual is not dually eligible (Medicare and Medicaid eligible), the DMAS *Request for Hospice Benefit* form (DMAS 420) is the only acceptable form for Medicaid hospice enrollment.

Hospice Providers must enter hospice admissions and disenrollments directly into the AE&D portal for FFS individuals enrolled in Hospice. This allows the Hospice FFS providers to

complete the process of electronic submission for all individuals who are enrolled in Hospice. FFS Hospice providers will no longer FAX the DMAS 421A to DMAS. The Hospice provider will maintain the DMAS 420, 420A and 421A in the individual's record. Hospice enrollment cannot be completed without an active Medicaid number.

For those enrolled in a managed care organization, please refer to and follow that particular MCO's hospice admission procedures.

Change or Revocation/Termination of Hospice Benefits

An individual, or his or her representative, may change the designation of the particular hospice provider from which hospice care is received once each election period by signing the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421). The new provider must maintain the signed DMAS 421 in the individual's medical record. (NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)

Changing the designated hospice provider is not a revocation of the election period for which it is made. The new hospice provider must obtain a new *Request for Hospice Benefits* form (DMAS 420). The new provider must enter the admission in the AE&D portal for FFS individuals. For those individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for a new provider. (NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)

An individual, or his or her representative, may revoke the election of hospice care at any time during an election period using the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421). The DMAS 421 must be maintained in the individual's medical record. Hospice providers must enter the discharge date into the AE&D portal, within five (5) business days, using the DMAS 421A, of this a change/revocation/termination. For those enrolled in a managed care organization, please refer to and follow that particular MCO's hospice revocation/termination notification procedures. The DMAS 421 must be maintained in the individual's medical record. Upon the revocation of the election of Medicaid hospice services, the individual is no longer covered by Medicaid for hospice care, but, if eligible, may resume Medicaid coverage under the regular scope of benefits. The individual may, at any time, elect to receive hospice coverage for any other benefit period(s) that he or she is still eligible to receive.

An election to receive hospice care will continue without a break as long as the individual remains in the care of a hospice, does not revoke the election of hospice services, and remains eligible for Medicaid. If an individual revokes hospice benefits during a benefit period, he or she is not eligible for the remainder of days in that benefit period. The individual may elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

Re-Election of Hospice Benefits

If an individual revokes the hospice benefit and subsequently re-elects the hospice benefit, a new *Request for Hospice Services* form (DMAS 420) must be signed and dated. The hospice medical director must also sign and date the certification of the appropriate benefit period and this form must be maintained in the individual's medical record. Hospice must obtain written certification within two calendar days of the beginning of the re-election benefit period. The provider must enter the admission into the AE&D portal for FFS hospice individuals. For individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for admission. *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)*

Accessing DMAS Forms

There are four hospice DMAS forms, including: (1) the *Request for Hospice Benefits* (DMAS 420); (2) the *Physician Recertification* (DMAS 420A); (3) the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421); and (4) the *Hospice Enrollment/Disenrollment Authorization Request* (DMAS 421A). The current versions of these forms are available on the Virginia Medicaid Portal located online at: www.virginiamedicaid.dmas.virginia.gov. To access the forms, visit the portal and click on the "Provider Services" tab highlighted in blue on the right side of the page. Once on the Provider Services page, click on "Provider Forms Search" in the center of the page. On the page that generates, select "Long Term Care Facility and Home Based Services" in the "Type" dropdown box, while selecting "Hospice" in the "Category" dropdown box. Finally, click the "Search" button at the bottom. The current versions of all DMAS hospice forms will populate on the next page. The provider must not alter any DMAS forms. In addition to the aforementioned portal, forms may be obtained through Commonwealth Martin at 804-780-0076.

NOTE: These forms and processes may be different for providers who participate in the CCC Plus network. Refer to your provider contract or guidance from the MCO for compliance audit specifications.

Documentation Requirements (Hospice)

The hospice provider is responsible for coordinating an individual's care as long as he or she is enrolled under the hospice benefit. Medical record documentation must be kept on each individual and will include, in addition to the necessary identifying information, the physician's progress notes (if applicable); the physician's certification and recertification of the need for hospice services; and the physician's plan of care, which includes the orders, treatments, medications, services to be rendered, diagnostic studies, therapies, activities, social services, special procedures and diet, diagnoses, and a general statement of the prognosis.

Documentation of hospice services shall, at a minimum:

- a. Describe the clinical signs and symptoms of the individual's terminal illness;
- b. Document an accurate and complete chronological picture of the individual's clinical course and treatments;
- c. Document an interdisciplinary plan of care specifically designed for the individual has been developed, updated as necessary, and is in compliance with physician orders;
- d. Document all treatment rendered to the individual in accordance with the plan of care, with specific attention to the frequency, duration, modality, and response. The identity of who provided care (include the full name, title, and date) will also be provided;
- e. Document the changes in each individual's condition;
- f. Identify the category of care as described in Chapter IV; and
- g. Document that waiver services, if applicable, are being provided and how these services interact with the hospice plan of care.

All categories of services and coordination of care must be documented in the individual's medical record. Services not specifically documented in the individual's medical record as having been rendered will be deemed not to have been rendered and reimbursement will not be provided. Reimbursement will be retracted upon post payment utilization review.

Utilization Review Visits

Utilization Review will be conducted by DMAS or its designated contractor. Unannounced

on-site visits will be made. Desk reviews will be conducted periodically of any Medicaid participating hospice provider. Reviews will include:

Care being provided to those who are enrolled;

Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each individual;

Necessity and desirability of the continued participation in hospice services by the individual;

Feasibility of meeting the individual's health needs in alternate care arrangements;

Verification of the existence of all documentation required by Medicaid; and

- Services not documented in the individual's record will be determined not to have been performed and reimbursement will be retracted.

Subsequent visits may be made to follow-up on deficiencies or problems, complaint investigation, or technical assistance.

Specific Medical Record Documentation Requirements (Hospice)

Physician Certification and Plan of Care

For the initial 90-day benefit period of hospice coverage, a written certification documented on page 2 of the *Request for Hospice Benefits* form (DMAS 420), must be signed and dated by the attending physician and hospice medical director. (*NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.*) This initial certification must be obtained prior to the request for authorization of enrollment. For individuals who are dually eligible (Medicare/Medicaid), Medicaid will accept the Medicare certification period(s) signed by both physicians (the attending

physician and the hospice medical director) within the required Medicare time frames. This will apply even when the individual becomes Medicare eligible after a period when Medicaid was the primary payer for hospice services. Hospice services cannot begin prior to the individual's election of the hospice benefit. This certification must be maintained in the individual's medical record.

DMAS will accept the Medicare definition and regulations regarding the "Certification of Terminal Illness" as cited in the *Code of Federal Regulations* at §418.22(a)(2) and (3), which reads as follows:

"a) *Timing of certification -- (1) General rule.* The Hospice must obtain written certification of terminal illness for each of the periods listed in §418.21, even if a single election continues in effect for an unlimited number of periods, as provided in §418.24(c).

(2) *Basic requirement.* Except as provided in paragraph (a)(3) of this section, the Hospice must obtain the written certification before it submits a claim for payment.

(3) *Exceptions.* (i) If the Hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment."

For any subsequent 90-day or 60-day hospice period, a written physician recertification must be signed and dated by the hospice medical director, or the physician member of the hospice interdisciplinary team, before or on the beginning day of the 90-day or 60-day hospice period. A *Physician Recertification* form (DMAS 420A) is provided for provider use. (NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.) This certification must include a statement that the individual's medical prognosis (his or her life expectancy) is six months or less, if the illness runs its normal course.

If the hospice provider cannot obtain the written certification within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment. Documentation must be in the chart that the provider received oral certification and date this certification was received. For individuals who are dually eligible (Medicare/Medicaid), Medicaid will accept the Medicare certification period(s) signed by both physicians (the attending physician and the hospice medical director) within the required Medicare time frames. This will apply even when the individual becomes Medicare eligible after a period when Medicaid was the primary payer

for hospice services. Hospice services cannot begin prior to the individual's election of the hospice benefit. This certification must be maintained in the individual's medical record.

The hospice medical director, or physician member of the interdisciplinary team, must review and renew the physician plan of care as often as the severity of the individual's condition requires, but not less than once every 60 days. The review must be conducted by the attending physician, hospice medical director, or the physician member of the interdisciplinary team, in consultation with the interdisciplinary team. The professional staff involved in the care of the individual shall promptly alert the attending physician or the hospice medical director of any changes in the individual's condition which indicate a need to alter the plan of care or to terminate the service. The plan must include the medication orders with dosages, frequencies, and routes of administration; the treatment orders; the diet order; and any orders for activities, social services, rehabilitative therapies, durable medical equipment and supplies, and ancillary services. The information may be incorporated in the interdisciplinary team plan of care. The attending physician, hospice medical director, or physician member of the interdisciplinary team sign and date the interdisciplinary team care plan as changes are made.

Physician progress notes should record the individual's status at the time of visits, as well as any significant changes between visits. The physician is responsible for signing (name, title) and dating (month, day, year) this required documentation.

All physician documentation must be signed with initials, last name, and title and dated with the month, day, and year. A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. These methods do not preclude other requirements that are not for Medicaid purposes. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide hospice 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 (with month, day, and year) all rubber-stamped signatures.

Nursing Documentation

The following components are required for nursing documentation:

Nursing Assessment - A thorough evaluation must be made by a registered nurse at

the time of admission to hospice services. The evaluation must include, but not be limited to, history of the individual's medical condition as it relates to the need for hospice services, a review of the individual's physical systems, and identification of the physical problems/disabilities. During the nursing evaluation, a determination may be made for further assessment and need for social services. The nursing evaluation must also include a pain assessment and management plan. This initial evaluation must be maintained in the individual's record.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all individuals and should indicate realistic individual/family needs, measurable goals and objectives, and specifically state the method by which they are to be accomplished. The nursing care plan is an integral part of the interdisciplinary team care plan and is not required as a separate document. If home health or homemaker aides are to be utilized, the care plan will reflect their duties and frequency.

Nursing Summaries/Progress Notes - Nursing summaries/progress notes, in addition to PRN (as needed) notes, are required at least every two weeks for individuals enrolled in hospice. They must give a current, written picture of the individual, his or her nursing needs, the care being provided, and the individual's response to treatment. They shall address the medical status, functional status in activities of daily living, emotional/mental status, any special therapies, nutritional status, any special nursing procedures, spiritual needs, potential referrals for other services, and identification and resolution of acute episodes.

All nursing documentation must be signed with the initial, last name, and title and dated completely with the month, day, and year. A rubber stamp or initial(s) is never acceptable on any portion of the required nursing documentation. Computer entry signatures and dates are acceptable as agency policy dictates.

Home Health Aide Documentation

Documentation of all services, including the time the aide was in the home on behalf of the individual enrolled in hospice, must be maintained in the individual's record. All aide notes must be signed and dated. Computer entry signatures and dates are

acceptable as agency policy dictates.

Coordination between aide services provided under the hospice benefit and those provided under the CCC Plus Waiver must be documented by the hospice nurse in the individual's record. If the individual receives aide services under any other programs or providers, the hospice nurse must document coordination of these services with the hospice benefit. This documentation shall include the hours the individual is receiving aide services from any other agency or program. It is not necessary to have the care plan in the medical record. Documentation of waiver services is maintained separately from hospice services.

Social Services Documentation

Social services must be provided as a part of the interdisciplinary care plan developed for each individual. The social worker assists the interdisciplinary team in understanding the significant social and emotional factors related to terminal illness. The social worker will assist the interdisciplinary team in achievement of maximum social function of each individual enrolled in hospice and the coping capacity of the individual's family. In fostering the human dignity and personal worth of each person, the social worker will assist in preparing the individual for changes in his or her living situation and the family in developing constructive and personally meaningful ways to provide support.

Social service documentation must include an initial psychosocial assessment of the individual and family, a social services plan of care as part of the interdisciplinary team plan of care, and progress notes. The care plan must include measurable goals with realistic time frames and must be updated as often as necessary, but at least every 60 days. Progress notes must be written, signed, and dated at the time of each contact with an individual and/or family member. Computer entry signatures and dates are acceptable as agency policy dictates. The social worker must participate in the development and periodic review of the interdisciplinary team care plan.

Counseling Services Documentation

Hospice must ensure individuals and their families receive visits, upon their request, from clergy or other members of religious organizations of their choice. Spiritual counseling may be provided through a working arrangement with individual clergy,

clergy associations and other religious organizations in the community, or by a clergy person employed by the hospice provider. There must be at least one individual, employed by hospice, who coordinates counseling services if a variety of individuals are providing these services. Counseling services must be available to both the individual and family. Spiritual counseling must include notice to individuals as to the availability of clergy. Dietary counseling, when required, must be provided by a qualified professional. Counseling may be provided by other members of the interdisciplinary team, as well as by other qualified professionals or trained volunteers, as determined by the hospice provider.

Required documentation includes an initial assessment and a plan of care. The plan of care should be a part of the interdisciplinary team care plan; a separate care plan is not required. The plan of care for counseling services must reflect family needs and may include dietary, spiritual, and any other counseling required and must be reviewed and updated at intervals specified in the plan, but no less than once every 60 days. Progress notes for counseling services must be written, signed, and dated at the time of any contact with an individual and/or family member. Computer entry signatures and dates are acceptable as agency policy dictates. The counselor must participate in the development and periodic review of the interdisciplinary care plan.

Bereavement Services Documentation

There must also be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for bereavement services shall clearly delineate the services to be provided, the individual(s) who will provide the services, the length of time the services will be provided, and the frequency of service delivery (up to one year following the death of the individual enrolled in hospice). Bereavement services must be documented by all persons involved in providing these services.

Interdisciplinary Care Plan and Interdisciplinary Team (IDT)

The IDT shall be comprised of a nurse, physician, and social worker or counselor. The member of the basic interdisciplinary team (IDT) who assesses the individual must consult with one other member of the IDT to establish the initial plan of care, in person or by telephone. At least one member of the IDT establishing the initial plan of care must be either a nurse or a physician. The hospice nurse or physician, in consultation with the individual's independent attending physician, if there is one,

must develop the initial plan of care. Two other members of the IDT must review the plan of care and provide input within two calendar days following the day of the assessment. If the date of the initial assessment is a Medicaid covered day of hospice care, the plan of care must be established on the initial assessment date.

The plan of care must be reviewed and updated at intervals specified in the plan, but at least once every 60 days.

The plan of care must be developed, reviewed, and updated using a coordinated interdisciplinary team approach with the participation of each core service, as well as any other disciplines providing services. The plan of care should be updated as the individual's condition improves or deteriorates. The plan must also include the assessment of the individual's needs and identification of services related to the management of pain and discomfort and symptom relief. The plan of care must state in detail the scope and frequency of services needed to meet the needs of the individual and his or her family. Reviews of all plans of care with signatures and dates must be maintained in the individual's medical record.

The plan of care must also include identification of any other services, regardless of the payer source, that may impact the coordination of the hospice plan of care, including, but not limited to, waiver services. It is not necessary to include another provider's plan of care; however, the hospice interdisciplinary plan of care must reflect the hospice provider's awareness and coordination of the individual's care and needs.

Other Services - Documentation (Hospice)

Rehabilitative Therapies

Physical therapy, occupational therapy, and speech-language pathology services must be ordered by a physician. The order must include a specific plan of treatment and frequency and duration of services to be provided. For each service provided, there must be an initial assessment and a plan of care, which includes measurable goals and objectives. Each plan of care must be reviewed by each therapist involved in providing care, at least every two weeks. Progress notes must be written, signed, and dated in the individual's medical record at the time of each visit. Computer signatures and dates are acceptable as agency policy dictates.

Other Services

Consultations with any other ancillary health care professionals, such as dietary services,

pharmacist, etc., must include an assessment and plan of care. Any documentation in the individual's record must include the name and title of the individual providing the consultation, as well as a complete date (month, day, and year). Each visit or consultation must be documented in the individual's medical record.

Volunteers

Hospice must provide appropriate orientation and training to volunteers consistent with acceptable standards of hospice practice. Volunteers must be used in administrative or direct recipient care roles and be under the supervision of a designated hospice employee. Hospice must document active and ongoing efforts to recruit and retain volunteers.

Hospice must have written policies and procedures regarding the training and use of volunteers.

Hospice must document the cost savings achieved through the use of volunteers. Documentation must include identification of necessary positions which are occupied by volunteers; the work time spent by volunteers occupying these positions; and estimates of the dollar costs the hospice provider would have incurred had paid employees occupied the positions for the time the volunteers occupied the positions.

Hospice must document and maintain a volunteer staff sufficient to provide administrative or direct individual care in an amount that, at a minimum, equals five percent of the total individual care hours of all paid hospice employees and contract staff. Hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, must be recorded.

Hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to individuals enrolled in hospice who request such visits and must advise them of this opportunity.

All services to individuals enrolled in hospice, including those performed by volunteers, must be documented in the individual's medical record.

Use of Electronic Signatures (Hospice)

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. An electronic signature meeting the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures 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 making it difficult for the signer to claim 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 they alone will have access to and use of 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 and federal requirements.

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