Renal Dialysis Clinic

Last Updated: 09/22/2022

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General Information

Updated: 2/22/2019

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

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

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

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

Program Background

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

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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

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

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

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

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

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

General Scope of the Program

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

Covered Services

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

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

- Blood glucose monitors and test strips for pregnant women

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

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

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

    - Health education

- Home health services

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

- Hearing services

- Inpatient psychiatric services for members under age 21

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

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

- Skilled nursing facilities for persons under 21 years of age

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

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

criteria for non-State Plan services under EPSDT.

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

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

- Emergency hospital services

- Emergency services for aliens

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

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

- Eye refractions

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

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

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

- Laboratory and radiograph services

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

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

- Mental Health:

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

- Substance Use Disorder:

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

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- “Organ and disease” panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

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

- Papanicolaou smear (Pap) test

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

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

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

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

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

- Reconstructive surgery - post-mastectomy (1998)

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

- Renal dialysis clinic services

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

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

Adult (Medicaid Expansion) covered group.

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

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

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

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

Examples of such non-covered services are as follows:

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

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

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

services which are unrelated to patient care

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

- Services determined not to be reasonable and/or medically necessary

- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent

- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners

- Unkept or broken appointments

- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients

- Weight loss programs

MEMBER COPAYS

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

Managed Care Programs

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

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

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

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

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

Managed Care Enrollment Broker (Maximus)

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

- **Medallion 4.0**

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

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

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

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

- **CCC Plus**

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

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

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

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

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

Eligibility and MCO Enrollment Verification

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

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

Continuity of Care

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

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
  - Assistive technology
  - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
  - Intensive in-home services
  - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

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

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

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

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

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

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

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

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

Client Medical Management (CMM)

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

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

Providers may refer Medicaid patients suspected of inappropriately using or abusing

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

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

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

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

Sources of Information

MediCall Automated Voice Response System

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

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

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

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

Automated Response System (ARS)

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

HELPLINE

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

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

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

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

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

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

ELECTRONIC FILING REQUIREMENTS

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

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

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

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

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

Provider Manual Updates

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

Notice of Provider Responsibility

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

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

The telephone numbers are:

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

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

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

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

HOW TO USE THE SYSTEM

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

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

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**

  Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
- Future month information is only available in the last week of the current month.
- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

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

- Press “1” for member eligibility verification.

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

MEMBER ELIGIBILITY VERIFICATION

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

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

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

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

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

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

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

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

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

PROVIDER CHECK LOG

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

CLAIMS STATUS

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

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

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

SERVICE AUTHORIZATION INFORMATION

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

SERVICE LIMITS INFORMATION

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

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

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

PRESCRIBING PROVIDER ID

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

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

The Automated Response System (ARS)

GENERAL INFORMATION

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

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

CITY/COUNTY CODES

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

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

COUNTIES

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

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

CITIES

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

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

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

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

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

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

MEMBER RESTRICTION

Utilization Review and Case Management

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

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

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

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

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

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

Member Enrollment Procedures

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

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

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

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

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

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

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

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

Designated Primary Care Physicians (PCP)

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

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

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

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

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

Designated Pharmacies

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

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

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

Changing Designated CMM Providers

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

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

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

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

A PCP No Longer in Practice

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

Covered Services and Limitations

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

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

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

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

- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

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

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

Services Excluded from PCP Referral

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

Covered services that do not need a referral include:

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

- Immunizations (member under age 21);

- Family planning services;

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

- Dental services (members under age 21);

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

- School-based services.

CMM Provider Affiliation Groups

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

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

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

Emergency Room Services

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

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

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

Emergency Pharmacy Services

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

Provider Reimbursement and Billing Instructions

Management Fees

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

PCP and Designated Pharmacy Providers

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

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

Affiliated Providers

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

Referral Providers

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

Physicians Billing Emergency Room Services

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

Facilities Billing Emergency Room Services with a Referral

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

Non-designated Pharmacy Providers

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

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

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

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

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

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

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

PROVIDER RESTRICTION

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

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

Provider Participation Requirements (Renal Dialysis)

Updated: 1/19/2022

Managed Care Enrolled Members

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

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

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

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

Ø Medallion 3.0:

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

Ø Commonwealth Coordinated Care (CCC):

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

Ø Commonwealth Coordinated Care Plus (CCC Plus):

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

Ø Program of All-Inclusive Care for the Elderly (PACE):

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

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

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

Participating Provider

A participating provider is a person who has a current, signed participation agreement with the Department of Medical Assistance Services.

Provider Enrollment

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid members. A copy of the provider agreement can be found on the DMAS website at www.virginiamedicaid.dmas.virginia.gov. The agreement is time-limited and applies to a specific time period. All participants are required to complete new agreement forms when a name change or change of ownership occurs.

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

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

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Requests for Enrollment

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

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

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

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

Provider Screening Requirements

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

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

Limited Risk Screening Requirements

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

Moderate Risk Screening Requirements

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

High Risk Screening Requirements

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

Application Fees

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

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

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

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

Out-of-State Provider Enrollment Requests

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

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

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

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

Ordering, Referring, and Prescribing (ORP) Providers

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

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

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

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

claims to ensure the timely adjudication of claims.

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

Participation Requirements

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.

Provider Responsibilities to Identify Excluded Individuals and Entities

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

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

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

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

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

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

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste 1300

Richmond, VA 23219

-or-

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

Participation Conditions (RD)

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. A freestanding renal dialysis center is eligible for participation in the Department of Medical Assistance Services program if the clinic is Medicare certified by the Virginia Department of Health, Division of Licensure and Certification, as meeting the conditions for participation under Title XVIII of Public Law 89-97.

A sample copy of the clinic participation agreement is provided on the DMAS website as apart of the provider enrollment application.

Certification and Recertification

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

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in

certain instances, only if there is a physician's recertification to the continued need for the covered services.

Requirements of the Section 504 of the Rehabilitation Act

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

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

Utilization of Insurance Benefits (RD)

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

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

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by workers' compensation.

- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

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

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

Documentation of Records (RD)

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are required:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.

- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every clinic visit billed to Medicaid.

- All laboratory tests billed to Virginia Medicaid must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully documented. Documentation examples are listed below:

Quantitative tests: WBC - 7,000/mm3

Glucose - 85 mg/100 ml

Qualitative tests: Monoscreen - positive

Pregnancy test - negative

Descriptive tests:

Urine microscopy - clear, yellow-brown, few wbc, rare renal epithelial cell

Urine culture - greater than 105/ml E. coli

Use of Rubber Stamps for Physician Documentation (RD)

[Effective Date: January 23, 1992]

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the Physician Manual.

Termination of Provider Participation

The provider participation agreement is time-limited with periodic renewals required. 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 DMAS 30 days prior to the effective date. The address is:

DMAS Provider Enrollment Services

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.

1.325(D." DMAS

In VAC Section 32.1-325 (D)3 **The**of the Virginia Administrative Code states that the Director of Medical Assistance Services is authorized to:

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (Virginia Administrative Code 12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

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

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

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

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

Appeal – means:

1) A member appeal is:

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

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

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

   a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the

MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

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

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

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

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

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

MEMBER APPEALS

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

PROVIDER APPEALS

Non-State Operated Provider

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

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

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

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

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

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

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

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

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

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

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

- Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
- Email to appeals@dmas.virginia.gov; or
- Fax to (804) 452-5454.

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

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

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

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

Repayment of Identified Overpayments

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

State-Operated Provider

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

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

The reconsideration process will consist of three phases: an informal review by the Division Director,

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

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

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

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

Client Appeals

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

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes (Y) or No (N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate - Revalidating High - Newly Enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate - Revalidating High - Newly Enrolling	Y
Home Health Agency - Private Owned	Moderate - Revalidating High - Newly Enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate - Revalidating High - Newly Enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate - Revalidating High - Newly Enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Moderate - Revalidating High - Newly Enrolling	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

Member Eligibility

Updated: 2/22/2019

Determining Eligibility

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

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

Groups Covered by Medical Assistance

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

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These

individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

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

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

Medically Needy Covered Groups and Spenddown

Through a process known as “spenddown,” Medicaid provides a limited period of full coverage for certain groups of “Medically Needy” individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

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

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

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

Emergency Medicaid Services for Aliens

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

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

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

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

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

Medicaid Eligibility for Institutionalized Individuals

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother

- Behavioral therapies including, but not limited to, applied behavior analysis;

  - Assistive technology

  - Blood lead testing

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

  - Intensive in-home services

  - Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)

- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

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

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

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

*Other co-payments may apply to other services.

Member Eligibility Card

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

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

Member Without an Eligibility Card

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

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover

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

Medicaid Applications -- Authorized Representative Policy

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

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

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

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

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

If it is determined that an individual cannot sign an application and does not have an attorney in-fact

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

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

Non-Medicaid Patient Relationship

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

Newborn Infant Eligibility

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

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

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

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

Medicaid Eligibility for Hospice Services

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

Guidelines on Institutional Status

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

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

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

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

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

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

Incarcerated Individuals

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

Incarcerated individuals include:

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

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

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

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

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

Juveniles

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

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

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

c. Type of Facility

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

Who is Not an Inmate of a Public Institution

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

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

Member Appeals

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

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

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

If the member is not able to get the form, he may write a letter. The letter must include the name of

the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person's date of birth, social security number, case number, the agency that took the action, and the date of the action.

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

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

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

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

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

Covered Services and Limitations (RD)

Updated: 5/21/1999

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

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

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

Clinical Laboratory Improvement Amendment (CLIA)

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

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

3600 West Broad Street Richmond,
Virginia 23230

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

Vaccines For Children Program

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, childhood immunizations and annual influenza vaccinations are covered according to the most current Advisory Committee for Immunization Practices (ACIP) schedule.

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

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

Requirement to Enroll in VFC

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

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

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine

provided and will assist VDH with its accountability plan which CMS requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

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

Reimbursement for Children Ages 19 and 20

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

VFC Coverage of Other Vaccines

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

Vaccines Not Available Under VFC

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

Situations Where Vaccines Are Not Covered Under VFC

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

Vaccines Provided Outside of the EPSDT Periodicity Schedule

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

Questions

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

Non-Covered Services (RD)

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

Copayments (RD)

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

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

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

calculated payment.

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

Medicare Catastrophic Coverage Act of 1988 (Podiatry)

[Effective Date: January 1989]

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

QMB Coverage Only

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

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

QMB Extended Coverage

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

All Others

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

Client Medical Management Program (RD)

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

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient.
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by DMAS which are excluded from Client Medical Management Program requirements.

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

Preauthorized Services For Retroactive Eligibility

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

Billing Procedures (RD)

Updated: 7/31/2015

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

Two major areas are covered in this chapter:

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

Electronic Submission of Claims

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 thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

Timely Filing (Podiatry)

The Medical Assistance Program regulations require the prompt

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

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

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

Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

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

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

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

Other Primary Insurance - The provider should bill other

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

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

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

Billing Instructions: Billing Invoices (DME)

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-1500 (02-12)

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However,

the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

Billing Instructions: Automated Crossover Claims Processing (DME)

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

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

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

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

Requests for Billing Materials

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

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

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

20402

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

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

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

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.

Billing Procedures (RD)

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

form.

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

Department of Medical
Assistance Services
Practitioner

P.O. Box 27444

Richmond, Virginia 23261-7444

Or

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

Billing Instructions: Electronic Filing Requirements

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

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

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

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

277 - Unsolicited Response (5010)

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

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

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

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

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

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

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

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

Billing Instructions: ClaimCheck

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits

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

- PTP Edits:

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together.

The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:

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

- Exempt Provider Types:

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

- Service Authorizations:

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

- Modifiers:

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

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

Reconsideration

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

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

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

Billing Instructions: Reconsideration (DME)

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

Payment Processing Unit, Claim Check

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day

limit will not be considered.

Billing Instructions Reference for Services Requiring Service Authorization

Please refer to the "Service Authorization" section in Appendix D of this manual.

Billing Instructions: Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

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

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

Billing Instructions: Place of Service Codes

CMS - 1500 CODE

00-10	Unassigned
11	Office location
12	Patient's home
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
35-40	Unassigned
41	Ambulance - land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned

99	Other unlisted facility

Billing Instructions: Special Billing Instructions -- Client Medical Management Program

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as preauthorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D'and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "Y" in Locator 24C and attach an explanation of the nature of the emergency.

LOCATOR SPECIAL INSTRUCTIONS

10d Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.

17 Enter the name of the referring primary care provider.

17a When a restricted enrollee is treated on referral from the primary physician, **red shaded** enter the qualifier '1D' and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.

Note: Please refer to the time line for the appropriate provider number as indicated in main instruction above.

17b When a restricted enrollee is treated on referral from the primary physician, **open** enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.

Note: This locator can only be used for claims received on or after March 26, 2007.

24C When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a “Y” in this Locator and explains the nature of the emergency in an attachment. Write “ATTACHMENT” in Locator 10d.

Special Billing Instructions Freestanding Renal Dialysis Clinic Manual

Locator 24D	Procedures, Services or Supplies CPT/HCPCS - Enter the procedure codes appropriate for the services rendered from the list given below. Dialysis codes M0916 and M0931 include the supplies used during treatment and the following routine laboratory tests: complete blood count (RBC, WBC, Hgb, Hct, WBC differential, platelet count), hepatitis profile (Anti-HAV, Anti HAV-IgM, HBsAg, H Be Ag, Anti-HBs, Anti-H Bc, Anti H Bc-IgM, and Anti-H Be), and blood chemistry tests (albumin, albumin/globulin ratio, alkaline phosphatase, bilirubin [total and direct], calcium, carbon dioxide content, chlorides, cholesterol, creatinine, globulin, glucose, lactic dehydrogenase, phosphorous, potassium, sodium, SGOT, SGPT, total protein, urea nitrogen, and uric acid). Use the appropriate *Physicians' Current Procedural Terminology* (CPT) or HCPCS codes for non-routine laboratory tests that are actually performed by the dialysis center. Procedure and Modifier codes for billing services are: 90945, 90947 U1 90935, 90937 93005, 93010 P9010 36430 To bill for medications administered by injection during the course of treatment, use the appropriate HCPCS code for the substance(s) given. Note: DMAS is requiring the NDC whenever a J-code is billed. Refer to locator 24A red shaded special note.

Billing Instructions: Instructions for Completing the Paper CMS-1500 (02-12) Form for Medicare and Medicare Advantage Plan Deductible, Coinsurance and Copay Payments for Professional Services (Effective 11/02/2014)

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be

submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's 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. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose:	A method of billing Medicare's deductible, coinsurance and copay for professional services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS1500 (02-12)
NOTE:	Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

Locator	**Instructions**	
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).**
1a	**REQUIRED**	**Insured's I.D. Number** - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name** - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To:** - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form. **Medicare/Medicare Advantage Plan EOB should be attached.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED**	**Insurance Plan or Program Name** Enter the word '**CROSSOVER**' **IMPORTANT: DO NOT** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word **'CROSSOVER'**
11d	**REQUIRED** **If Applicable**	**Is There Another Health Benefit Plan?** If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation

17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab?
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.**
22	**REQUIRED If Applicable**	**Resubmission Code** – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:

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

Enter one of the following resubmission codes for a void:

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

Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

• A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
• An explanation about the refund.
• A copy of the remittance page(s) as it relates to the refund check amount.
• Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement
Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

23	**REQUIRED** **If Applicable**	**Prior Authorization (PA) Number** – Enter the PA number for approved services that require a service authorization. **NOTE:** The locators 24A thru 24J have been divided into open and shaded line areas. **The shaded area is ONLY for supplemental information.** DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. **ENTER REQUIRED INFORMATION ONLY.**
24A lines 1-6 open area	**REQUIRED**	**Dates of Service -** Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).
24A-H lines 1- 6 red shaded	**REQUIRED** **If Applicable**	**NEW INFORMATION! DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:** **• A1 = Deductible (Example: A120.00) = $20.00 ded** **• A2 = Coinsurance (Example: A240.00) = $40.00 coins** **• A7= Copay (Example: A735.00) = $35.00 copay** **• AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount** **• MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below** **• CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below** **• N4 = National Drug Code (NDC)+Unit of Measurement** **'MA'**: This qualifier is to be used to show **Medicare/Medicare Advantage Plan's** payment. The 'MA' qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter **MA27.08** in the red shaded area '**CM**': This qualifier is to be used to show the amount paid by the insurance carrier **other than Medicare/Medicare Advantage plan**. The '**CM**' qualifier is to be followed by the dollar/cents amount of the payment by the other insurance. Example: Payment by the other insurance plan is $27.08; enter **CM27.08** in the red shaded area NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required. **DMAS is requiring the use of the qualifier 'N4'**. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC. Example: N400026064871UN1.0 **Any spaces unused for the quantity should be left blank.** **Unit of Measurement Qualifier Codes:** **• F2 – International Units** **• GR – Gram** **• ML – Milliliter** **• UN – Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules – bill per UN** **b. Oral Liquids – bill per ML** **c. Reconstituted (or liquids) injections – bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders – bill per GR** **f. Inhalers – bill per GR** **Note: All supplemental information entered in locator 24A thru 24H is to be left justified.** **Examples:** 1. **Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is $16.00, Coinsurance is $4.00.** - **Enter:A110.00 AB20.00 MA16.00 A24.00** 2. **Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00 Medicare/Medicare Advantage Plan Allowed Amt is $100.00** - **Enter: A735.00 MA0.00 AB100.00** 3. **Medicare/Medicare Advantage Plan Paid Amt is $10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is 12345678911, Unit of measure is 2 grams** - **Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2** ****Allow a space in between each qualifier set****
24B open area	**REQUIRED**	**Place of Service** - Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator** - Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier** - Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank will be denied.
24F open area	**REQUIRED**	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. **NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.**
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J
24 I redshaded	**REQUIRED If applicable**	**ID QUALIFIER –**The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J redshaded	**REQUIRED If applicable**	**Rendering provider ID# -** If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number

26	**REQUIRED**	**Patient's Account Number –** Up to FOURTEEN alphanumeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
29	**REQUIRED If applicable**	**Amount Paid –** For personal care and waiver services only – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED If applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED If applicable**	**Other ID#: -** The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** The qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number. The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to: Department of Medical Assistance Services CMS Crossover P. O. Box 27444 Richmond, Virginia 23261-7444

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files.
Mail the completed claims to:

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

Invoice Processing (PP)

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

- Remittance Voucher
- **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.

- **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.

Please use this link to search for DMAS Forms:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch

Billing Instructions: Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

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

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.

- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

Appendix A: Definition of Terms

Updated: 12/5/2008

Term	Definition
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid/FAMIS Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally-recognized standards for health care. Abuse also means the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation of an individual.
Accommodation	A type of room; e.g., private,semi-private, ward, etc. Adjudicate To determine whether a claim should be paid or disallowed.
Adjustments	Changes made to correct an error in the billing or processing of a claim.
Atypical Provider Identifier (API)	A unique 10-digit identification Number issued to providers by DMAS. An API Number is issued for non-health care (atypical) providers and for providers in an MCO network who do not participate with Medicaid/FAMIS.
Adverse Action	Any action taken by DMAS or its designee to deny, reduce, terminate, delay or suspend a covered service. Any action taken to deny payment in whole or part to a provider of Medicaid services.
Aid Category	A designation within federal or State regulations under which an individual may be eligible for public assistance. Also, a numerical identifier for VAMMIS of the covered group in which the person is enrolled.
Allowed Charge	That part of the reported charge that qualified as a covered benefit, and is eligible for payment under the Virginia Medicaid/FAMIS Program.
Ancillary Services	Services available to individuals other than room and board for which charges are customarily made in addition to a routine service charge; e.g., pharmacy, x-ray, lab, and medical supplies.
Appeal	A request for review of an adverse action to determine whether the action complied with Medicaid laws, regulations, and/or policy, or a challenge to any DMAS adverse action affecting a provider's reimbursement.

Term	Definition
Appeal Procedure	The process of reviewing, at the member's request, any adverse action taken by DMAS or its designee to deny, reduce, terminate, delay, or suspend eligibility or a covered service in accordance with 42 CFR §431 et seq., and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, or the process for challenging an action taken by DMAS adversely affecting a provider's reimbursement, in accordance with the Virginia Administrative Process Act §2.2 - 4000 et seq and DMAS appeal regulations at 12VAC30-20-500 et seq. The appeal procedure shall be governed by the Department's regulations and any and all applicable laws and court orders.
Attending Physician	The physician who has the overall responsibility for the patient’s medical care and treatment.
Automated Response System (ARS)	Web-based Internet Eligibility Verification system that provides twentyfour-hour-a- day, seven-day-a-week Internet access to eligibility information, service limits, claim status, prior authorizations, provider check status,pharmacy prescriber identification lookup, as well as MCO enrollment information.
BabyCare	Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
Barrier Crime	Barrier crime laws, as defined in Code of Virginia § 63.2-1719, prohibit persons convicted of certain statutorily defined crimes from obtaining employment with certain employers, mostly those employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities.
Benefits	Services covered under the Virginia Medicaid/FAMIS Program.
CAP	Corrective Action Plan.
Capitation Payment	A payment the Department makes periodically to a Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular member receives services during the period covered by the fee.
Capitation Rate	The monthly amount, payable to the Contractor, per member, for all expenses incurred by the Contractor in the provision of contract services as defined herein.
Categorically Needy	Under Medicaid, categorically needy cases are aged, blind, or individuals with disabilities or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for Aid to Dependent Children (ADC), Supplemental Security Income (SSI), or an optional state supplement.
CFR (Code of Federal Regulation)	Medicaid federal regulations are located at 42 CFR 430 through 42 CFR 505.
CHIP	Virginia’s Child Health Insurance program (CHIP) for low-income children. The program is funded under Title XXI of the Social Security Act, and is known as FAMIS.

Term	Definition
Claim	An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB04.
ClaimCheck	McKesson ClaimCheck is an automated procedure coding review software. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. All Claim Checked its are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or postoperative time frame. The process involves all Physician and Laboratory Service claims. ClaimCheck edits are based on guidelines as specified in the CPT Manual as well as guidelines from the American Medical Association (AMA), the Centers for Medicare and Medicaid (CMS) to include the Correct Coding Initiative (CCI) edits and specialty society guidelines.
Client Medical Management Program (CMM)	An utilization-control program designed to promote proper medical management of essential health care and enhance service efficiency.
Clinic	A facility for the diagnosis and treatment of outpatients.
Centers for Medicare and Medicaid Services (CMS)	The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.
CMS-1500	The CMS-1500 is the uniform professional hardcopy claim form. It is the only hardcopy claim form that CMS accepts from professional pr o v i d e r s (e.g., physicians, DME providers, Independent Laboratories, etc.)
Coinsurance	The portion of Medicare- or other insurance- allowed charges for which the patient would be responsible if no other insurance is responsible.
Community Services Board	A citizens' board, which provides mental health, intellectual disability, and substance abuse programs and services within the political subdivision or political subdivisions participating on the board.
Comprehensive Services Act (CSA)	The legislation that created a collaborative system of services and funding that is child centered, family focused, and community based to address the strengths and needs of troubled and at-risk youth and their families.
Concurrent Review	Encompasses aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
Copayment	The portion of Medicaid/FAMIS-allowed charges which an individual is required to pay directly to the provider for certain services or procedures rendered.
Cosmetic Surgery	Cosmetic surgery includes any surgical procedure solely directed at improving appearance.
Covered Group	Federal and state laws describe the groups of people who may be eligible for Medicaid/FAMIS. These groups of people are called Medicaid/FAMIS covered groups. The eligibility rules and medical services available are different for certain covered groups. People who meet one o f the covered groups criteria may be eligible for Medicaid/FAMIS coverage if their income and resources are within the required limits of the covered group.
Covered Services	Services and supplies for which Medicaid/FAMIS will reimburse.

Term	Definition
Crossover Claims	Claims for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for services rendered to a member entitled to benefits under both programs.
Cultural Competency	The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.
Current Procedural Terminology (CPT)	A HCPCS component developed by the American Medical Association.
Customary Charge	The amount providers usually bill Medicaid individuals for furnishing particular services or supplies.
Date of Service (DOS)	The date or span of days that services were received by an individual.
Direct Data Entry (DDE)	An alternative way to submit claims via the web. Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer. Virginia Medicaid is currently working with the fiscal agent on a DDE solution.
Deductible (Medicare)	The dollar amount that the Medicare/Medicaid member must pay toward the cost of covered benefits before Medicare payment can be made for additional services. Medicaid pays the Medicare Part B deductible for eligible members. Medicare Part A deductible is paid by Medicaid within the Program limits.
Dental Benefits	The covered dental services available to Medicaid/FAMIS eligible children as well as the limited, emergency services available to Medicaid eligible adults.
Dental Benefits Administrator	The DMAS-contracted entity through which Medicaid dental benefits are offered. Also known as a DBA.
Department	The Virginia Department of Medical Assistance Services (DMAS).
Dependent	A spouse or child who is entitled to benefits under the Virginia Medicaid/FAMIS Program.
DESI Drugs	Drug products identified by the Federal Food and Drug Administration, in the Drug Efficacy Study Implementation Program, as lacking substantial evidence of effectiveness.
Diagnosis	The identity to recognize the nature of a condition, cause, or disease.
Direct Personal Supervision	Supervision rendered at the site of treatment by the responsible participating provider.
Diagnostic Related Groupings (DRGs)	A classification system for inpatient hospital claims for reimbursement purposes. DMAS currently uses it to reimburse inpatient hospital medical-surgical services.
DMAS	The Department of Medical Assistance Services. The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
Department of Social Services (DSS)	The agency responsible for determining eligibility for medical assistance programs and the provision of related social services. This includes the local and the state DSS.
Dual Eligibles	Medicare beneficiaries who are also enrolled in the Medicaid program

Term	Definition
Duplicate Claim	A claim which is the same as one previously paid. Also, a claim deemed by DMAS to be an identical claim as one previously submitted.
Enhanced Ambulatory Patient Grouping	Enhanced Ambulatory Patient Grouping (EAPG) is the new payment methodology developed and licensed by 3M for Virginia Medicaid's Ambulatory Surgical Centers (ASCs) with dates of service on or after April 5, 2010. The methodology defines EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by ASCs. DMAS currently uses it to reimburse ambulatory surgery centers.
Early Intervention (EI)	Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. §440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
–OR– Early Intervention (EI)	Developmental supports and services that are performed in natural environments to meet the developmental needs of Medicaid or FAMIS eligible children, ages zero to three years of age, who have a 2% or greater delay in one or more developmental areas, atypical development, or diagnosed condition with a high probability of delay.
Elective Surgery	Surgery which is not medically necessary to restore or materially improve a body function.
Eligible Person	An individual satisfying the requirement for Virginia Medicaid/FAMIS in accordance with the State Plan of the Virginia Medical Assistance Program under Title XIX or FAMIS under Title XXI, who has been certified and enrolled as such by a local social services department or FAMIS CPU.
Emergency Custody Order (ECO)	An emergency custody order by local law enforcement to take custody of a person believed to be mentally ill and in need of an psychiatric evaluation ECO limited to maximum 4 hours.
Encounter	Any covered or enhanced service received by a member through a DMAS contractor.
Encryption	A security measure process involving the conversion of data into a format that cannot be interpreted by outside parties.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Medicaid's comprehensive and preventive child health program for individuals under the age of 21.
Estimated Acquisition Cost (EAC)	Cost for drugs determined by the Virginia Medicaid Program for reimbursement.
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected individuals to allow them to confirm the services which they received.

Term	Definition
Family Access to Medical Insurance Security (FAMIS)	Virginia's CHIP program that operates under Title XXI of the Social Security Act and provides comprehensive health benefits to children through the age of 18, in families with incomes at or below 200 percent of the federal poverty level who do not have any health insurance coverage and are not eligible for Medicaid.
Family Planning Services	Any medically-approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling, which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.
FAMIS Member	Persons enrolled in DMAS' FAMIS program who are eligible to receive services under the State Child Health Plan under Title XXI of the Social Security Act.
FAMIS Plus Member	Child under the age of 19 who meets "medically indigent" criteria under Medicaid program rules, and who receives the full Medicaid benefit package and have no cost- sharing responsibilities.
FAMIS Moms	Virginia's Health Insurance program for low-income pregnant women whose family income is above Medicaid limits and at or below 200% FPL. It is a TitleXXI of the Social Security Act program, known as FAMIS MOMS. FAMIS Select Virginia's Child Health Insurance Premium Assistance program for FAMIS eligible children. It is a Title XXI of the Social Security Act program, known as FAMIS Select. Benefits are provided through the private or employer sponsored plan. There is no wrap around coverage in FAMIS Select, with the exception of immunizations.
Federal Information Processing Standards Codes (FIPS codes)	A standardized set of numeric or a lphabetic (also known as city/county code) codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies.
Federally Qualified Health Centers (FQHCs)	Community-based facilities that provide comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services.
Fee-for-Service (FFS)	The Department's traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide.
Fiscal Year (State)	Fiscal Year is from July 1 through June 30. Fraud An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
Freedom of Choice	The patient's freedom to choose between institutional placement or community based services, and/or an available program, service, or a participating provider of service.
FTE	Full-time equivalent position.

Term	Definition
Health Insurance Portability & Accountability Act of 1996 (HIPAA)	Title II of HIPAA protects the confidentiality and integrity of individually identifiable health information past, present, or future.
Home and Community–Based Services Waiver	The range of community services approved (HCBS) by the Centers for Medicare and M edicaid Services (CMS) pursuant to C1915c of the Social Security Act 420.SC. § 1396 (c) to be offered to individuals as an alternative to i nstitutionalization.
HCPCS	The Centers for Medicare and Medicaid Services Common Procedure Coding System (HCPCS) contains services not included in CPT, such as ambulance, audiology, physical therapy, speech pathology, and vision care and such supplies as drugs, durable medical equipment, orthotics, prosthetics, and other medical and surgical supplies.
Health Insurance Premium Payment Program (HIPP)	Premium assistance program for individuals enrolled in full coverage Medicaid that provides premium assistance subsidy for the employee share of employer sponsored group health insurance when it is determined to be cost effective.
HIPP For Kids	Premium assistance program for children under the age of 19 enrolled in full coverage Medicaid that reimburses the employee share of qualified employer sponsored coverage. The employer must contribute at least 40% to cost of the premium.
International Classification of Diseases, Clinical Modification (ICD-CM)	A standardized listing of descriptive terms and identifying codes for reporting diagnoses and medical services performed in the inpatient or outpatient facility.
Inpatient	An individual admitted to a hospital, nursing facility, an intermediate care facility, or a residential treatment center.
Intermediate Care Facility (ICF/MR)	A facility or distinct part of another facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an intermediate care facility for persons with mental retardation/intellectual disability or related conditions. These facilities must address the total needs of the resident which include physical, intellectual, social, emotional, and habilitation and must provide “active treatment”.
Institution for Mental Disease (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis,treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with mental retardation/intellectual disability is not an institution for mental diseases.
Intensive Care	Constant observation care to critically ill or injured patients in a critical care unit.

Term	Definition
Length of Stay (LOS)	The total number of days a patient stays in a facility such as a hospital. Length of stay would only apply to acute general psychiatric and intensive rehab hospital admissions.
Legend Drugs	Drugs which bear the federal caution: "Federal Law Prohibits Dispensing a Drug Without a Prescription."
Level of Care (LOC)	The level of service that an individual needs based on their assessment which includes functional activities of daily living, medical and/or nursing, or behavioral needs.
Long-Stay Hospital (LSH)	A Virginia Medicaid designation for hospital care that is a slightly higher level of care than Nursing Facilities.
Long-Term Acute Care Hospitals (LTAC)	A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in heating patients with serious and often complex medical conditions, DMAS recognizes these facilities as Acute Care Facilities.
Maintenance Drug	A drug that is prescribed to treat a medical condition that requires continuous administration for an indefinite period of time.
Managed Care Organization (MCO)	An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion 3.0 and FAMIS programs. Virginia Medicaid Managed Care is a state program that helps people who have Medicaid get the health care services they need.
Maximum Allowable Cost (MAC) (Upper Limits)	The upper limit allowed by the Virginia Medicaid Program for certain drugs.
Medallion 3.0	A fully capitated, risk-based, mandatory Medicaid/FAMIS Plus managed care program.
Medicaid Member	Any person identified by the Department who is enrolled in Medicaid.
Medicaid Fraud Control Unit (MFCU)	The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for the Code of Virginia § 32.1- 320, as amended.
Medicaid Works (Medicaid Buy-In Program)	Medicaid Works allows working people with disabilities whose income is no greater than 80% FPL to pay a premium to participate in the Medicaid program.
MediCall	A toll-free telephone number providing 24- hour-per-day, seven-day-a-week access to current member data necessary to verify eligibility for Medicaid/FAMIS services.
Medical Necessity	Those services which are reasonable and necessary for the diagnosis or treatment of an illness, condition, injury, or to improve the function of a disability, consistent with community standards of medical practice and in accordance with Medicaid/FAMIS policy.
Medically Complex	Those who have a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability. Also includes individuals who receive long-term services and supports.

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

Term	Definition
Outpatient	A beneficiary who receives medical services but is not admitted to a hospital, hospital, or other institutional settings.
Over-Utilization	Medically unnecessary use of the Virginia Medicaid/FAMIS Program by any provider and/or Medicaid individual.
PACE (Program of All-inclusive Care for the Elderly)	PACE provides the entire spectrum of health and long-term care services (preventive, primary, acute and long-term care services) to their members on a per member, per month basis.
Participating Provider	A person, organization, or institution with a current valid participation agreement with DMAS who or which will (1) provide the service, (2) submit the claim, and (3) accept as payment in full the amount paid by the Virginia Medicaid/FAMIS Program.
Payer of Last Resort	The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
Personal Comfort	Items Items which do not contribute directly to the treatment of a condition, illness, or injury or to the functioning of a malformed body part and are not covered by Medicaid/FAMIS.
Plan of Care	Plan of care is comprised of individual service plans as dictated by the persons' health care and support needs.
Plan First	The limited benefit Medicaid fee-for-service family planning program. Men and women who have income less than or equal to 200 percent of the federal poverty level may be eligible for Plan First if they are not eligible for a full benefit medical assistance program.
Pre-admission Screening Team (PAS)	The team comprised of a nurse and social worker from the local departments of health and local departments of social services OR the hospital discharge planners charged to perform the assessment to determine the appropriate level of care needs for longterm care services for an individual. The entity contracted with DMAS that is responsible for performing preadmission screening pursuant to 32.1-330 of the Code of Virginia.
Primary Care Physician	A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
Primary Care Provider (PCP)	A primary care physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
Procedure Code	A code used to identify a medical service or procedure performed by a provider.
Protected Health Information (PHI)	Individually identifiable patient information, including demographics, which relates to a person's health, health care, or payment for health care.

Term	Definition
Provider	An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Department.
Provider Number	A ten-digit number assigned to identify each provider of services.
Qualified Medicare Beneficiary (QMB)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit less any applicable copayments on allowed charges for Medicare-covered services.
Qualified Medicare Beneficiary-- Extended (QMB--Extended)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services.
Qualified Disabled and Working Individuals (QDWI)	Persons with disabilities who are working and who meet certain income limits and are eligible for Medicaid payment of the Medicare Part A premiums only.
Quality Monitoring (QM)	The ongoing process of assuring that the provision of health care service is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards.
Referral	A request by a provider for a participant to be evaluated and/or treated by a different physician, usually a specialist, or to receive specific services.
Remittance Voucher	A notice sent to providers that advises on the status of claims received. Paid, denied, pended, voided, and adjusted claims are reported on remittance vouchers.
Reported Charge	The total amount submitted on the claim form by a provider of services for reimbursement.
Resident	An individual admitted to a nursing facility, assisted living facility, or other institutional placement.
Residential Treatment Facility	A 24-hour-per-day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders of individuals 21 years old or younger. All services must be provided at the facility as part of the therapeutic milieu.
Retroactive Eligibility	Eligibility in which a person was determined to be eligible for a period of time prior to the month in which the application was initiated. The retroactive period is the three months prior to the application month. Once retroactive eligibility is established, Medicaid/FAMIS coverage begins the first day of the earliest retroactive month in which eligibility exists. Retroactive coverage in FAMIS is only available for newborns.
Retrospective Review	Warranted when a patient's eligibility for Medicaid/FAMIS coverage has been determined after the service has been rendered and retroactive eligibility has been granted or as otherwise allowed by the appropriate manuals/regulations.

Term	Definition
Routine Services	Inpatient routine services in a facility are those services included by the provider in a daily service charge - sometimes referred to as the "room and board" charge. Included in routine services are certain services, supplies, and use of equipment and facilities for which a separate charge is not customarily made.
Rural Health Clinic	Is a clinic located in a rural, medically under-served area; facility as defined in 42C.F.R. § 491.2.
School Health Services	Any service rendered on property of a local education agency or public school. Services must be included in an individualized education program (IEP).
Secure Email	Applies to sensitive email being passed over the Internet in some form of encrypted format.
Service Authorization (Srv Auth)	Formerly referred to as prior authorization, the approval necessary for specified services for a specified member by a specified provider before the requested services may be performed and payment made.
Service Authorization Request	Where not otherwise defined in this manual, a service authorization request shall consist of a written request from the provider (prior to providing the service), identifying the requested service (including the CPT/HCPCS or ADA codes), the patient's name and Medicaid number, and the condition being (to be) treated with documentation supporting the medical necessity, a description of the requested service, the anticipated length of treatment, the prognosis, and the estimated cost of the service.
Services Facilitator (CDSF)	A provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer-directed care. Shall Indicates a mandatory requirement or a condition to be met.
Spend-Down	A Medicaid individual eligible for Medicaid for a limited period of time because his or her income exceeds the limits and all other eligibility factors are met. The applicant's incurred medical expenses must equal or exceed the difference between his or her income and the Medicaid income limit.
Supplemental Security Income (SSI)	The federal program administered by the Social Security Administration (SSA) that pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits. In Virginia, SSI members must apply for Medicaid separately; Medicaid is not automatic. State Commonwealth of Virginia.
State Agency	The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
State Fair Hearing	The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the member to the DMAS Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R. §.§ 431.200 through 431.250 and 12 VAC 30-110- 10 through 12 VAC 30-1 10-380.

Term	Definition
State Plan for Medical Assistance (State Plan)	The comprehensive written statement submitted by the Department to the Centers for Medicare and Medicaid Services (CMS) for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation.
Temporary Detention Order (TDO)	A temporary custody order by sworn petition to any magistrate to take into custody a person believed to be mentally ill and in need of hospitalization and transported to a location to be evaluated pursuant to 42 D.F.R. 441.150 and Code of Virginia, 16.1-335 et seq. and 37.1-67.1 et seq. Centers for Medicare and Medicaid Services.
Third Party Liability (TPL)	Any individual, entity or program (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for which benefits were paid by the medical assistance programs under the State Plan.
Title XVIII	That portion of the Social Security Act which authorizes the Medicare Program.
Title XIX	That portion of the Social Security Act which authorizes the Medicaid Program.
Title XXI	That portion of the Social Security Act that authorizes the Children's Health Insurance Program, known as FAMIS.
Treatment Foster Care	Case Management Is a component of treatment foster care through which a case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board... UB-04 The UB-04, also known as the Form CMS1450, is the uniform institutional provider hardcopy claim form. It is the only hardcopy claim form that CMS accepts from institutional providers (e.g., hospitals, Skilled Nursing Facilities, Home Health Agencies, etc.)
UMCF (Uninsured Medical Catastrophe UMCF was established by the 1999 General Fund)	Assembly to provide funds for uninsured persons who need treatment for a life threatening illness or injury. An uninsured medical catastrophe includes a life- threatening illness or injury requiring specializedmedical treatment, hospitalization or both that if left untreated would more than likely result in death. There is a three page application form that must be completed and mailed to DMAS. Eligibility for funds are determined on a first come, first served basis based on the date the original application is received.
Uniform Assessment Instrument (UAI)	The multidimensional, standardized Assessment tool, which assists the assessor to determine a member's social, physical health, mental health, and functional abilities, and provides a comprehensive assessment of the individual.
Utilization Management	The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Term	Definition
Virginia's Acute and Long Term Care Program (VALTC)	Delivery system that integrates acute and long-term care. Effective September 1 , 2007, individuals already M C O-enrolled who then become eligible for Home and Community-Based Waiver programs except for the Technology Assisted Waiver will remain in their MCO for acute care services.
Virginia Administrative Code (VAC)	Contains administrative regulations for State Agencies. Available as a searchable database at http://leg1.state.va.us/lis.htm
Virginia Medicaid Management Information System (VAMMIS)	The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services.
Web Portal	A secure web site offering a broad array of resources and services to registered providers.

Appendix C (Podiatry)

Updated: 10/1/2000

The codes listed in this appendix are the only codes which DMAS will cover for podiatry. (Refer to CPT-4 for complete definitions and guidelines to the use of CPT codes.)

Multiple Source Drugs with HCFA Upper Limits

The Health Care Financing Administration (HCFA) continually revises the maximum allowed drug cost payments for multiple source drugs. A list identifying the multiple source drugs by generic name and the commonly known brand name products with the revised HCFA Upper Limits is available upon request by calling the Medicaid "HELPLINE". The revisions and additions are identified for pharmacy providers in attachments to the monthly report listing HCFA Upper Limits and Virginia/MAC Costs.

Evaluation and Management Services

99201 -Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making

99202 -Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making

99203 -Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity

99211 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services

99212 -Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making

99213 -Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity

99217 - Observation care discharge day management

99218 - Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or

comprehensive examination; and medical decision making that is straightforward or of low complexity

99221 - Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity

99222 - Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

99231 - Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity

99232 - Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity

99238 - Hospital discharge day management; 30 minutes or less

99241 - Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making

99242 - Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making

99251 - Initial inpatient consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making

99252 - Initial inpatient consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making

99261 - Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity

99262 - Follow-up inpatient consultation for an established patient which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity

99281 - Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; problem focused examination; and straightforward medical decision making

99282 - Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity

99283 - Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity

99301 - Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making that is straightforward or of low complexity

99302 - Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making of moderate to high complexity

99311 -Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity

99312 -Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity

99321 -Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity

99322 -Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: a expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity

99331 -Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity

99332 -Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity

99341 - Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making

99342 - Home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity

99347 - Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and straightforward medical decision making

99348 - Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of low complexity

Supplies

99070 -Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, supplies, or materials provided)*

* When using this code, enter "ATTACHMENT" in Locator 10-D of the HCFA-1500 claim form, and attach a description of the item and the invoice documenting the actual cost of the item. Routine supplies (e.g., gauze, tape, culture plates) are included in the office visit fee.

The 99070 code should be used in place of the 00020 code that is currently listed in the Podiatry Manual.

Administrative Services

99000 - Handling and/or conveyance of specimens for transfer from the

physician’s office to a laboratory

36415 - Routine venipuncture or finger/heel/ear stick for the collection of specimen(s)

Surgery (Services are limited strictly to treatment of foot/ankle)

10060 -Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscesses, cyst, furuncle, or paronychia); simple or single

10061 - complicated or multiple

10120 - Incision and removal of foreign body, subcutaneous tissues; simple

10121 - complicated

10140 - Incision and drainage of hematoma, seroma or fluid collection

10160 - Puncture aspiration of abscess, hematoma, bulla, or cyst

10180 - Incision and drainage , complex, postoperative wound infection

11000 - Debridement of extensive eczematous or infected skin; up to 10% of body surface

11040 - Debridement; skin, partial thickness

11041 - skin, full thickness

11042 - skin, and subcutaneous tissue

11043 - skin, subcutaneous tissue, and muscle

11044 - skin, subcutaneous tissue, muscle, and bone

11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion.

11056 - two to four lesions

11057 - more than four lesions

11100 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion

11101 - each separate/additional lesion

11305 - Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

11306 - lesion diameter 0.6 to 1.0 cm

11307 - lesion diameter 1.1 to 2.0 cm

11308 - lesion diameter over 2.0 cm

11420 -Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

11421 - lesion diameter 0.6 to 1.0 cm

11422 - lesion diameter 1.1 to 2.0 cm

11423 - lesion diameter 2.1 to 3.0 cm

11424 - lesion diameter 3.1 to 4.0 cm

11426 - lesion diameter over 4.0 cm

11620 - Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

11621 - lesion diameter 0.6 to 1.0 cm

11622 - lesion diameter 1.1 to 2.0 cm

11623 - lesion diameter 2.1 to 3.0 cm

11624 - lesion diameter 3.1 to 4.0 cm

11626 - lesion diameter over 4.0 cm

11719 - Trimming of nondystrophic nails, any number

11720 - Debridement of nail(s) by any method(s); one to five

11721 - six or more

11730 - Avulsion of nail plate, partial or complete, simple; single

11731 - second nail plate

11732 - each additional nail plate

11750 -Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail) for permanent removal;

11752 - with amputation of tuft of distal phalanx

11755 - Biopsy of nail unit, any method (eg, plate , bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

11760 - Repair of nail bed

11762 - Reconstruction of nail bed with graft

11765 - Wedge resection of skin of nail fold (eg, for ingrown toenail)

11900 - Injection, intralesional: up to and including seven lesions

11901 - more than seven lesions

12001 -Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

12002 - 2.6 cm to 7.5 cm

12004 - 7.6 cm to 12.5 cm

12005 - 12.6 cm to 20.0 cm

12006 - 20.1 cm to 30.0 cm

12007 - over 30.0 cm

12020 - Treatment of superficial wound dehiscence; simple closure

12021 - with packing

12041 - Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less

12042 - 2.6 cm to 7.5 cm

12044 - 7.6 cm to 12.5 cm

12045 - 12.6 cm to 20.0 cm

12046 - 20.1 cm to 30.0 cm

12047 - over 30.0 cm

13131 - Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet;

1.1 cm to 2.5 cm

13132 - 2.6 cm to 7.5 cm

13160 - Secondary closure of surgical wound or dehiscence, extensive or complicated

13300 - Repair, unusal, complicated, over 7.5 cm, any area

14040 - Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq. cm or less

14041 - defect 10.1 sq. cm to 30 sq. cm

14300 - Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or

complicated, any area

14350 - Filleted finger or toe flap, including preparation of recipient site

15000 -Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as a separate service in addition to the skin graft)

15050 - Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter

15100 - Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); 100 sq. cm or less, or each one percent of body area of infants and children (except 15050)

15120 - Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; 100 sq cm or less, or each one percent of body area of infants and children (except 15050)

15240 - Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq. cm or less

15241 - each additional 20 sq cm

15350 - Application of allograft, skin

15400 - Application of xenograft, skin

15574 -Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet

15620 - Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands (except 15625), or feet

15738 - Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

15740 - Flap; island pedicle

15750 - neurovascular pedicle

15770 - Graft; derma-fat-fascia

15839 - Excision, excessive skin and subcutaneous tissue (including lipectomy); other area

15850 - Removal of sutures under anesthesia (other than local), same surgeon

15851 - Removal of sutures under anesthesia (other than local), other surgeon

15852 - Dressing change (for other than burns) under anesthesia (other than local)

16000 - Initial treatment, first degree burn, when no more than local treatment is required

16010 - Dressings and/or debridement, initial or subsequent; under anesthesia, small

16015 - under anesthesia, medium or large, or with major debridement

16020 - without anesthesia, office or hospital, small

16025 - without anesthesia, medium (eg, whole face or whole extremity)

16030 - without anesthesia, large (eg, more than one extremity)

17000 - Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion

17003 - second through 14 lesions, each

17004 - 15 or more lesions

17110 - Destruction by any method of flat warts, molluscum contagiosum, or milia; up to 14 lesions

17111 - 15 or more lesions

17250 - Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)

17270 - Destruction, malignant lesion, any method, scalp, neck, hands, feet, genitalia; lesion diameter

0.5 cm or less

17271 - lesion diameter 0.6 to 1.0 cm

17272 - lesion diameter 1.1 to 2.0 cm

17273 - lesion diameter 2.1 to 3.0 cm

17274 - lesion diameter 3.1 to 4.0 cm

17276 - lesion diameter over 4.0 cm

20000 - Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial

20005 - deep or complicated

20200 - Biopsy, muscle; superficial

20205 - deep

20206 - Biopsy, muscle, percutaneous needle

20520 - Removal of foreign body in muscle or tendon sheath; simple

20525 - deep or complicated

20550 - Injection, tendon sheath, ligament, trigger points or ganglion cyst

20600 - Arthrocentesis, aspiration, and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)

20605 - intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

20615 - Aspiration and injection for treatment of bone cyst

20650 -Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)

20670 - Removal of implant; superficial (eg, buried wire, pin, or rod)

20680 - deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

20690 - Application of a uniplane (pins or wires in one plane), unilateral, external fixation system

20900 - Bone graft, any donor area; minor or small (eg, dowel or button)

20922 - Fascia lata graft; by incision and area exposure, complex or sheet

20924 - Tendon graft, from a distance (eg, palmiris, toe extensor, plantaris)

20926 - Tissue grafts, other (eg, paraton, fat, dermis)

20950 -Monitoring of interstitial fluid pressure (includes insertion of device, eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome

20962 - Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal

20972 - Free osteocutaneous flap with microvascular anastomosis; metatarsal

20973 - great toe with web space

20974 - Electrical stimulation to aid bone healing; noninvasive (nonoperative)

27602 - Decompression fasciotomy, leg; anterior and/or lateral, and posteior compartment(s)

27603 - Incision and drainage, leg or ankle, deep abscess or hematoma

27604 - infected bursa

27605 - Tenotomy, Achilles tendon, subcutaneous; local anesthesia

27606 - general anesthesia

27607 - Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), leg or ankle

27610 - Arthrotomy, ankle, for infection, with exploration, drainage or removal of foreign body

27612 - Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening

27613 - Biopsy, soft tissue of leg or ankle area; superficial

27614 - deep

27615 - Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area

27618 - Excision, tumor, leg or ankle area; subcutaneous

27619 - deep, subfascial or intramuscular

27620 - Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body

27625 - Arthrotomy, ankle, with synovectomy

27640 - Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or exostosis); tibia

27641 - fibula

27645 - Radical resection of tumor, bone; tibia

27647 - Radical resection of tumor, talus or calcaneus

27650 - Repair, primary, open or percutaneous, ruptured Achilles tendon;

27652 - with graft (including obtaining graft)

27654 - Repair, secondary, ruptured Achilles tendon, with or without graft

27658 - Repair or suture of flexor tendon of leg; primary, without graft, single, each

27659 - secondary with or without graft, single tendon, each

27664 - Repair or suture of extensor tendon of leg; primary, without graft, single, each

27665 - secondary with or without graft, single tendon, each **27675** - Repair for dislocating peroneal tendons; without fibular osteotomy **27676** - with fibular osteotomy

27680 - Tenolysis, including tibia, fibula, and ankle flexor; single

27681 - multiple (through same incision), each

27685 - Lengthening or shortening of tendon, leg or ankle; single (separate procedure)

27686 - Multiple (through same incision), each

27690 - Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)

27691 - deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallicus longus, or peroneal tendon to midfoot or hindfoot)

28001 - Incision and drainage, infected bursa, foot

28002 -Deep dissection below fascia, for deep infection of foot, with or without tendon sheath involvement; single bursal space, specify

28003 - multiple areas.

28005 - Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), foot

28008 - Fasciotomy, foot and/or toe

28010 - Tenotomy, subcutaneous, toe; single

28011 - multiple

28020 -Arthrotomy, with exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint

28022 - metatarsophalangeal joint

28024 - interphalangeal joint

28030 - Neurectomy of intrinsic musculature of foot

28035 - Tarsal tunnel release (posterior tibial nerve decompression)

28043 - Excision, tumor, foot; subcutaneous

28045 - deep, subfascial, intramuscular

28046 - Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot

28050 - Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint

28052 - metatarsophalangeal joint

28054 - interphalangeal joint

28060 - Fasciectomy, excision of plantar fascia, partial (separate procedure)

28062 - radical (separate procedure)

28070 - Synovectomy; intertarsal or tarsometatarsal joint, each

28072 - metatarsophalangeal joint, each

28080 - Excision of interdigital (Morton) neuroma, single, each

28086 - Synovectomy, tendon sheath, foot; flexor

28088 - extensor

28090 - Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot

28092 - toes

28100 - Excision or curettage of bone cyst or benign tumor, talus or calcaneus

28103 - with allograft

28104 - Excision or curettage or bone cyst of benign tumor, tarsal or metatarsal bones, except talus or calcaneus

28107 - with allograft

28108 - Excision or curettage of bone cyst or benign tumor, phalanges of foot

28110 - Ostectomy, partial excision, fifth metatarsal head (bunionette)

28111 - Ostectomy; complete excision; first metatarsal head

28112 - other metatarsal head (second, third, or fourth)

28113 - fifth metatarsal head

28114 - all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)

28116 - Ostectomy, excision of tarsal coalition

28118 - Ostectomy, calcaneus

28119 - for spur, with or without plantar fascial release

28120 - Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), talus or calcaneus

28122 - Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), tarsal or metatarsal bone, except talus or calcaneus

28124 - Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or dorsal bossing) phalanx of toe

28126 - Resection, partial or complete, phalangeal base, single toe, each

28130 - Talectomy (astragalectomy)

28140 - Metatarsectomy

28150 - Phalangectomy of toe, single, each

28153 - Resection, head of phalanx, toe

28160 - Hemiphalangectomy or interphalangeal joint excision, toe, single, each

28171 - Radical resection of tumor, bone; tarsal (except talus or calcaneus)

28173 - metatarsal

28175 - phalanx of toe

28190 - Removal of foreign body, foot; subcutaneous

28192 - deep

28193 - complicated

28200 - Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon

28202 - secondary with free graft, each tendon (includes obtaining graft)

28208 - Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon

28210 - secondary with free graft, each tendon (includes obtaining graft)

28220 - Tenolysis, flexor, foot; single

28222 - multiple (through same incision)

28225 - Tenolysis, extensor, foot; single

28226 - multiple (through same incision)

28230 - Tenotomy, open, flexor; foot, single or multiple (separate procedure)

28232 - toe, single (separate procedure)

28234 - Tenotomy, open, extensor, foot or toe

28238 - Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure)

28240 - Tenotomy, lengthening, or release, abductor hallucis muscle

28250 - Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)

28260 - Capsulotomy, midfoot; medial release only (separate procedure)

28261 - with tendon lengthening

28262 - extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity

28264 - Capsulotomy, midtarsal (Heyman type procedure)

28270 - Capsulotomy, for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint

28272 - interphalangeal joint, single, each joint

28280 - Webbing operation (create syndactylism of toes) for soft corn (Kelikian type procedure)

28285 - Hammertoe operation; one toe (eg, interphalangeal fusion, filleting, phalangectomy)

28286 - cock-up fifth toe with plastic skin closure (Ruiz-Mora type procedure)

28288 - Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, first through fifth, each metatarsal head

28290 - Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)

28292 - Keller, McBride, or Mayo type procedure

28293 - resection of joint with implant

28294 - with tendon transplants (Joplin type procedure)

28296 - with metatarsal osteotomy (eg, Mitchell, Chevron or concentric procedures)

28297 - Lapidus type procedure

28298 - by phalanx osteotomy

28299 - by other methods (eg, double osteotomy)

28300 - Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation

28302 - talus

28304 - Osteotomy, midtarsal bones, other than calcaneus or talus

28305 - with autograft (includes obtaining graft) (Fowler type)

28306 -Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; first metatarsal

28307 - first metatarsal with autograft

28308 - other than first metatarsal

28309 - Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)

28310 - Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

28312 - other phalanges, any toe

28213 -Reconstruction, angular deformity of toe (overlapping second toe, fifth toe, curly toes), soft tissue procedures only

28315 - Sesamoidectomy, first toe

28320 - Repair of nonunion or malunion; tarsal bones (eg, calcaneus, talus)

28322 - metatarsal, with or without bone graft (includes obtaining graft)

28340 - Reconstruction, toe, macrodactyly; soft tissue resection

28341 - requiring bone resection

28344 - Reconstruction, toe(s); polydactyl

28360 - Reconstruction, cleft foot

28400 - Closed treatment of calcaneal fracture; without manipulation

28405 - with manipulation

28406 - Percutaneous skeletal fixation of calcaneal fracture; with manipulation

28415 - Open treatment of calcaneal fracture; with or without internal or external fixation

28420 - with primary iliac or other autogenous bone graft (includes obtaining graft)

28430 - Closed treatment of talus fracture; without manipulation

28435 - with manipulation

28436 - Percutaneous skeletal fixation of talus fracture, with manipulation

28445 - Open treatment of talus fracture, with or without internal or external fixation

28450 - Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each

28455 - with manipulation, each

28456 -Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus); with manipulation, each

28465 - Open treatment of tarsal bone fracture (except talus and calcaneus); with or without internal or external skeletal fixation, each

28470 - Closed treatment of metatarsal fracture; without manipulation, each

28475 - with manipulation, each

28476 - Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each

28485 - Open treatment of metatarsal fracture; with or without internal or external fixation, each

28490 - Closed treatment of fracture great toe, phalanx or phalanges; without manipulation

28495 - with manipulation

28496 - Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation

28505 - Open treatment of fracture great toe, phalanx or phalanges; with or without internal or external fixation

28510 - Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each

28515 - with manipulation, each

28525 - Open treatment of fracture, phalanx or phalanges, other than great toe; with or without internal or external fixation, each

28540 - Closed treatment of tarsal bone dislocation; other than talotarsal, without anesthesia

28545 - requiring anesthesia

28546 - Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation

28555 - Open treatment of tarsal bone dislocation, with or without internal or external fixation

28570 - Closed treatment of talotarsal joint dislocation; without anesthesia

28575 - requiring anesthesia

28576 - Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation

28585 - Open treatment of talotarsal joint dislocation, with or without internal or external fixation

28600 - Closed treatment of tarsometatarsal joint dislocation; without anesthesia

28605 - requiring anesthesia

28606 - Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation

28615 - Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation

28630 - Closed treatment of metatarsophalangeal joint dislocation; without anesthesia

28635 - requiring anesthesia

28636 - Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation

28645 -Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation

28660 - Closed treatment of interphalangeal joint dislocation; without anesthesia

28665 - requiring anesthesia

28666 - Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation

28675 - Open treatment of interphalangeal joint dislocation, with or without internal or external fixation

28705 - Pantalar arthrodesis **28715** - Triple arthrodesis **28725** - Subtalar arthrodesis

28730 - Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;

28735 - with osteotomy as for flatfoot correction

28737 - Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure)

28740 - Arthrodesis, midtarsal or tarsometatarsal, single joint **28750** - Arthrodesis, great toe; metatarsophalangeal joint **28755** - interphalangeal joint

28760 -Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

28820 - Amputation, toe; metatarsophalangeal joint

28825 - interphalangeal joint

28899 - Unlisted procedure, foot or toes (requires description of medical necessity)

The listed procedures apply when the cast application or strapping is a replacement procedure used during or after the period of follow-up care. Additional visits are reportable only if significant identifiable further services are provided at the time of the cast application or strapping.

If cast application or strapping is provided as an initial procedure in which no surgery is performed (eg, casting of a sprained ankle or knee), use the appropriate office evaluation and management code in addition to 99070 for supplies.

Listed procedures include removal of cast or strapping.

29345 - Application of long leg cast (thigh to toes);

29355 - walker or ambulatory type

29405 - Application of short leg cast (below knee to toes);

29425 - walking or ambulatory type

29435 - Application of patellar tendon bearing (PTB) cast

29440 - Adding walker to previously applied cast

29450 - Application of clubfoot cast with molding or manipulation, long or short leg

29505 - Application of long leg splint (thigh to ankle to toes)

29515 - Application of short leg splint (calf to foot)

29540 - Strapping; ankle

29550 - toes

29580 - Unna boot

29590 - Denis-Browne splint strapping

Codes for cast removals should be employed only for casts applied by another provider

29705 - Removal or bivalving; full arm or full leg cast

29730 - Windowing of cast

29740 - Wedging of cast (except clubfoot casts)
29750 - Wedging of clubfoot cast
Endoscopy/Arthroscopy

29894 - Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body

29895 - synovectomy, partial
29897 - debridement, limited
29898 - debridement, extensive

29909 - Unlisted procedure, arthroscopy (requires description of medical necessity)

Other Procedure(s):

64450 - Injection, anesthesic agent; other peripheral nerve or branch **64640** - Destruction by neurolytic agent; other peripheral nerve or branch **64787** - Implantation of nerve end into bone or muscle

64830 - Microdissection and/or microrepair of nerve **64831** - Suture of digital nerve, hand or foot; one nerve **64832** - each additional digital nerve

64834 - Suture of one nerve, hand or foot; common sensory nerve

64840 - Suture of posterior tibial nerve

93922 - Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral

93923 - Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study

93965 -Non-invasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phlebortheography, impedance plethysmography)

Radiology Procedures

73600 - Radiologic examination, ankle; anteroposterior and lateral views

73610 - complete, minimum of three views

73615 - Radiologic examination, ankle, arthrography, radiological supervision and interpretation

73620 - Radiologic examination, foot; anteroposterior and lateral views

73630 - complete, minimum of three views

73650 - Radiologic examination; calcaneus, minimum of two views

73660 - toe(s), minimum of two views

Laboratory Procedures

80049 - Basic metabolic panel. This panel must include the following: Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (845201)

80050 -General health panel. This panel must include the following: Comprehensive metabolic panel (80054). Hemogram, automated, and manual differential WBC count (CBC) (85022) OR Hemogram and platelet count, automated, and automated complete differential WBC count (CBC) (85025) Thyroid stimulating hormone (TSH) (84443)

80051 -Electrolyte panel. This panel must include the following: Carbon dioxide (82374) Chloride (82435) Potassium (84132) Sodium (84295)

80054 -Comprehensive metabolic panel. This panel must include the following: Albumin (82040) Bilirubin, Total OR direct (82250) Calcium (82310) Chloride (82435) Creatinine (82565)

Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, aspartate amino (AST) (SGOT) (84450) Urea Nitrogen (BUN) (84520)

80072 -Arthritis panel. This panel must include the following: Uric acid, blood, chemical (84550) Sedimentation rate, erythrocyte, non-automated (85651) Fluorescent antibody, screen, each antibody (86255) Rheumatoid factor, qualitative (86430)

81000 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of constituents; with microscopy

81002 - non-automated, without microscopy

82310 - Calcium; total

82435 - Chloride; blood

82465 - Cholesterol, serum, total

82540 - Creatine

82565 - Creatinine; blood

82947 - Glucose; quantitative

82948 - blood, reagent strip

84075 - Phosphatase, alkaline

84100 - Phosphorus inorganic (phosphate)

84132 - Potassium; serum

84155 - Protein; total, except refractometry

84295 - Sodium; serum

84450 - Transferase; aspartate amino (AST)(SGOT)

84460 - alanine amino (ALT)(SGPT)

84478 - Triglycerides

84525 - Urea nitrogen; semiquantitative (eg, reagent strip test)

84550 - Uric acid; blood

85002 - Bleeding time

85007 -Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)

85009 - differential WBC count, buffy coat

85014 - other than spun hematocrit

85018 - hemoglobin

85021 - hemogram, automated (RBC, WBC, Hgb, Hct and indices only)

85022 - hemogram, automated, and manual differential WBC count (CBC)

85031 -Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)

85041 - red blood cell (RBC) only

85044 - reticulocyte count, manual

85048 - white blood cell (WBC)

85610 - Prothrombin time

85651 - Sedimentation rate, erythrocyte, non-automated

85730 - Thromboplastin time, partial, (PTT); plasma or whole blood

86060 - Antistreptolysis 0; titer

86063 - screen

86215 - Deoxyribonuclease, antibody

87040 - Culture, bacterial, definitive; blood (includes anaerobic screen)

87075 - Culture, bacterial, any source; anaerobic (isolation)

87081 - Culture, bacterial, screening only, for single organisms

87101 - Culture, fungi, isolation (with or without presumptive identification); skin

87184 - Sensitivity studies, antibiotic disk method, per plate (12 or fewer disks)

87205 - Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types

87210 - Smear, primary source with interpretation; wet mount with simple stain, for bacteria, fungi, ova and/or parasites